AMENDMENT TO H.R. 2563

OFFERED BY MR. NORWOOD OF GEORGIA

Amend section 402 to read as follows:

SEC. 402. AVAILABILITY OF CIVIL REMEDIES.

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following:

''(n) CAUSE OF ACTION RELATING TO CLAIMS FOR HEALTH BENEFITS.—

''(1) CAUSE OF ACTION.—

''(A) IN GENERAL.—With respect to an action commenced by a participant or beneficiary (or the estate of the participant or beneficiary) in connection with a claim for benefits under a group health plan, if—

''(i) a designated decisionmaker described in paragraph (2) fails to exercise ordinary care—

''(I) in making a determination denying the claim for benefits under section 503A (relating to an initial claim for benefits),

''(II) in making a determination denying the claim for benefits under

section 503B (relating to an internal appeal), or

"(III) in failing to authorize coverage in compliance with the written determination of an independent medical reviewer under section 503C(d)(3)(F) that reverses a determination denying the claim for benefits, and

"(ii) the delay in receiving, or failure to receive, benefits attributable to the failure described in clause (i) is the proximate cause of personal injury to, or death of, the participant or beneficiary,

such designated decisionmaker shall be liable to the participant or beneficiary (or the estate) for economic and noneconomic damages in connection with such failure and such injury or death (subject to paragraph (4)).

"(B) REBUTTABLE PRESUMPTION.—In the case of a cause of action under subparagraph (A)(i)(I) or (A)(i)(II), if an independent medical reviewer under section 503C(d) or 503C(e)(4)(B) upholds the determination denying the claim for benefits involved, there shall

be a presumption (rebuttable by clear and convincing evidence) that the designated decisionmaker exercised ordinary care in making such determination.

''(2) DESIGNATED DECISIONMAKER.—

''(A) APPOINTMENT.—

''(i) IN GENERAL.—The plan sponsor or named fiduciary of a group health plan shall, in accordance with this paragraph with respect to a participant or beneficiary, designate a person that meets the requirements of subparagraph (B) to serve as a designated decisionmaker with respect to the cause of action described in paragraph (1), except that—

''(I) with respect to health insurance coverage offered in connection with a group health plan, the health insurance issuer shall be the designated decisionmaker unless the plan sponsor and the issuer specifically agree in writing (on a form to be prescribed by the Secretary) to substitute another person as the designated decisionmaker; or

"(II) with respect to the designation of a person other than a plan sponsor or health insurance issuer, such person shall satisfy the requirements of subparagraph (D).

"(ii) PLAN DOCUMENTS.—The designated decisionmaker shall be specifically designated as such in the written instruments of the plan (under section 402(a)) and be identified as required under section 121(b)(15) of the Bipartisan Patient Protection Act.

"(B) REQUIREMENTS.—For purposes of this paragraph, a designated decisionmaker meets the requirements of this subparagraph with respect to any participant or beneficiary if—

"(i) such designation is in such form as may be specified in regulations prescribed by the Secretary,

"(ii) the designated decisionmaker—

"(I) meets the requirements of subparagraph (C),

"(II) assumes unconditionally all liability arising under this subsection

in connection with actions and failures to act described in subparagraph (A) (whether undertaken by the designated decisionmaker or the employer, plan, plan sponsor, or employee or agent thereof) during the period in which the designation under this paragraph is in effect relating to such participant or beneficiary, and

''(III) where subparagraph (C)(ii) applies, assumes unconditionally the exclusive authority under the group health plan to make determinations on claims for benefits (irrespective of whether they constitute medically reviewable determinations) under the plan with respect to such participant or beneficiary, and

''(iii) the designated decisionmaker and the participants and beneficiaries for whom the decisionmaker has assumed liability are identified in the written instrument required under section 402(a) and as required under section 121(b)(15) of the Bipartisan Patient Protection Act.

Any liability assumed by a designated decisionmaker pursuant to this paragraph shall be in addition to any liability that it may otherwise have under applicable law.

''(C) QUALIFICATIONS FOR DESIGNATED DECISIONMAKERS.—

''(i) IN GENERAL.—Subject to clause (ii), an entity is qualified under this subparagraph to serve as a designated decisionmaker with respect to a group health plan if the entity has the ability to assume the liability described in subparagraph (A) with respect to participants and beneficiaries under such plan, including requirements relating to the financial obligation for timely satisfying the assumed liability, and maintains with the plan sponsor certification of such ability. Such certification shall be provided to the plan sponsor or named fiduciary upon designation under this paragraph and not less frequently than annually thereafter, or if such designation constitutes a multiyear arrangement, in conjunction with the renewal of the arrangement.

"(ii) SPECIAL QUALIFICATION IN THE CASE OF CERTAIN REVIEWABLE DECISIONS.—In the case of a group health plan that provides benefits consisting of medical care to a participant or beneficiary only through health insurance coverage offered by a health insurance issuer, such issuer is the only entity that may be qualified under this subparagraph to serve as a designated decisionmaker with respect to such participant or beneficiary, and shall serve as the designated decisionmaker unless the employer or other plan sponsor acts affirmatively to prevent such service.

"(D) REQUIREMENTS RELATING TO FINANCIAL OBLIGATIONS.—For purposes of subparagraphs (A)(i)(II) and (C)(i), the requirements relating to the financial obligation of an entity for liability shall include—

"(i) coverage of such entity under an insurance policy or other arrangement, secured and maintained by such entity, to effectively insure such entity against losses arising from professional liability claims, including those arising from its service as

a designated decisionmaker under this subsection; or

''(ii) evidence of minimum capital and surplus levels that are maintained by such entity to cover any losses as a result of liability arising from its service as a designated decisionmaker under this subsection.

The appropriate amounts of liability insurance and minimum capital and surplus levels for purposes of clauses (i) and (ii) shall be determined by an actuary using sound actuarial principles and accounting practices pursuant to established guidelines of the American Academy of Actuaries and in accordance with such regulations as the Secretary may prescribe and shall be maintained throughout the term for which the designation is in effect. The provisions of this subparagraph shall not apply in the case of a designated decisionmaker that is a group health plan, plan sponsor, or health insurance issuer and that is regulated under Federal law or a State financial solvency law.

''(E) LIMITATION ON APPOINTMENT OF TREATING PHYSICIANS.—A treating physician

who directly delivered the care or treatment or provided services which is the subject of a cause of action by a participant or beneficiary under paragraph (1) may not be appointed (or deemed to be appointed) as a designated decisionmaker under this paragraph with respect to such participant or beneficiary.

''(F) FAILURE TO APPOINT.—With respect to any cause of action under paragraph (1) relating to a denial of a claim for benefits where a designated decisionmaker has not been appointed in accordance with this paragraph, the plan sponsor or named fiduciary responsible for determinations under section 503 shall be deemed to be the designated decisionmaker.

''(G) EFFECT OF APPOINTMENT.—The appointment of a designated decisionmaker in accordance with this paragraph shall not affect the liability of the appointing plan sponsor or named fiduciary for the failure of the plan sponsor or named fiduciary to comply with any other requirement of this title.

''(H) TREATMENT OF CERTAIN TRUST FUNDS.—For purposes of this subsection, the terms 'employer' and 'plan sponsor', in connec-

tion with the assumption by a designated decisionmaker of the liability of employer or other plan sponsor pursuant to this paragraph, shall be construed to include a trust fund maintained pursuant to section 302 of the Labor Management Relations Act, 1947 (29 U.S.C. 186) or the Railway Labor Act (45 U.S.C. 151 et seq.).

''(3) REQUIREMENT OF EXHAUSTION OF INDEPENDENT MEDICAL REVIEW.—

''(A) IN GENERAL.—Paragraph (1) shall apply only if—

''(i) a final determination denying a claim for benefits under section 503B has been referred for independent medical review under section 503C(d) and a written determination by an independent medical reviewer has been issued with respect to such review, or

''(ii) the qualified external review entity has determined under section 503C(c)(3) that a referral to an independent medical reviewer is not required.

''(B) INJUNCTIVE RELIEF FOR IRREPARABLE HARM.—A participant or beneficiary may seek relief under subsection (a)(1)(B) prior

to the exhaustion of administrative remedies under section 503B or 503C (as required under subparagraph (A)) if it is demonstrated to the court, by a preponderance of the evidence, that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Any determinations that already have been made under section 503A, 503B, or 503C in such case, or that are made in such case while an action under this subparagraph is pending, shall be given due consideration by the court in any action under subsection (a)(1)(B) in such case. Notwithstanding the awarding of such relief under subsection (a)(1)(B) pursuant to this subparagraph, no relief shall be available under paragraph (1), with respect to a participant or beneficiary, unless the requirements of subparagraph (A) are met.

''(C) RECEIPT OF BENEFITS DURING APPEALS PROCESS.—Receipt by the participant or beneficiary of the benefits involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or of any action commenced under this subsection—

"(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

"(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

The court in any action commenced under this subsection shall take into account any receipt of benefits during such administrative processes or such action in determining the amount of the damages awarded.

"(4) LIMITATIONS ON RECOVERY OF DAMAGES.—

"(A) MAXIMUM AWARD OF NONECONOMIC DAMAGES.—The aggregate amount of liability for noneconomic loss in an action under paragraph (1) may not exceed $1,500,000.

"(B) LIMITATION ON AWARD OF PUNITIVE DAMAGES.—In the case of any action commenced pursuant to paragraph (1), the court may not award any punitive, exemplary, or similar damages against a defendant, except that the court may award punitive, exemplary, or similar damages (in addition to damages de-

scribed in subparagraph (A)), in an aggregate amount not to exceed $1,500,000, if—

''(i) the denial of a claim for benefits involved in the case was reversed by a written determination by an independent medical reviewer under section 503C(d)(3)(F); and

''(ii) there has been a failure to authorize coverage in compliance with such written determination.

''(C) PERMITTING APPLICATION OF LOWER STATE DAMAGE LIMITS.—A State may limit damages for noneconomic loss or punitive, exemplary, or similar damages in an action under paragraph (1) to amounts less than the amounts permitted under this paragraph.

''(5) ADMISSIBILITY.—In an action described in subclause (I) or (II) of paragraph (1)(A) relating to a denial of a claim for benefits, any determination by an independent medical reviewer under section 503C(d) or 503C(e)(4)(B) relating to such denial is admissible.

''(6) WAIVER OF INTERNAL REVIEW.—In the case of any cause of action under paragraph (1), the waiver or nonwaiver of internal review under section

503B(a)(4) by the group health plan, or health insurance issuer that offers health insurance coverage in connection with a group health plan, shall not be used in determining liability.

''(7) LIMITATIONS ON ACTIONS.—Paragraph (1) shall not apply in connection with any action that is commenced more than 5 years after the date on which the failure described in such paragraph occurred or, if earlier, not later than 2 years after the first date the participant or beneficiary became aware of the personal injury or death referred to in such paragraph.

''(8) EXCLUSION OF DIRECTED RECORDKEEPERS.—

''(A) IN GENERAL.—Paragraph (1) shall not apply with respect to a directed record keeper in connection with a group health plan.

''(B) DIRECTED RECORDKEEPER.—For purposes of this paragraph, the term 'directed record keeper' means, in connection with a group health plan, a person engaged in directed recordkeeping activities pursuant to the specific instructions of the plan, the employer, or another plan sponsor, including the distribution of enrollment information and distribution of dis-

closure materials under this Act or title I of the Bipartisan Patient Protection Act and whose duties do not include making determinations on claims for benefits.

''(C) LIMITATION.—Subparagraph (A) does not apply in connection with any directed recordkeeper to the extent that the directed recordkeeper fails to follow the specific instruction of the plan or the employer or other plan sponsor.

''(9) PROTECTION OF THE REGULATION OF QUALITY OF MEDICAL CARE UNDER STATE LAW.—Nothing in this subsection shall be construed to preclude any action under State law against a person or entity for liability or vicarious liability with respect to the delivery of medical care. A cause of action that is based on or otherwise relates to a group health plan's determination on a claim for benefits shall not be deemed to be the delivery of medical care under any State law for purposes of this paragraph. Any such cause of action shall be maintained exclusively under this section. Nothing in this paragraph shall be construed to alter, amend, modify, invalidate, impair, or supersede section 514.

''(10) COORDINATION WITH FIDUCIARY REQUIREMENTS.—A fiduciary shall not be treated as failing to meet any requirement of part 4 solely by reason of any action taken by a fiduciary which consists of full compliance with the reversal under section 503C (relating to independent external appeals procedures for group health plans) of a denial of claim for benefits (within the meaning of section 503C(i)(2)).

''(11) CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing a cause of action under paragraph (1) for the failure of a group health plan or health insurance issuer to provide an item or service that is specifically excluded under the plan or coverage.

''(12) LIMITATION ON CLASS ACTION LITIGATION.—A claim or cause of action under this subsection may not be maintained as a class action, as a derivative action, or as an action on behalf of any group of 2 or more claimants.

''(13) PURCHASE OF INSURANCE TO COVER LIABILITY.—Nothing in section 410 shall be construed to preclude the purchase by a group health plan of insurance to cover any liability or losses arising

under a cause of action under subsection (a)(1)(C) and this subsection.

''(14) RETROSPECTIVE CLAIMS FOR BENEFITS.—A cause of action shall not arise under paragraph (1) where the claim for benefits relates to an item or service that has already been provided to the participant or beneficiary under the plan or coverage and the claim relates solely to the subsequent denial of payment for the provision of such item or service.

''(15) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

''(A) a member of a board of directors of an employer or plan sponsor; or

''(B) a member of an association, committee, employee organization, joint board of trustees, or other similar group of representatives of the entities that are the plan sponsor of plan maintained by two or more employers and one or more employee organizations;

shall not be personally liable under this subsection for conduct that is within the scope of employment or of plan-related duties of the individuals unless the

individual acts in a fraudulent manner for personal enrichment.

''(16) DEFINITIONS AND RELATED RULES.—For purposes of this subsection:

''(A) CLAIM FOR BENEFITS.—The term 'claim for benefits' shall have the meaning given such term in section 503A(e).

''(B) GROUP HEALTH PLAN.—The term 'group health plan' shall have the meaning given such term in section 733(a).

''(C) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 733(b)(1).

''(D) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 733(b)(2).

''(E) ORDINARY CARE.—The term 'ordinary care' means, with respect to a determination on a claim for benefits, that degree of care, skill, and diligence that a reasonable and prudent individual would exercise in making a fair determination on a claim for benefits of like kind to the claims involved.

''(F) PERSONAL INJURY.—The term 'personal injury' means a physical injury and in-

cludes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

''(G) TREATMENT OF EXCEPTED BENEFITS.—The provisions of this subsection (and subsection (a)(1)(C)) shall not apply to excepted benefits (as defined in section 733(c)), other than benefits described in section 733(c)(2)(A), in the same manner as the provisions of part 7 do not apply to such benefits under subsections (b) and (c) of section 732.

(2) CONFORMING AMENDMENT.—Section 502(a)(1) of such Act (29 U.S.C. 1132(a)(1)) is amended—

(A) by striking ''or'' at the end of subparagraph (A);

(B) in subparagraph (B), by striking ''plan;'' and inserting ''plan, or''; and

(C) by adding at the end the following new subparagraph:

''(C) for the relief provided for in subsection (n) of this section.''.

(b) AVAILABILITY OF ACTIONS IN STATE COURT.—

(1) JURISDICTION OF STATE COURTS.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)) is amended—

(A) in the first sentence, by striking ''subsection (a)(1)(B)'' and inserting ''paragraphs (1)(B), (1)(C), and (7) of subsection (a)'';

(B) in the second sentence, by striking ''paragraphs (1)(B) and (7)'' and inserting ''paragraphs (1)(B), (1)(C), and (7)''; and

(C) by adding at the end the following new sentence: ''State courts of competent jurisdiction in the State in which the plaintiff resides and district courts of the United States shall have concurrent jurisdiction over actions under subsections (a)(1)(C) and (n).''.

(2) LIMITATION ON REMOVABILITY OF CERTAIN ACTIONS IN STATE COURT.—Section 1445 of title 28, United States Code, is amended by adding at the end the following new subsection:

''(e)(1) A civil action brought in any State court under subsections (a)(1)(C) and (n) of section 502 of the Employee Retirement Income Security Act of 1974 against any party (other than the employer, plan, plan sponsor, or other entity treated under section 502(n) of such Act as such) arising from a medically reviewable determination may not be removed to any district court of the United States.

''(2) For purposes of paragraph (1), the term 'medically reviewable decision' means a denial of a claim for benefits under the plan which is described in section 503C(d)(2) of the Employee Retirement Income Security Act of 1974.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to acts and omissions, from which a cause of action arises, occurring on or after the applicable effective date under section 601.

Amend section 403 to read as follows:

SEC. 403. LIMITATION ON CERTAIN CLASS ACTION LITIGATION.

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 402, is further amended by adding at the end the following:

''(o) LIMITATION ON CLASS ACTION LITIGATION.—Any claim or cause of action that is maintained under this section (other than under subsection (n)) or under section 1962 or 1964(c) of title 18, United States Code, in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative claimant, or the group of

claimants is limited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such class, such derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to actions commenced on or after August 2, 2001. Notwithstanding the preceding sentence, with respect to class actions, the amendment made by subsection (a) shall apply with respect to civil actions which are pending on such date in which a class action has not been certified as of such date.

Amend section 603 to read as follows:

SEC. 603. SEVERABILITY.

(a) IN GENERAL.—Except as provided in subsections (b) and (c), if any provision of this Act, an amendment made by this Act, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this Act, the amendments made by this Act, and the application of the provi-

sions of such to any person or circumstance shall not be affected thereby.

(b) DEPENDENCE OF REMEDIES ON APPEALS.—If any provision of section 503A, 503B, or 503C of the Employee Retirement Income Security Act of 1974 (as inserted by section 131) or the application of either such section to any person or circumstance is held to be unconstitutional, section 502(n) of such Act (as inserted by section 402) shall be deemed to be null and void and shall be given no force or effect.

(c) REMEDIES.—If any provision of section 502(n) of the Employee Retirement Income Security Act of 1974 (as inserted by section 402), or the application of such section to any person or circumstance, is held to be unconstitutional, the remainder of such section shall be deemed to be null and void and shall be given no force or effect.

Page 16, line 10, strike ''on a timely basis'' and insert ''in accordance with the applicable deadlines established under this section and section 503B''.

Page 29, line 14, strike ''or modify''.

Page 36, line 12, strike ''upheld, reversed, or modified'' and insert ''upheld or reversed''.

Page 39, line 23, strike ''uphold, reverse, or modify'' and insert ''uphold or reverse''.

Page 40, line 8, and page 44, line 9, strike ''or modify''.

Page 23, line 18; page 41, line 19; page 43, line 2; , , strike ''reviewer (or reviewers)'' and insert ''a review panel''.

Page 33, line 7, strike ''reviewer'' and insert ''review panel''.

Page 34, line 25, strike ''reviewer'' and insert ''review panel composed of 3 independent medical reviewers''.

Page 34, lines 8 and 13; page 36, line 8; page 37, line 3; page 38, lines 6 and 20; page 39, line 4, 20, and 21; page 40, lines 1, 2 and 14; page 41, line 6; page 43, lines 6, 17, and 20; page 44, lines 5, 9, and 14; page 45, line 24; page 61, line 5; page 67, line 3; page 68, line 25; , strike ''reviewer'' and insert ''review panel''.

Page 36, line 14; page 43, line 21; page 44, line 12; , strike ''reviewer's'' and insert ''review panel's''.

Page 41, line 4, strike ''reviewer (or reviewers)'' and insert ''review panel''.

Page 47, line 15, strike ''independent external reviewer'' and insert ''independent medical review panel''.

Page 50, line 20, strike ''1 or more individuals'' and insert ''an independent medical review panel''.

Page 51, amend lines 4 through 6 to read as follows:

''(B) with respect to each review, the review panel meets the requirements of paragraph (4) and at least 1 reviewer on the panel meets the requirements described in paragraph (5); and

Page 51, line 8, strike ''the reviewer'' and insert ''each reviewer''.

Page 53, line 21, strike ''a reviewer'' and insert ''each reviewer''.

Page 54, line 6, strike ''a reviewer (or reviewers)'' and insert ''the independent medical review panel''.

Page 61, line 5, insert ''or any independent medical review panel'' after ''reviewer''.

Page 64, lines 1 and 5, strike ''reviewers'' and insert ''review panel''.

Page 64, line 14; page 69, lines 16 and 19, strike ''reviewers'' and insert ''review panels''.

Page 8, after line 17, insert the following (and place the text from page 8, line 18, through page 16, line 20 in quotation marks):

Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by inserting after section 503 (29 U.S.C. 1133) the following:

''SEC. 503A. PROCEDURES FOR INITIAL CLAIMS FOR BENEFITS AND PRIOR AUTHORIZATION DETERMINATIONS.

Page 16, after line 21, insert the following (and place the text from page 16, line 22, through page 25, line 13 in quotation marks):

Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as amended by section 102) is amended further by inserting after section 503A (29 U.S.C. 1133) the following:

''SEC. 503B. INTERNAL APPEALS OF CLAIMS DENIALS.

Page 25, after line 15, insert the following (and place the text from page 25, line 16, through page 69, line 22 in quotation marks):

Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as amended by sec-

tions 102 and 103) is amended further by inserting after section 503B (29 U.S.C. 1133) the following:

"SEC. 503C. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

Page 119, line 1, insert after "treatment." the following: "The name of the designated decisionmaker (or decisionmakers) appointed under paragraph (2) of section 502(n) of the Employee Retirement Income Security Act of 1974 for purposes of such section.".

Page 138, line 21, insert after "plan" the following: "and only with respect to patient protection requirements under section 101 and subtitles B, C, and D and this subtitle".

Page 145, line 12, strike "and the provisions of sections 502(a)(1)(C), 502(n), and 514(d) of the Employee Retirement Income Security Act of 1974 (added by section 402)".

Page 148, line 15, after "Act" insert the following: "and sections 503A through 503C of the Employee Retirement Income Security Act of 1974".

Page 149, line 9, after "Act" insert the following: "and sections 503A through 503C of the Employee Retirement Income Security Act of 1974 (with respect to enrollees under individual health insurance coverage in

the same manner as they apply to participants and beneficiaries under group health insurance coverage)''.

Page 152, line 16, insert ''section 101 and subtitles B, C, D, and E of'' before ''title I''.

Page 155, strike lines 1 through 19 (and redesignate the subsequent paragraphs accordingly).

Page 158, strike lines 19 through 25 and insert the following:

''(b)(1)(A) Subject to subparagraphs (B) and (C), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of sections 503A, 503B, and 503C, and such requirements shall be deemed to be incorporated into this subsection.

''(B) With respect to the internal appeals process required to be established under section 503B, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such process and system (and is not liable for the issuer's failure to provide for such process and system), if the issuer is obligated to provide for (and provides for) such process and system.

''(C) Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external review entity for the conduct of external appeal activities in accordance with section 503C, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

''(2) In the case of a group health plan, compliance with the requirements of sections 503A, 503B, and 503C, and compliance with regulations promulgated by the Secretary, in connection with a denial of a claim under a group health plan shall be deemed compliance with subsection (a) with respect to such claim denial.

''(3) Terms used in this subsection which are defined in section 733 shall have the meanings provided such terms in such section.''.

Page 210, line 19, after ''Act'' insert the following: ''and sections 503A through 503C of the Employee Retirement Income Security Act of 1974''.

Make such additional technical and conforming changes to the text of the bill as are necessary to do the following:

(1) Replace references to sections 102, 103, and 104 of the bill with references to sections 503A,

503B, and 503C of the Employee Retirement Income Security Act of 1974, as amended by the bill.

(2) In sections 102, 103, and 104, strike any reference to ''enrollee'' or ''enrollees'' and insert ''in connection with the group health plan'' after ''health insurance coverage'', and make necessary conforming grammatical changes.