

**AMENDMENT IN THE NATURE OF A SUBSTITUTE
TO H.R. 2089
OFFERED BY MR. BOEHNER**

Strike all after the enacting clause and insert the following:

1 SECTION 1. SHORT TITLE.

2 This Act may be cited as the “Group Health Plan
3 Review Standards Act of 1999”.

4 SEC. 2. SPECIAL RULES FOR GROUP HEALTH PLANS.

5 (a) IN GENERAL.—Section 503 of the Employee Re-
6 tirement Income Security Act of 1974 (29 U.S.C. 1133)
7 is amended—

8 (1) by inserting “(a) IN GENERAL.—” after
9 “SEC. 503.”;

10 (2) by inserting “(other than a group health
11 plan)” after “employee benefit plan”; and

12 (3) by adding at the end the following new sub-
13 section:

14 “(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

15 “(1) COVERAGE DETERMINATIONS.—Every
16 group health plan shall—

17 “(A) provide adequate notice in writing in
18 accordance with this subsection to any partici-
19 pant or beneficiary of any adverse coverage de-

1 cision with respect to benefits of such partici-
2 pant or beneficiary under the plan, setting forth
3 the specific reasons for such coverage decision
4 and any rights of review provided under the
5 plan, written in a manner calculated to be un-
6 derstood by the average participant;

7 “(B) provide such notice in writing also to
8 any treating medical care provider of such par-
9 ticipant or beneficiary, if such provider has
10 claimed reimbursement for any item or service
11 involved in such coverage decision, or if a claim
12 submitted by the provider initiated the proceed-
13 ings leading to such decision;

14 “(C) afford a reasonable opportunity to
15 any participant or beneficiary who is in receipt
16 of the notice of such adverse coverage decision,
17 and who files a written request for review of the
18 initial coverage decision within 90 days after re-
19 ceipt of the notice of the initial decision, for a
20 full and fair review of the decision by an appro-
21 priate named fiduciary who did not make the
22 initial decision; and

23 “(D) meet the additional requirements of
24 this subsection.

1 “(2) TIME LIMITS FOR MAKING INITIAL COV-
2 ERAGE DECISIONS FOR BENEFITS AND COMPLETING
3 INTERNAL APPEALS.—

4 “(A) TIME LIMITS FOR DECIDING RE-
5 QUESTS FOR BENEFIT PAYMENTS, REQUESTS
6 FOR ADVANCE DETERMINATION OF COVERAGE,
7 AND REQUESTS FOR REQUIRED DETERMINA-
8 TION OF MEDICAL NECESSITY.—Except as pro-
9 vided in subparagraph (B)—

10 “(i) INITIAL DECISIONS.—If a request
11 for benefit payments, a request for advance
12 determination of coverage, or a request for
13 required determination of medical necessity
14 is submitted to a group health plan in such
15 reasonable form as may be required under
16 the plan, the plan shall issue in writing an
17 initial coverage decision on the request be-
18 fore the end of the initial decision period
19 under paragraph (10)(I) following the fil-
20 ing completion date. Failure to issue a cov-
21 erage decision on such a request before the
22 end of the period required under this
23 clause shall be treated as an adverse cov-
24 erage decision for purposes of internal re-
25 view under clause (ii).

1 “(ii) INTERNAL REVIEWS OF INITIAL
2 DENIALS.—Upon the written request of a
3 participant or beneficiary for review of an
4 initial adverse coverage decision under
5 clause (i), a review by an appropriate
6 named fiduciary (subject to paragraph (3))
7 of the initial coverage decision shall be
8 completed, including issuance by the plan
9 of a written decision affirming, reversing,
10 or modifying the initial coverage decision,
11 setting forth the grounds for such decision,
12 before the end of the internal review period
13 following the review filing date. Such deci-
14 sion shall be treated as the final decision
15 of the plan, subject to any applicable re-
16 consideration under paragraph (4). Failure
17 to issue before the end of such period such
18 a written decision requested under this
19 clause shall be treated as a final decision
20 affirming the initial coverage decision.

21 “(B) TIME LIMITS FOR MAKING COVERAGE
22 DECISIONS RELATING TO ACCELERATED NEED
23 MEDICAL CARE AND FOR COMPLETING INTER-
24 NAL APPEALS.—

1 “(i) INITIAL DECISIONS.—A group
2 health plan shall issue in writing an initial
3 coverage decision on any request for expedited
4 advance determination of coverage or
5 for expedited required determination of
6 medical necessity submitted, in such reasonable
7 form as may be required under the
8 plan before the end of the accelerated need
9 decision period under paragraph (10)(K),
10 in cases involving accelerated need medical
11 care, following the filing completion date.
12 Failure to approve or deny such a request
13 before the end of the applicable decision
14 period shall be treated as a denial of the
15 request for purposes of internal review
16 under clause (ii).

17 “(ii) INTERNAL REVIEWS OF INITIAL
18 DENIALS.—Upon the written request of a
19 participant or beneficiary for review of an
20 initial adverse coverage decision under
21 clause (i), a review by an appropriate
22 named fiduciary (subject to paragraph (3))
23 of the initial coverage decision shall be
24 completed, including issuance by the plan
25 of a written decision affirming, reversing,

1 or modifying the initial converge decision,
2 setting forth the grounds for the decision
3 before the end of the accelerated need deci-
4 sion period under paragraph (10)(K) fol-
5 lowing the review filing date. Such decision
6 shall be treated as the final decision of the
7 plan, subject to any applicable reconsider-
8 ation under paragraph (4). Failure to issue
9 before the end of the applicable decision
10 period such a written decision requested
11 under this clause shall be treated as a final
12 decision affirming the initial coverage deci-
13 sion.

14 “(3) PHYSICIANS MUST REVIEW INITIAL COV-
15 ERAGE DECISIONS INVOLVING MEDICAL APPRO-
16 PRIATENESS OR NECESSITY OR INVESTIGATIONAL
17 ITEMS OR EXPERIMENTAL TREATMENT.—If an ini-
18 tial coverage decision under paragraph (2)(A)(i) or
19 (2)(B)(i) is based on a determination that provision
20 of a particular item or service is excluded from cov-
21 erage under the terms of the plan because the provi-
22 sion of such item or service does not meet the plan’s
23 requirements for medical appropriateness or neces-
24 sity or would constitute provision of investigational
25 items or experimental treatment or technology, the

1 review under paragraph (2)(A)(ii) or (2)(B)(ii), to
2 the extent that it relates to medical appropriateness
3 or necessity or to investigational items or experi-
4 mental treatment or technology, shall be conducted
5 by a physician who is selected by the plan and who
6 did not make the initial denial.

7 “(4) ELECTIVE EXTERNAL REVIEW BY INDE-
8 PENDENT MEDICAL EXPERT AND RECONSIDERATION
9 OF INITIAL REVIEW DECISION.—

10 “(A) IN GENERAL.—In any case in which
11 a participant or beneficiary, who has received
12 an adverse coverage decision which is not re-
13 versed upon review conducted pursuant to para-
14 graph (1)(C) (including review under paragraph
15 (2)(A)(ii) or (2)(B)(ii)) and who has not com-
16 menced review of the coverage decision under
17 section 502, makes a request in writing, within
18 30 days after the date of such review decision,
19 for reconsideration of such review decision, the
20 requirements of subparagraphs (B), (C), (D)
21 and (E) shall apply in the case of such adverse
22 coverage decision, if the requirements of clause
23 (i), (ii), or (iii) are met.

24 “(i) MEDICAL APPROPRIATENESS OR
25 INVESTIGATIONAL ITEM OR EXPERI-

1 MENTAL TREATMENT OR TECHNOLOGY.—
2 The requirements of this clause are met if
3 such coverage decision is based on a deter-
4 mination that provision of a particular
5 item or service that would otherwise be
6 covered under the terms of the plan is ex-
7 cluded from coverage under the terms of
8 the plan because the provision of such item
9 or service—

10 “(I) does not meet the plan’s re-
11 quirements for medical appropriate-
12 ness or necessity; or

13 “(II) would constitute provision
14 of an investigational item or experi-
15 mental treatment or technology.

16 “(ii) CATEGORICAL EXCLUSION OF
17 ITEM OR SERVICE REQUIRING EVALUATION
18 OF MEDICAL FACTS OR EVIDENCE.—The
19 requirements of this clause are met if—

20 “(I) such coverage decision is
21 based on a determination that a par-
22 ticular item or service is not covered
23 under the terms of the plan because
24 provision of such item or service is

1 categorically excluded from coverage
2 under the terms of the plan, and

3 “(II) an independent contract ex-
4 pert finds under subparagraph (C), in
5 advance of any review of the decision
6 under subparagraph (D), that such
7 determination primarily requires the
8 evaluation of medical facts or medical
9 evidence by a health professional.

10 “(iii) SPECIFIC EXCLUSION OF ITEM
11 OR SERVICE REQUIRING EVALUATION OF
12 MEDICAL FACTS OR EVIDENCE.—The re-
13 quirements of this clause are met if—

14 “(I) such coverage decision is
15 based on a determination that a par-
16 ticular item or service is not covered
17 under the terms of the plan because
18 provision of such item or service is
19 specifically excluded from coverage
20 under the terms of the plan, and

21 “(II) an independent contract ex-
22 pert finds under subparagraph (C), in
23 advance of any review of the decision
24 under subparagraph (D), that such
25 determination primarily requires the

1 evaluation of medical facts or medical
2 evidence by a health professional.

3 “(iv) MATTERS SPECIFICALLY NOT
4 SUBJECT TO REVIEW.—The requirements
5 of subparagraphs (B), (C), (D), and (E)
6 shall not apply in the case of any adverse
7 coverage decision if such decision is based
8 on—

9 “(I) a determination of eligibility
10 for benefits,

11 “(II) the application of explicit
12 plan limits on the number, cost, or
13 duration of any benefit, or

14 “(III) a limitation on the amount
15 of any benefit payment or a require-
16 ment to make copayments under the
17 terms of the plan.

18 Review under this paragraph shall not be avail-
19 able for any coverage decision that has pre-
20 viously undergone review under this paragraph.

21 “(B) LIMITS ON ALLOWABLE ADVANCE
22 PAYMENTS.—The review under this paragraph
23 in connection with an adverse coverage decision
24 shall be available subject to any requirement of
25 the plan (unless waived by the plan for financial

1 or other reasons) for payment in advance to the
2 plan by the participant or beneficiary seeking
3 review of an amount not to exceed the greater
4 of (i) the lesser of \$100 or 10 percent of the
5 cost of the medical care involved in the decision,
6 or (ii) \$25, with such dollar amount subject to
7 compounded annual adjustments in the same
8 manner and to the same extent as apply under
9 section 215(i) of the Social Security Act, except
10 that, for any calendar year, such amount as so
11 adjusted shall be deemed, solely for such cal-
12 endar year, to be equal to such amount rounded
13 to the nearest \$10. No such payment may be
14 required in the case of any participant or bene-
15 ficiary whose enrollment under the plan is paid
16 for, in whole or in part, under a State plan
17 under title XIX or XXI of the Social Security
18 Act. Any such advance payment shall be subject
19 to reimbursement if the recommendation of the
20 independent medical expert or experts under
21 subparagraph (D)(iii) is to reverse or modify
22 the coverage decision.

23 “(C) REQUEST TO INDEPENDENT CON-
24 TRACT EXPERTS FOR DETERMINATION OF
25 WHETHER COVERAGE DECISION REQUIRED

1 EVALUATION OF MEDICAL FACTS OR EVI-
2 DENCE.—

3 “(i) IN GENERAL.—In the case of a
4 request for review made by a participant or
5 beneficiary as described in subparagraph
6 (A), if the requirements of clause (ii) or
7 (iii) of subparagraph (A) are met (and re-
8 view is not otherwise precluded under sub-
9 subparagraph (A)(iv)), the terms of the plan
10 shall provide for a procedure for initial re-
11 view by an independent contract expert se-
12 lected by the plan under which the expert
13 will determine whether the coverage deci-
14 sion requires the evaluation of medical
15 facts or evidence by a health professional.
16 If the expert determines that the coverage
17 decision requires such evaluation, reconsid-
18 eration of such adverse decision shall pro-
19 ceed under this paragraph. If the expert
20 determines that the coverage decision does
21 not require such evaluation, the adverse
22 decision shall remain the final decision of
23 the plan.

24 “(ii) INDEPENDENT CONTRACT EX-
25 PERTS.—For purposes of this subpara-

1 graph, the term ‘independent contract ex-
2 pert’ means a professional—

3 “(I) who has appropriate creden-
4 tials and has attained recognized ex-
5 pertise in the applicable area of con-
6 tract interpretation;

7 “(II) who was not involved in the
8 initial decision or any earlier review
9 thereof; and

10 “(III) who is selected in accord-
11 ance with subparagraph (G)(i) and
12 meets the requirements of subpara-
13 graph (G)(ii).

14 “(D) RECONSIDERATION OF INITIAL RE-
15 VIEW DECISION.—

16 “(i) IN GENERAL.—In the case of a
17 request for review made by a participant or
18 beneficiary as described in subparagraph
19 (A), if the requirements of subparagraph
20 (A)(i) are met or reconsideration proceeds
21 under this paragraph pursuant to subpara-
22 graph (C), the terms of the plan shall pro-
23 vide for a procedure for such reconsider-
24 ation in accordance with clause (ii).

1 “(ii) PROCEDURE FOR RECONSIDER-
2 ATION.—The procedure required under
3 clause (i) shall include the following—

4 “(I) One or more independent
5 medical experts will be selected in ac-
6 cordance with subparagraph (F) to re-
7 consider any coverage decision de-
8 scribed in subparagraph (A) to deter-
9 mine whether such decision was in ac-
10 cordance with the terms of the plan
11 and this title.

12 “(II) The record for review (in-
13 cluding a specification of the terms of
14 the plan and other criteria serving as
15 the basis for the initial review deci-
16 sion) will be presented to such expert
17 or experts and maintained in a man-
18 ner which will ensure confidentiality
19 of such record.

20 “(III) Such expert or experts will
21 reconsider the initial review decision
22 to determine whether such decision
23 was in accordance with the terms of
24 the plan and this title. Such reconsid-
25 eration shall include the initial deci-

1 sion of the plan, the medical condition
2 of the patient, and the recommenda-
3 tions of the treating physician. The
4 experts shall take into account in the
5 course of such reconsideration any
6 guidelines adopted by the plan
7 through a process involving medical
8 practitioners and peer-reviewed medi-
9 cal literature identified as such under
10 criteria established by the Food and
11 Drug Administration.

12 “(IV) Such expert or experts will
13 issue a written decision affirming,
14 modifying, or reversing the initial re-
15 view decision, setting forth the
16 grounds for the decision.

17 “(E) TIME LIMITS FOR RECONSIDER-
18 ATION.—Any review under this paragraph (in-
19 cluding any review under subparagraph (C))
20 shall be completed before the end of the recon-
21 sideration period (as defined in paragraph
22 (10)(L)) following the review filing date in con-
23 nection with such review. The decision under
24 this paragraph affirming, reversing, or modify-
25 ing the initial review decision of the plan shall

1 be the final decision of the plan. Failure to
2 issue a written decision before the end of the
3 reconsideration period in any reconsideration
4 requested under this paragraph shall be treated
5 as a final decision affirming the initial review
6 decision of the plan.

7 “(F) INDEPENDENT MEDICAL EXPERTS.—

8 “(i) IN GENERAL.—For purposes of
9 this paragraph, the term ‘independent
10 medical expert’ means, in connection with
11 any coverage decision by a group health
12 plan, a professional—

13 “(I) who is a physician or, if ap-
14 propriate, another medical profes-
15 sional;

16 “(II) who has appropriate cre-
17 dentials and has attained recognized
18 expertise in the applicable medical
19 field;

20 “(III) who was not involved in
21 the initial decision or any earlier re-
22 view thereof;

23 “(IV) who has not history of dis-
24 ciplinary action or sanctions (includ-
25 ing, but not limited to, loss of staff

1 privileges or participation restriction)
2 taken or pending by any hospital,
3 health carrier, government, or regu-
4 latory body; and

5 “(V) who is selected in accord-
6 ance with subparagraph (G)(i) and
7 meets the requirements of subpara-
8 graph (G)(ii).

9 “(G) SELECTION OF EXPERTS.—

10 “(i) IN GENERAL.—An independent
11 contract expert or independent medical ex-
12 pert is selected in accordance with this
13 clause if—

14 “(I) the expert is selected by an
15 intermediary which itself meets the re-
16 quirements of clause (ii), by means of
17 a method which ensures that the iden-
18 tity of the expert is not disclosed to
19 the plan, any health insurance issuer
20 offering health insurance coverage to
21 the aggrieved participant or bene-
22 ficiary in connection with the plan,
23 and the aggrieved participant or bene-
24 ficiary under the plan, and the identi-
25 ties of the plan, the issuer, and the

1 aggrieved participant or beneficiary
2 are not disclosed to the expert; or

3 “(II) the expert is selected, by an
4 intermediary or otherwise, in a man-
5 ner that is, under regulations issued
6 pursuant to negotiated rulemaking,
7 sufficient to ensure the expert’s inde-
8 pendence, including selection by the
9 plan in cases where it is determined
10 that a suitable intermediary is not
11 reasonably available,

12 and the method of selection is devised to
13 reasonably ensure that the expert selected
14 meets the independence requirements of
15 clause (ii).

16 “(ii) INDEPENDENCE REQUIRE-
17 MENTS.—An independent contract expert
18 or independent medical expert or another
19 entity described in clause (i) meets the
20 independence requirements of this clause
21 if—

22 “(I) the expert or entity is not
23 affiliated with any related party;

24 “(II) any compensation received
25 by such expert or entity in connection

1 with the external review is reasonable
2 and not contingent on any decision
3 rendered by the expert or entity;

4 “(III) under the terms of the
5 plan and any health insurance cov-
6 erage offered in connection with the
7 plan, the plan and the issuer (if any)
8 have no recourse against the expert or
9 entity in connection with the external
10 review; and

11 “(IV) the expert or entity does
12 not otherwise have a conflict of inter-
13 est with a related party as determined
14 under any regulations which the Sec-
15 retary may prescribe.

16 “(iii) RELATED PARTY.—For pur-
17 poses of clause (i)(I), the term ‘related
18 party’ means—

19 “(I) the plan or any health insur-
20 ance issuer offering health insurance
21 coverage in connection with the plan
22 (or any officer, director, or manage-
23 ment employee of such plan or issuer);

24 “(II) the physician or other medi-
25 cal care provider that provided the

1 medical care involved in the coverage
2 decision;

3 “(III) the institution at which
4 the medical care involved in the cov-
5 erage decision is provided;

6 “(IV) the manufacturer of any
7 drug or other item that was included
8 in the medical care involved in the
9 coverage decision; or

10 “(V) any other party determined
11 under any regulations which the Sec-
12 retary may prescribe to have a sub-
13 stantial interest in the coverage deci-
14 sion.

15 “(iv) AFFILIATED.—For purposes of
16 clause (ii)(I), the term ‘affiliated’ means,
17 in connection with any entity, having a fa-
18 milial, financial, or professional relation-
19 ship with, or interest in, such entity.

20 “(H) MISBEHAVIOR BY EXPERTS.—Any
21 action by the expert or experts in applying for
22 their selection under this paragraph or in the
23 course of carrying out their duties under this
24 paragraph which constitutes—

1 “(i) fraud or intentional misrepresenta-
2 tion by such expert or experts, or

3 “(ii) demonstrates failure to adhere to
4 the standards for selection set forth in sub-
5 paragraph (G)(ii),

6 shall be treated as a failure to meet the require-
7 ments of this paragraph and therefore as a
8 cause of action which may be brought by a fidu-
9 ciary under section 502(a)(3).

10 “(5) PERMITTED ALTERNATIVES TO REQUIRED
11 INTERNAL REVIEW.—

12 “(A) IN GENERAL.—In accordance with
13 such regulations (if any) as may be prescribed
14 by the Secretary for purposes of this paragraph,
15 in the case of any initial coverage decision for
16 benefits under paragraph (2)(A)(ii) or
17 (2)(B)(ii), a group health plan may provide an
18 alternative dispute resolution procedure meeting
19 the requirements of subparagraph (B) for use
20 in lieu of the procedures set forth under the
21 preceding provisions of this subsection relating
22 review of such decision. Such procedure may be
23 provided in one form for all participants and
24 beneficiaries or in a different form each group

1 of similarly situated participants and bene-
2 ficiaries.

3 “(B) REQUIREMENTS.—An alternative dis-
4 pute resolution procedure meets the require-
5 ments of this subparagraph, in connection with
6 any initial coverage decision, if—

7 “(i) such procedure is utilized solely—

8 “(I) accordance with the applica-
9 ble terms of a bona fide collective bar-
10 gaining agreement pursuant to which
11 the plan (or the applicable portion
12 thereof governed by the agreement) is
13 established or maintained, or

14 “(II) upon election by all parties
15 to such decision,

16 “(ii) the procedure incorporates time
17 limits not exceeding the time limits other-
18 wise applicable under paragraphs (2)(A)(ii)
19 and (2)(B)(ii);

20 “(iii) the procedure incorporates any
21 otherwise applicable requirement for review
22 by a physician under paragraph (3), unless
23 waived by the participant or beneficiary (in
24 a manner consistent with such regulations

1 as the Secretary may prescribe to ensure
2 equitable procedures); and

3 “(iv) the means of resolution of dis-
4 pute allow for adequate presentation by
5 each party of scientific and medical evi-
6 dence supporting the position of such
7 party.

8 “(C) WAIVERS.—In any case in which uti-
9 lization of the alternative dispute resolution
10 procedure is voluntarily elected by all parties in
11 connection with a coverage decision, the plan
12 may require or allow under such procedure (in
13 a manner consistent with such regulations as
14 the Secretary may prescribe to ensure equitable
15 procedures) any party to waive review of the
16 coverage decision under paragraph (3), to waive
17 further review of the coverage decision under
18 paragraph (4) or section 502, and to elect an
19 alternative means of external review (other than
20 review under paragraph (4)).

21 “(6) PERMITTED ALTERNATIVES TO REQUIRED
22 EXTERNAL REVIEW.—A group health plan shall not
23 be treated as failing to meet the requirements of this
24 subsection in connection with review of coverage de-
25 cisions under paragraph (4) if the aggrieved partici-

1 participant or beneficiary elects to utilize a procedure in
2 connection with such review which is made generally
3 available under the plan (in a manner consistent
4 with such regulations as the Secretary may prescribe
5 to ensure equitable procedures) under which—

6 “(A) the plan agrees in advance of the rec-
7 ommendations of the independent medical ex-
8 pert or experts under paragraph (4)(C)(iii) to
9 render a final decision in accordance with such
10 recommendations; and

11 “(B) the participant or beneficiary waives
12 in advance any right to review of the final deci-
13 sion under section 502.

14 “(7) REVIEW REQUIREMENTS.—In any review
15 of a decision issued under this subsection—

16 “(A) the record below shall be maintained
17 for purposes of review in accordance with
18 standards which shall be prescribed in regula-
19 tions of the Secretary designed to facilitate
20 such review, and

21 “(B) any decision upon review which modi-
22 fies or reverses a decision below shall specifi-
23 cally set forth a determination that the record
24 upon review is sufficient to rebut a presumption
25 in favor of the decision below.

1 “(8) COMPLIANCE WITH FIDUCIARY STAND-
2 ARDS.—The issuance of a decision under a plan
3 upon review in good faith compliance with the re-
4 quirements of this subsection shall not be treated as
5 a violation of part 4.

6 “(9) GROUP HEALTH PLAN DEFINED.—For
7 purposes of this section—

8 “(A) IN GENERAL.—The term ‘group
9 health plan’ shall have the meaning provided in
10 section 733(a).

11 “(B) TREATMENT OF PARTNERSHIPS.—
12 The provisions of paragraphs (1), (2), and (3)
13 of section 732(d) shall apply.

14 “(10) OTHER DEFINITIONS.—For purposes of
15 this subsection—

16 “(A) REQUEST FOR BENEFIT PAY-
17 MENTS.—The term ‘request for benefit pay-
18 ments’ means a request, for payment of benefits
19 by a group health plan for medical care, which
20 is made by, or (if expressly authorized) on be-
21 half of, a participant or beneficiary after such
22 medical care has been provided.

23 “(B) REQUIRED DETERMINATION OF MED-
24 ICAL NECESSITY.—The term ‘required deter-
25 mination of medical necessity’ means a deter-

1 mination required under a group health plan
2 solely that proposed medical care meets, under
3 the facts and circumstances at the time of the
4 determination, the plan's requirements for med-
5 ical appropriateness or necessity (which may be
6 subject to exceptions under the plan for fraud
7 or misrepresentation), irrespective of whether
8 the proposed medical care otherwise meets
9 other terms and conditions of coverage, but
10 only if such determination does not constitute
11 an advance determination of coverage (as de-
12 fined in subparagraph (C)).

13 “(C) ADVANCE DETERMINATION OF COV-
14 ERAGE.—The term ‘advance determination of
15 coverage’ means a determination under a group
16 health plan that proposed medical care meets,
17 under the facts and circumstances at the time
18 of the determination, the plan's terms and con-
19 ditions of coverage (which may be subject to ex-
20 ceptions under the plan for fraud or misrepre-
21 sentation).

22 “(D) REQUEST FOR ADVANCE DETERMINA-
23 TION OF COVERAGE.—The term ‘request for ad-
24 vance determination of coverage’ means a re-
25 quest for an advance determination of coverage

1 of medical care which is made by, or (if ex-
2 pressly authorized) on behalf of, a participant
3 or beneficiary before such medical care is pro-
4 vided.

5 “(E) REQUEST FOR EXPEDITED ADVANCE
6 DETERMINATION OF COVERAGE.—The term ‘re-
7 quest for expedited advance determination of
8 coverage’ means a request for advance deter-
9 mination of coverage, in any case in which the
10 proposed medical care constitutes accelerated
11 need medical care.

12 “(F) REQUEST FOR REQUIRED DETER-
13 MINATION OF MEDICAL NECESSITY.—The term
14 ‘request for required determination of medical
15 necessity’ means a request for a required deter-
16 mination of medical necessity for medical care
17 which is made by or on behalf of a participant
18 or beneficiary before the medical care is pro-
19 vided.

20 “(G) REQUEST FOR EXPEDITED REQUIRED
21 DETERMINATION OF MEDICAL NECESSITY.—
22 The term ‘request for expedited required deter-
23 mination of medical necessity’ means a request
24 for required determination of medical necessity

1 in any case in which the proposed medical care
2 constitutes accelerated need medical care.

3 “(H) ACCELERATED NEED MEDICAL
4 CARE.—The term ‘accelerated need medical
5 care’ means medical care in any case in which
6 an appropriate physician has certified in writing
7 (or as otherwise provided in regulations of the
8 Secretary) that the participant or beneficiary is
9 stabilized and—

10 “(i) that failure to immediately pro-
11 vide the care to the participant or bene-
12 ficiary could reasonably be expected to re-
13 sult in—

14 “(I) placing the health of such
15 participant or beneficiary (or, with re-
16 spect to such a participant or bene-
17 ficiary who is a pregnant woman, the
18 health of the woman or her unborn
19 child) in serious jeopardy;

20 “(II) serious impairment to bod-
21 ily functions; or

22 “(III) serious dysfunction of any
23 bodily organ or part; or

24 “(ii) that immediate provision of the
25 care is necessary because the participant

1 or beneficiary has made or is at serious
2 risk of making an attempt to harm himself
3 or herself or another individual.

4 “(I) INITIAL DECISION PERIOD.—The term
5 ‘initial decision period’ means a period of 30
6 days, or such longer period as may be pre-
7 scribed in regulations of the Secretary.

8 “(J) INTERNAL REVIEW PERIOD.—The
9 term ‘internal review period’ means a period of
10 30 days, or such longer period as may be pre-
11 scribed in regulations of the Secretary.

12 “(K) ACCELERATED NEED DECISION PE-
13 RIOD.—The term ‘accelerated need decision pe-
14 riod’ means a period of 3 days, or such period
15 as may be prescribed in regulations of the Sec-
16 retary.

17 “(L) RECONSIDERATION PERIOD.—The
18 term ‘reconsideration period’ means a period of
19 25 days, or such longer period as may be pre-
20 scribed in regulations of the Secretary, except
21 that—

22 “(i) in the case of a decision involving
23 urgent medical care, such term means the
24 urgent decision period; and

1 “(ii) in the case of a decision involving
2 accelerated need medical care, such term
3 means the accelerated need decision period.

4 “(M) FILING COMPLETION DATE.—The
5 term ‘filing completion date’ means, in connec-
6 tion with a group health plan, the date as of
7 which the plan is in receipt of all information
8 reasonably required (in writing or in such other
9 reasonable form as may be specified by the
10 plan) to make an initial coverage decision.

11 “(N) REVIEW FILING DATE.—The term
12 ‘review filing date’ means, in connection with a
13 group health plan, the date as of which the ap-
14 propriate named fiduciary (or the independent
15 medical expert or experts in the case of a review
16 under paragraph (4)) is in receipt of all infor-
17 mation reasonably required (in writing or in
18 such other reasonable form as may be specified
19 by the plan) to make a decision to affirm, mod-
20 ify, or reverse a coverage decision.

21 “(O) MEDICAL CARE.—The term ‘medical
22 care’ has the meaning provided such term by
23 section 733(a)(2).

24 “(P) HEALTH INSURANCE COVERAGE.—
25 The term ‘health insurance coverage’ has the

1 meaning provided such term by section
2 733(b)(1).

3 “(Q) HEALTH INSURANCE ISSUER.—The
4 term ‘health insurance issuer’ has the meaning
5 provided such term by section 733(b)(2).

6 “(R) WRITTEN OR IN WRITING.—

7 “(i) IN GENERAL.—A request or deci-
8 sion shall be deemed to be ‘written’ or ‘in
9 writing’ if such request or decision is pre-
10 sented in a generally recognized printable
11 or electronic format. The Secretary may by
12 regulation provide for presentation of in-
13 formation otherwise required to be in writ-
14 ten form in such other forms as may be
15 appropriate under the circumstances.

16 “(ii) MEDICAL APPROPRIATENESS OR
17 INVESTIGATIONAL ITEMS OR EXPERI-
18 MENTAL TREATMENT DETERMINATIONS.—
19 For purposes of this subparagraph, in the
20 case of a request for advance determina-
21 tion of coverage, a request for expedited
22 advance determination of coverage, a re-
23 quest for required determination of medical
24 necessity, or a request for expedited re-
25 quired determination of medical necessity,

1 if the decision on such request is conveyed
2 to the provider of medical care or to the
3 participant or beneficiary by means of tele-
4 phonic or other electronic communications,
5 such decision shall be treated as a written
6 decision.”.

7 **SEC. 3. CLARIFICATION OF ERISA PREEMPTION RULES.**

8 (a) IN GENERAL.—Section 514 of the Employee Re-
9 tirement Income Security Act of 1974 (29 U.S.C. 1144)
10 is amended—

11 (1) by redesignating subsection (d) as sub-
12 section (e); and

13 (2) by inserting after subsection (c) the follow-
14 ing new subsection:

15 “(d) The procedures and remedies required or pro-
16 vided under sections 502 and 503 in connection with—

17 “(1) review of claims for benefits under em-
18 ployee benefit plans and for review of decisions deny-
19 ing such claims (including review of coverage deci-
20 sions referred to in section 503(b) and decisions
21 upon review of such coverage decisions), and

22 “(2) causes of action brought to recover plan
23 benefits, to enforce rights under the terms of the
24 plan or this title, or to clarify rights to future bene-
25 fits under the terms of the plan or this title,

1 are the exclusive procedures and remedies with respect to
2 any such review or cause of action and supersede any pro-
3 vision of State law providing for any such review or cause
4 of action.”.

5 (b) CONFORMING AMENDMENT.—Section
6 514(b)(2)(A) of such Act (42 U.S.C. 1144(b)(2)(A)) is
7 amended by inserting “or subsection (d)” after “subpara-
8 graph (B)”.

9 **SEC. 4. EFFECTIVE DATE.**

10 (a) IN GENERAL.—The amendments made by this
11 Act shall apply with respect to grievances arising in plan
12 years beginning on or after January 1 of the second cal-
13 endar year following 12 months after the date the Sec-
14 retary of Labor issues all regulations necessary to carry
15 out amendments made by this Act.

16 (b) LIMITATION ON ENFORCEMENT ACTIONS.—No
17 enforcement action shall be taken, pursuant to the amend-
18 ments made by this Act, against a group health plan or
19 health insurance issuer with respect to a violation of a re-
20 quirement imposed by such amendments before the date
21 of issuance of final regulations issued in connection with
22 such requirement, if the plan or issuer has sought to com-
23 ply in good faith with such requirement.

24 (c) COLLECTIVE BARGAINING AGREEMENTS.—Any
25 plan amendment made pursuant to a collective bargaining

1 agreement relating to the plan which amends the plan
2 solely to conform to any requirement added by this Act
3 shall not be treated as a termination of such collective bar-
4 gaining agreement.