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AMENDMENT TO H.R. 3962

OFFERED BY MR. SHADEGG OF ARIZONA

Strike section 251(a)(2) and insert the following:

(2) APPLICATION OF RIGHTS AND REMEDIES.—Notwithstanding section 514 of the Employee Retirement Security Act of 1974, but subject to section 502(n) of such Act, individual rights and remedies under state laws shall apply for injury or wrongful death.

(3) CONSTRUCTION.—Subject to section 502(n) of the Employee Retirement Income Security Act of 1974, in the case of coverage described in paragraph (1), nothing in such paragraph shall be construed as preventing the application of rights and remedies under State laws.

(4) APPLICABILITY OF CIVIL REMEDIES UNDER ERISA.—

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

(i) 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 initial claim for benefits under the internal claims and appeals process described in section 232(b) of the Affordable Health Care for America Act,

"(II) in making a determination denying the claim for benefits under an appeal under such process, or

"(III) in failing to authorize coverage in compliance with the written determination of the reviewer under the external review process described in section 232(c) of such Act that re-

verses 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 the reviewer under the external review process described in section 232(c) of the Affordable Health Care for America Act 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 and the participants and beneficiaries for whom the decisionmaker has assumed liability shall be specifically identified and designated as such in the written instruments of the plan (under section 402(a)).

"(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 em-

ployee 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 subparagraph (A)(ii).

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 des-

ignated 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 of this Act and section 232(b) of the Affordable Health Care for America Act 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 connection 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 the internal claims and appeals process described in section 232(b) of the Affordable Health Care for America Act has been referred for review under the external review process described in section 232(c) of such Act and a written determination by the reviewer under such external review process has been issued with respect to such review, or

"(ii) review under the external review process described in such section 232(c) is determined in accordance with such process to not be 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 the internal claims and appeals process and the external review process under section 232 of the Affordable Health Care for America Act (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 the review processes described in such section 232 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 admin-

istrative 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 described 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 a reviewer under the external review process described in section 232(c) of the Affordable Health Care for America Act; 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 the reviewer under the external review process described in section 232(c) of the Affordable Health

Care for America Act relating to such denial is admissible.

"(6) WAIVER OF INTERNAL REVIEW.—In the case of any cause of action under paragraph (1), any waiver or nonwaiver of internal review under the internal review and appeals process described in section 232(b) of the Affordable Health Care for America Act 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 disclosure materials under this Act or title II of division A of the Affordable Health Care for America 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 the external review process described in section 232(c) of the Affordable Health Care for America Act of a denial of claim for benefits.

"(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' means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

"(B) DENIAL OF A CLAIM FOR BENEFITS.—The term 'denial of a claim for benefits' means, with respect to a claim for benefits, a denial (in whole or in part) of, or a failure to act on a timely basis upon, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under the plan, this title, or title II of division A of the Affordable Health Care for America Act.

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

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

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

"(F) 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.

"(G) PERSONAL INJURY.—The term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

"(H) 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.".

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

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

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

(III) 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.—

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

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

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

(III) 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).".

(ii) 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 (as defined in section 502(n)(16)(B) of the Employee Retirement Income Security Act of 1974).".

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to acts and omissions, from which a cause of action arises, occurring on or after January 1, 2013.