EC–1208. A communication from the Director of the Federal Mediation and Conciliation Service, transmitting, pursuant to law, the report under the Federal Managers' Financial Intergrity Act; to the Committee on Governmental Affairs.

EC–1209. A communication from the Chairman of the Nuclear Regulatory Commission, transmitting, pursuant to law, the report under the Government in the Sunshine Act for calendar year 1996; to the Committee on Governmental Affairs.

EC–1210. A communication from the Associate Director for Management of the Peace Corps, transmitting, pursuant to law, the report of amendment to system of records; to the Committee on Governmental Affairs.

EC–1211. A communication from the Executive Director of the Committee for Purchase From People Who Are Blind or Severely Disabled, transmitting, pursuant to law, the 1996 report under the Freedom of Information Act; to the Committee on Governmental Affairs.

EC–1212. A communication from the Chairman of the Armed Forces Retirement Home Board, transmitting, pursuant to law, the report concerning the Federal Managers Financial Integrity Act for fiscal year 1996; to the Committee on Governmental Affairs.

EC–1213. A communication from the Administrator of the Office of Independent Counsel, transmitting, pursuant to law, the report on audit and investigative activities; to the Committee on Governmental Affairs.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. MCCONNELL (for himself, Mr. BIDEN, and Mr. LEAHY):

S. 348. A bill to amend title I of the Omnibus Crime Control and Safe Streets Act of 1968 to encourage States to enact a Law Enforcement Officers' Bill of Rights, to provide standards and protection for the conduct of internal police investigations, and for other purposes; to the Committee on the Judiciary.

By Mrs. BOXER (for herself, Mr. KENNEDY, and Mr. HOLLINGS):

S. 349. A bill to amend the Public Health Service Act to provide for expanding, intensifying, and coordinating activities of the National Heart, Lung, and Blood Institute with respect to heart attack, stroke, and other cardiovascular diseases in women; to the Committee on Labor and Human Resources.

By Mr. THURMOND:

S. 350. A bill to authorize payment of special annuities to surviving spouses of deceased members of the uniformed services who are ineligible for a survivor annuity under transition laws relating to the establishment of the Survivor Benefit Plan under chapter 73 of title 10, United States Code; to the Committee on Armed Services.

By Mrs. MURRAY:

S. 351. A bill to provide for teacher technology training; to the Committee on Labor and Human Resources.

By Mr. BIDEN:

S. 352. A bill to require the United States Sentencing Commission to amend the Federal sentencing guidelines to provide an enhanced penalty for follow-on bombings; to the Committee on the Judiciary.

By Mr. KENNEDY:

S. 353. A bill to amend title XXVII of the Public Health Service Act and part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 to establish standards for protection of consumers in managed care plans and other health plans; to the Committee on Labor and Human Resources.

By Mr. KENNEDY (for himself and Mr. KERRY):

S. 354. A bill to amend the Federal Property and Administrative Services Act of 1949 to prohibit executive agencies from awarding contracts that contain a provision allowing for the acquistion by the contractor, at Government expense, of certain equipment or facilities to carry out the contract if the principal purpose of such provision is to increase competition by establishing an alternative source of supply for property or services; to the Committee on Governmental Affairs.

By Mr. GRAMM (for himself and Mrs. HUTCHISON):

S. 355. A bill to amend the Internal Revenue Code of 1986 to make the research credit permanent; to the Committee on Finance.

By Mr. GRAHAM (for himself, Mr. HUTCHINSON, Ms. MIKULSKI, and Mr. CHAFEE):

S. 356. A bill to amend the Internal Revenue Code of 1986, the Public Health Service Act, the Employee Retirement Income Security Act of 1974, the title XVIII and XIX of the Social Security Act to assure access to emergency medical services under group health plans, health insurance coverage, and the medicare and medicaid programs; to the Committee on Finance.

By Mr. BENNETT (for himself, Mr. HATCH, Mr. MURKOWSKI, Mr. CRAIG, Mr. BURNS, and Mr. THOMAS):

S. 357. A bill to authorize the Bureau of Land Management to manage the Grand Staircase-Escalante National Monument, and for other purposes; to the Committee on Energy and Natural Resources.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. KENNEDY (for himself, Mr. MACK, Mr. MOYNIHAN, and Mr. D'AMATO):

S. Res. 59. A resolution designating the month of March of each year as ''Irish American Heritage Month''; to the Committee on the Judiciary.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. MCCONNELL (for himself, Mr. BIDEN, and Mr. LEAHY):

S. 348. A bill to amend title I of the Omnibus Crime Control and Safe Streets Act of 1968 to encourage States to enact a Law Enforcement Officers' Bill of Rights, to provide standards and protection for the conduct of internal police investigations, and for other purposes; to the Committee on the Judiciary.

THE LAW ENFORCEMENT OFFICERS' BILL OF RIGHTS ACT OF 1997

• Mr. MCCONNELL. Mr. President, American families turn on the news every night and get bombarded by the reality that the war against crime and drugs is escalating. No one understands the dangers of this domestic war better than the men and women who serve on the front lines. I'm talking about our Nation's police officers.

These dedicated individuals offer up their lives as an act of service every day. They know the stress and the strain of walking the daily beat, of being caught in the crossfire in a world of gangs and drugs. These officers experience first-hand the casualties of our national epidemic.

As the Washington Post reported this Sunday, seven law enforcement officers right here in the Nation's Capital have been killed—in little more than 2 years. Moreover, the ambush of these ''men and women wearing badges [occurred]—even though the officers posed no immediate threat to their attackers.''

Our Nation's police officers endure unfathomable pressure every day as they fight to take back our streets. In the words of one officer, ''the ultimate sacrifice could occur at any time. * * * [The gangs and criminals] have rewritten the rule book.''

To make matters worse, the pressure of crime and drugs—of gangs and thugs—is multiplied by the fear of unjust disciplinary actions. Our law enforcement officers face intrusive investigations into their professional and personal lives—oftentimes at the behest of some recently arrested criminal looking for a payback.

Our officers live in the fear of: being investigated without notice; being interrogated without an attorney; and being dismissed without a hearing.

We must act now to address this situation by guaranteeing our police officers their basic and fundamental rights. So, today, along with Mr. BIDEN and Mr. LEAHY, I proudly introduce the Law Enforcement Officers' Bill of Rights.

This bill protects rights that most of us take for granted. For example, it allows police officers to be involved in, or refrain from, political activity.

The bill also gives significant due process rights to every police officer subject to investigation for noncriminal disciplinary action. Some of these rights include:

The right to be informed of the administrative charges prior to being questioned; the right to be advised of the results of an investigation; the right to a hearing and an opportunity to respond; and the right to be represented by counsel or other representative.

We owe our law enforcement officers a national debt of gratitude for their valiant fight in a battle that must be won. I ask my colleagues to show their appreciation and understanding of the plight of our police force. We must act boldly to equip every officer with basic and fundamental rights.

Finally, I must conclude by explaining that this bill is a product of years of input from the men and women who have experienced these daily pressures, and continue to endure them. This legislation has benefited from the thoughtful ideas and past support of many law enforcement groups, including the Fraternal Order of Police, the National Association of Police Organizations, and the International Brotherhood of Police Officers.

In particular, I am grateful to the contribution made by the Fraternal Order of Police. Over the past 6 years, I have worked closely with the Kentucky FOP to develop and promote this legislation. Seasoned and well-informed officers like Ray Franklin and Mike Hettich, both of whom are National FOP officers from my home State, have worked with me in refining the language of this bill and developing grassroots momentum. I would also like to say a personal word of thanks to Verlin Flaherty, Rick McCubbin, and Martin Scott.

The time has come to protect those who protect us. We must give our law enforcement officers the basic and fundamental rights that they desperately need and deserve.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 348

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Law Enforcement Officers' Bill of Rights Act of 1997''.

SEC. 2. RIGHTS OF LAW ENFORCEMENT OFFICERS.

(a) IN GENERAL.—Part H of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3781 et seq.) is amended by adding at the end the following:

''SEC. 820. RIGHTS OF LAW ENFORCEMENT OFFICERS.

''(a) DEFINITIONS.—In this section:

''(1) DISCIPLINARY ACTION.—The term 'disciplinary action' means the suspension, demotion, reduction in pay or other employment benefit, dismissal, transfer, or similar action taken against a law enforcement officer as punishment for misconduct.

''(2) DISCIPLINARY HEARING.—The term 'disciplinary hearing' means an administrative hearing initiated by a law enforcement agency against a law enforcement officer, based on probable cause to believe that the officer has violated or is violating a rule, regulation, or procedure related to service as an officer and is subject to disciplinary action.

''(3) EMERGENCY SUSPENSION.—The term 'emergency suspension' means temporary action imposed by the head of the law enforcement agency if that official determines that there is probable cause to believe that a law enforcement officer—

''(A) has committed a felony; or

''(B) poses an immediate threat to the safety of the officer or others or the property of others.

''(4) INVESTIGATION.—The term 'investigation'—

''(A) means the action of a law enforcement agency, acting alone or in cooperation with another agency, or a division or unit within an agency, or the action of an individual law enforcement officer, taken with respect to another enforcement officer, if such action is based on reasonable suspicion that the law enforcement officer has violated, is violating, or will in the future violate a statute or ordinance, or administrative rule, regulation, or procedure relating to service as a law enforcement officer; and

''(B) includes—

''(i) asking questions of other law enforcement officers or nonlaw enforcement officers;

''(ii) conducting observations;

''(iii) evaluating reports, records, or other documents; and

''(iv) examining physical evidence.

''(5) LAW ENFORCEMENT AGENCY.—The term 'law enforcement agency' means a State or local public agency charged by law with the duty to prevent or investigate crimes or apprehend or hold in custody persons charged with or convicted of criminal offenses.

''(6) LAW ENFORCEMENT OFFICER.—The terms 'law enforcement officer' and 'officer'—

''(A) mean a member of a law enforcement agency serving in a law enforcement position, which is usually indicated by formal training (regardless of whether the officer has completed or been assigned to such training) and is usually accompanied by the power to make arrests; and

''(B) include—

''(i) a member who serves full-time, whether probationary or nonprobationary, commissioned or noncommissioned, career or noncareer, tenured or nontenured, and merit or nonmerit; and

''(ii) the chief law enforcement officer of a law enforcement agency.

''(7) SUMMARY PUNISHMENT.—The term 'summary punishment' means punishment imposed for a minor violation of a rule, regulation, or procedure of a law enforcement agency that does not result in suspension, demotion, reduction in pay or other employment benefit, dismissal, or transfer.

''(b) APPLICATION OF SECTION.—

''(1) IN GENERAL.—This section sets forth rights that shall be afforded any law enforcement officer who is the subject of an investigation.

''(2) NONAPPLICABILITY.—This section does not apply in the case of—

''(A) a criminal investigation of the conduct of a law enforcement officer; or

''(B) a nondisciplinary action taken in good faith on the basis of the employment related performance of a law enforcement officer.

''(c) POLITICAL ACTIVITY.—Except if on duty or acting in an official capacity, no law enforcement officer shall be prohibited from engaging in political activity or be denied the right to refrain from engaging in such activity.

''(d) RIGHTS OF LAW ENFORCEMENT OFFICERS UNDER INVESTIGATION.—If a law enforcement officer is under investigation that could lead to disciplinary action, each of the following minimum standards shall apply:

''(1) NOTICE OF INVESTIGATION.—A law enforcement officer shall be notified of the investigation within a reasonable time after the commencement of the investigation. Notice shall include the general nature and scope of the investigation and all departmental violations for which reasonable suspicion exists. No investigation based on a complaint from outside the law enforcement agency may commence unless the complainant provides a signed detailed statement. An investigation based on a complaint from outside the agency shall commence not later than 15 days after receipt of the complaint by the agency.

''(2) NOTICE OF INVESTIGATIVE FINDINGS AND RECOMMENDATION FOR DISCIPLINARY ACTION.—At the conclusion of the investigation, the person in charge of the investigation shall inform the law enforcement officer under investigation, in writing, of the investigative findings and any recommendation for disciplinary action that the person intends to make.

''(e) RIGHTS OF LAW ENFORCEMENT OFFICERS BEFORE AND DURING QUESTIONING.—If a law enforcement officer is subjected to questioning that could lead to disciplinary action, each of the following minimum standards shall apply:

''(1) REASONABLE HOURS.—Questioning of a law enforcement officer shall be conducted at a reasonable hour, preferably during the time that the law enforcement officer is on duty, unless exigent circumstances otherwise require.

''(2) PLACE OF QUESTIONING.—Questioning of the law enforcement officer shall take place at the offices of the persons who are conducting the investigation or the place where the law enforcement officer reports for duty, unless the officer consents in writing to being questioned elsewhere.

''(3) IDENTIFICATION OF QUESTIONER.—The law enforcement officer under investigation shall be informed, at the commencement of any questioning, of the name, rank, and command of the officer conducting the questioning.

''(4) SINGLE QUESTIONER.—During any single period of questioning of the law enforcement officer, all questions shall be asked by or through a single investigator.

''(5) NOTICE OF NATURE OF INVESTIGATION.—The law enforcement officer under investigation shall be informed in writing of the nature of the investigation not less than 72 hours before any questioning.

''(6) REASONABLE TIME PERIOD.—Any questioning of a law enforcement officer in connection with an investigation shall be for a reasonable period of time and shall allow for reasonable periods for the rest and personal necessities of the law enforcement officer.

''(7) NO THREATS OR PROMISES.—Threats against, harassment of, or promise of reward shall not be made in connection with an investigation to induce the answering of any question. No statement given by the officer may be used in a subsequent criminal proceeding unless the officer has received a written grant of use and derivative use immunity or transactional immunity.

''(8) RECORDATION.—All questioning of any law enforcement officer in connection with the investigation shall be recorded in full, in writing or by electronic device, and a copy of the transcript shall be made available to the officer under investigation.

''(9) COUNSEL.—The law enforcement officer under investigation shall be entitled to counsel (or any other one person of the officer's choice) during any questioning of the officer, unless the officer consents in writing to being questioned outside the presence of counsel.

''(f) DISCIPLINARY HEARING.—

''(1) NOTICE OF OPPORTUNITY FOR HEARING.—Except in a case of summary punishment or emergency suspension described in subsection (h), if an investigation of a law enforcement officer results in a recommendation of disciplinary action, the law enforcement agency shall notify the law enforcement officer that the law enforcement officer is entitled to a hearing on the issue by a hearing officer or board before the imposition of any disciplinary action.

''(2) REQUIREMENT OF DETERMINATION OF VIOLATION.—No disciplinary action may be taken unless a hearing officer or board determines, pursuant to a fairly conducted disciplinary hearing, that the law enforcement officer violated a statute, ordinance, or published administrative rule, regulation, or procedure.

''(3) TIME LIMIT.—No disciplinary charges may be brought against a law enforcement officer unless filed not later than 90 days after the commencement of an investigation, except for good cause shown.

''(4) NOTICE OF FILING OF CHARGES.—The law enforcement agency shall provide written, actual notification to the law enforcement officer, not later than 30 days after the

filing of disciplinary charges, of the following:

''(A) DATE, TIME, AND LOCATION OF HEARING.—The date, time, and location of the disciplinary hearing, which shall take place not sooner than 30 days and not later than 60 days after notification to the law enforcement officer under investigation unless waived in writing by the officer.

''(B) INFORMATION RELATING TO HEARING OFFICER.—The full name and mailing address of the hearing officer.

''(C) INFORMATION RELATING TO PROSECUTOR.—The name, rank, and command of the prosecutor, if a law enforcement officer, or the name, position, and mailing address of the prosecutor, if not a law enforcement officer.

''(5) REPRESENTATION.—During a disciplinary hearing, an officer shall be entitled to be represented by counsel or other representative.

''(6) HEARING BOARD AND PROCEDURE.—

''(A) IN GENERAL.—Subject to subparagraph (B), a State shall determine the composition of a disciplinary hearing board and the procedures for a disciplinary hearing.

''(B) MEMBERSHIP.—A disciplinary hearing board that includes employees of the law enforcement agency of which the officer who is the subject of the hearing is a member shall include not less than 1 law enforcement officer of equal or lesser rank to the officer who is the subject of the hearing.

''(7) ACCESS TO EVIDENCE.—A law enforcement officer who is brought before a disciplinary hearing board shall be provided access to all transcripts, records, written statements, written reports, analyses, and electronically recorded information pertinent to the case that—

''(A) contain exculpatory information;

''(B) are intended to support any disciplinary action; or

''(C) are to be introduced in the disciplinary hearing.

''(8) IDENTIFICATION OF WITNESSES.—The disciplinary advocate for the law enforcement agency of which the officer who is the subject of the hearing is a member shall notify the law enforcement officer, or his attorney if he is represented by counsel, not later than 15 days before the hearing, of the name and addresses of all witnesses for the law enforcement agency.

''(9) COPY OF INVESTIGATIVE FILE.—The disciplinary advocate for the law enforcement agency of which the officer who is the subject of the hearing is a member shall provide to the law enforcement officer, upon the request of the law enforcement officer, not later than 15 days before the hearing, a copy of the investigative file, including all exculpatory and inculpatory information, except that the law enforcement agency may exclude confidential sources, unless the law enforcement officer is entitled to such sources under subparagraph (A), (B), or (C) of paragraph (7).

''(10) EXAMINATION OF PHYSICAL EVIDENCE.—The disciplinary advocate for the law enforcement agency of which the officer who is the subject of the hearing is a member shall notify the law enforcement officer, at the request of the officer, not later than 15 days before the hearing, of all physical, nondocumentary evidence, and provide reasonable date, time, place, and manner for the officer to examine such evidence not less than 10 days before the hearing.

''(11) SUMMONSES.—The hearing board shall have the power to issue summonses to compel testimony of witnesses and production of documentary evidence. If confronted with a failure to comply with a summons, the hearing officer or board may petition a court to issue an order, with failure to comply being subject to contempt of court.

''(12) CLOSED HEARING.—A disciplinary hearing shall be closed to the public unless the law enforcement officer who is the subject of the hearing requests, in writing, that the hearing be open to specified individuals or the general public.

''(13) RECORDATION.—All aspects of a disciplinary hearing, including prehearing motions, shall be recorded by audio tape, video tape, or transcription.

''(14) SEQUESTRATION OF WITNESSES.—Either side in a disciplinary hearing may move for and be entitled to sequestration of witnesses.

''(15) TESTIMONY UNDER OATH.—The hearing officer or board shall administer an oath or affirmation to each witness, who shall testify subject to the applicable laws of perjury.

''(16) VERDICT ON EACH CHARGE.—At the conclusion of all the evidence, and after oral argument from both sides, the hearing officer or board shall deliberate and render a verdict on each charge.

''(17) BURDEN OF PERSUASION.—The burden of persuasion of the prosecutor shall be by clear and convincing evidence as to each charge involving false representation, fraud, dishonesty, deceit, or criminal behavior and by a preponderance of the evidence as to all other charges.

''(18) FINDING OF NOT GUILTY.—If the law enforcement officer is found not guilty of the disciplinary violations, the matter is concluded and no disciplinary action may be taken.

''(19) FINDING OF GUILTY.—If the law enforcement officer is found guilty, the hearing officer or board shall make a written recommendation of a penalty. The sentencing authority may not impose greater than the penalty recommended by the hearing officer or board.

''(20) APPEAL.—A law enforcement officer may appeal from a final decision of a law enforcement agency to a court to the extent available in any other administrative proceeding, in accordance with the applicable State law.

''(g) WAIVER OF RIGHTS.—A law enforcement officer may waive any of the rights guaranteed by this section subsequent to the time that the officer has been notified that the officer is under investigation. Such a waiver shall be in writing and signed by the officer.

''(h) SUMMARY PUNISHMENT AND EMERGENCY SUSPENSION.—

''(1) IN GENERAL.—This section does not preclude a State from providing for summary punishment or emergency suspension.

''(2) HEALTH BENEFITS.—An emergency suspension shall not affect or infringe on the health benefits of a law enforcement officer or any dependent of the officer.

''(i) RETALIATION FOR EXERCISING RIGHTS.—There shall be no penalty or threat of penalty against a law enforcement officer for the exercise of the rights of the officer under this section.

''(j) OTHER REMEDIES NOT IMPAIRED.—Nothing in this section shall be construed to impair any other legal right or remedy that a law enforcement officer may have as a result of a constitution, statute, ordinance, regulation, collective bargaining agreement or other sources of rights.

''(k) DECLARATORY OR INJUNCTIVE RELIEF.—A law enforcement officer who is being denied any right afforded by this section may petition a State court for declaratory or injunctive relief to prohibit the law enforcement agency from violating such right.

''(l) PROHIBITION OF ADVERSE MATERIAL IN OFFICER'S FILE.—A law enforcement agency shall not insert any adverse material into the file of any law enforcement officer, or possess or maintain control over any adverse material in any form within the law enforcement agency, unless the officer has had an opportunity to review and comment in writing on the adverse material.

''(m) DISCLOSURE OF PERSONAL ASSETS.—A law enforcement officer shall not be required or requested to disclose any item of the officer's personal property, income, assets, sources of income, debts, or personal or domestic expenditures (including those of any member of the officer's household), unless—

''(1) the information is necessary to the investigation of a violation of any Federal, State or local law, rule, or regulation with respect to the performance of official duties; and

''(2) such disclosure is required by Federal, State, or local law.

''(n) STATES' RIGHTS.—This section does not preempt State laws in existence on the effective date of this section that confer rights that equal or exceed the rights and coverage afforded by this section. This section shall not be a bar to the enactment of a police officer's bill of rights, or similar legislation, by any State. A State law that confers fewer rights or provides less protection to law enforcement officers than this section shall be preempted by this section.

''(o) MUTUALLY AGREED UPON COLLECTIVE BARGAINING AGREEMENTS.—This section does not preempt any mutually agreed upon collective bargaining agreement in existence on the effective date of this section that is substantially similar to the rights and coverage afforded under this section.

''(p) EFFECTIVE DATE.—This section shall take effect with respect to each State on the earlier of—

''(1) 2 years after the date of enactment of the Law Enforcement Officers' Bill of Rights Act of 1997; or

''(2) upon the conclusion of the second legislative session of the State that begins on or after the date of enactment of the Law Enforcement Officers' Bill of Rights Act of 1997.''.

(b) TECHNICAL AMENDMENT.—The table of contents of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. preceding 3701) is amended by inserting after the item relating to section 819 the following:

''Sec. 820. Rights of law enforcement officers.''.●

● Mr. BIDEN. Mr. President, today, we renew our call for the congress to pass the ''law enforcement officers' bill of rights act.'' For 6 years, I have been working with Senator MCCONNELL, other Senators, and the Nation's police officers to pass into law a bill protecting the rights of law enforcement officers on the front line of this Nation's fight against violent crime and drug trafficking.

Before addressing the specifics of this legislation, I want to discuss the reality of law enforcement today. The simple fact is that as Federal, State, and local officials push to expand ''community'' or ''problem-solving'' policing we are necessarily requiring police officers to move away from standard procedures and towards more creative approaches.

Of course, as we encourage creativity, there is always the need to guarantee the highest standards of police conduct.

Unfortunately, because police department's internal disciplinary procedures vary so widely across the Nation, we are literally moving at cross-purposes. On the one hand, we are calling on police officers to take more creative approaches—which naturally raises the

chances of technical violations of department procedures.

While, on the other hand, we subject police officers to varying, often ad hoc, disciplinary procedures which do make clear what specific conduct is appropriate, nor what will happen should the conduct turn out to be a mistake.

In fact, the practices that many departments use to guide internal investigations frequently allow police executives to take arbitrary and unfair actions against innocent police officers, while allowing culpable officers to avoid any punishment at all.

The law enforcement officers' bill of rights is designed to replace the ad hoc nature of many internal police investigations by encouraging States to provide minimum procedural standards to guide such investigations. The standards and protections offered by this bill are modeled on the standards for law enforcement agencies developed by the National Commission on Accreditation for Law Enforcement.

As the preface to the commission's standards on internal affairs notes:

''The internal affairs function is important for the maintenance of professional conduct in a law enforcement agency. The integrity of the agency depends on the personal integrity and discipline of each employee. To a large degree, the pubic image of the agency is determined by the quality of the internal affairs function in responding to allegations of misconduct by the agency or its employees.''

The specific standards and rights guaranteed by the law enforcement officers bill of rights are designed to improve and enhance the quality of the internal affairs function, including: The right to be informed by a written statement of the charges brought against an officer; The right to be free from undue coercion or harassment during an investigation; and The right to counsel during an investigation.

The provisions of this bill will take effect at the end of the second full legislative term of each State. After such time, a law enforcement officer whose rights have been abridged may sue in state court for pecuniary and other damages, including full reinstatement.

Although the bill provides certain procedural rights, it gives States considerable discretion in implementing these safeguards, including the flexibility to provide for summary punishment and emergency suspensions of law enforcement officers.

It is also important to note what the bill does not do. The bill explicitly provides that the standards and protections governing internal investigations shall not apply to investigations of criminal misconduct by law enforcement officers. As a result, criminal investigations of law enforcement officers would not be affected by this bill.

Moreover, the protections in this bill do not apply to minor violations of departmental rules or regulations, nor to actions taken on the basis of an officers' employment-related performance.

I would also like to acknowledge the hard work of several of the Nation's leading law enforcement organizations on this important bill. The real leaders behind this effort—and they have been the leaders since the police officers' bill of rights won passage in the Senate in 1991—are the Fraternal Order of Police, the National Association of Police Organizations, the International Brotherhood of Police Officers, and the National Troopers Coalition. No one should be confused about where the force behind the law enforcement officers bill of rights lies—it lies with these organizations.●

● Mr. LEAHY. Mr. President, I join as an original sponsor of the Law Enforcement Officers' Bill of Rights Act of 1997.

Our State and local law enforcement officers are the backbone of our nation's anticrime, antigang and antidrug efforts. Together with local prosecutors and an energized public, our local law enforcement officers are responsible for much of the good news we have had over the last few years, as crime rates across the county have declined. The President's community policing program, which is assisting local law enforcement to add 100,000 additional cops on the beat, is paying off. More police officers are patrolling our neighborhoods, towns, cities, and rural areas, and it is helping communities across America.

On the first day of this Congress, I joined in sponsoring S. 15 with the minority leader and other Democrats. With that bill, we hope to take the next step against crime by redoubling our efforts against youth gangs and drugs. State and local officers are essential participants in these initiatives.

When I was privileged to serve as state's attorney for Chittenden County, I had the good fortune to work alongside a number of dedicated State and local officers. These public servants literally put their lives on the line each day to protect all of us. Since coming to the Senate, I have tried to do my best to support local law enforcement. Their responsibilities require split-second judgment, dedication, timing, and guts. We hold the men and women who serve in law enforcement to the highest standards because public respect for the law is so critical.

This legislation is an effort to spell out what the Constitution's guarantee of due process means to law enforcement officers subjected to administrative disciplinary proceedings. It is our hope that these standards will serve the public by helping specify fair, prompt procedures for determining whether a rule relating to an officer's service has been violated. This measure should make unnecessary prolonged litigation challenging whether disciplinary procedures were sufficient to satisfy officers' constitutional rights to due process. These kinds of fair processes should provide the public and law enforcement officers with confidence in both the outcome of such administrative proceedings as well as the fairness of the procedures used to determine questions of possible misconduct.

When a law enforcement officer engages in wrongdoing, it reflects badly on all law enforcement. No one is harder on those few officers who go bad than fellow law enforcement officers. This bill will do nothing to protect those wrongdoers. Officers under criminal investigation or those subject to immediate suspension because there is probable cause to believe they committed a felony or pose a threat to public safety will find no comfort here. This bill should not affect criminal investigations, nor for that matter, civil lawsuits against officers.

The procedural protections provided by this bill attach in administrative proceedings. They provide officers with a minimum threshold of due process protection by requiring that the officers be informed of charges against them, have a right to a fair hearing, be allowed representation, be advised of the results of internal investigations and be afforded an opportunity to review and comment on adverse actions.

I hope that we can make progress on this bill and look forward to working with representatives of State and local government, police chiefs, sheriffs, troopers, and other interested parties as we proceed. As a cosponsor, I will work to improve this bill. For example, I would like to be able to provide greater privacy protection for officers' medical records as well as for the financial information already included in the bill. At the same time, I remain concerned that disciplinary actions be open to the public. When a hearing is justifiably closed, its results should nonetheless be made public. I am confident that we can work out such details in a consensus, bipartisan effort.

I am convinced that it is worth the effort to reassure those who serve us that we respect their rights and reputations. While no one is above the law, everyone is entitled to be treated fairly.●

By Mrs. BOXER (for herself, Mr. KENNEDY and Mr. HOLLINGS):

S. 349. A bill to amend the Public Health Service Act to provide for expanding, intensifying, and coordinating activities of the National Heart, Lung, and Blood Institute with respect to heart attack, stroke, and other cardiovascular diseases in women; to the Committee on Labor and Human Resources.

THE WOMEN'S CARDIOVASCULAR DISEASES RESEARCH AND PREVENTION ACT

● Mrs. BOXER. Mr. President, today I am introducing the Women's Cardiovascular Diseases Research and Prevention Act, a bill to expand and intensify research and educational outreach programs regarding cardiovascular diseases in women. This bill will aid our Nation's doctors and scientists in developing a coordinated and comprehensive strategy for fighting this terrible disease.

Cardiovascular disease is the No. 1 killer of women in the United States. Over 479,000 women die from cardiovascular disease each year and 1 in 5 women has some form of the disease. Research is our best hope for averting this national tragedy which strikes so many of our grandmothers, mothers, aunts, and daughters.

The Women's Cardiovascular Diseases Research and Prevention Act authorizes $140 million to the National Heart, Lung and Blood Institute to expand and intensify research, prevention, and educational outreach programs for heart attack, stroke, and other cardiovascular diseases in women.

This bill will educate women and doctors about the dire threat heart disease poses to women's health. It will help train doctors to better recognize symptoms of cardiovascular disease which are unique to women. It would also teach women about risk factors, such as smoking, obesity, and physical inactivity, which greatly increase their chances of developing coronary heart disease.

For years, women have been underrepresented in studies conducted on heart disease and stroke. Models and tests for detection have been conducted largely on men. This legislation will help ensure that women are well represented in future heart and stroke research studies.

The Women's Cardiovascular Diseases Research and Prevention Act is being introduced in the House today by Representative MAXINE WATERS.

I urge my colleagues to commit to combating cardiovascular disease by supporting this bill.

I ask unanimous consent that the full text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 349

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Women's Cardiovascular Diseases Research and Prevention Act''.

SEC. 2. FINDINGS.

The Congress finds as follows with respect to women in the United States:

(1) Heart attack, stroke, and other cardiovascular diseases are the leading causes of death in women.

(2) Heart attacks and strokes are leading causes of disability in women.

(3) Cardiovascular diseases claim the lives of more women each year than does cancer. Each year more than 479,000 females die of cardiovascular diseases, while approximately 246,000 females die of cancer. Heart attack kills more than 5 times as many females as breast cancer. Stroke kills twice as many females as breast cancer.

(4) One in 5 females has some form of cardiovascular disease. Of females under age 65, each year more than 20,000 die of heart attacks. In the case of African-American women, from ages 35 to 74 the death rate from heart attacks is approximately twice that of white women and 3 times that of women of other races.

(5) Each year since 1984, cardiovascular diseases have claimed the lives of more females than males. In 1992, of the number of individuals who died of such diseases, 52 percent were females and 48 percent were males.

(6) The clinical course of cardiovascular diseases is different in women than in men, and current diagnostic capabilities are less accurate in women than in men. Once a woman develops a cardiovascular disease, she is more likely than a man to have continuing health problems, and she is more likely to die.

(7) Of women who have had a heart attack, approximately 44 percent die within 1 year of the attack. Of men who have had such an attack, 27 percent die within 1 year. At older ages, women who have had a heart attack are twice as likely as men to die from the attack within a few weeks. Women are more likely than men to have a stroke during the first 6 years following a heart attack. More than 60 percent of women who suffer a stroke die within 8 years. Long-term survivorship of stroke is better in women than in men. Of individuals who die from a stroke, each year approximately 61 percent are females. In 1992, 87,124 females died from strokes. Women have unrecognized heart attacks more frequently than men. Of women who died suddenly from heart attack, 63 percent had no previous evidence of disease.

(8) More than half of the annual health care costs that are related to cardiovascular diseases are attributable to the occurrence of the diseases in women, each year costing this Nation hundreds of billions of dollars in health care costs and lost productivity.

SEC. 3. EXPANSION AND INTENSIFICATION OF ACTIVITIES REGARDING HEART ATTACK, STROKE, AND OTHER CARDIOVASCULAR DISEASES IN WOMEN.

Subpart 2 of part C of title IV of the Public Health Service Act (42 U.S.C. 285b et seq.) is amended by inserting after section 424 the following:

''HEART ATTACK, STROKE, AND OTHER CARDIOVASCULAR DISEASES IN WOMEN

''SEC. 424A. (a) IN GENERAL.—The Director of the Institute shall expand, intensify, and coordinate research and related activities of the Institute with respect to heart attack, stroke, and other cardiovascular diseases in women.

''(b) COORDINATION WITH OTHER INSTITUTES.—The Director of the Institute shall coordinate activities under subsection (a) with similar activities conducted by the other national research institutes and agencies of the National Institutes of Health to the extent that such Institutes and agencies have responsibilities that are related to heart attack, stroke, and other cardiovascular diseases in women.

''(c) CERTAIN PROGRAMS.—In carrying out subsection (a), the Director of the Institute shall conduct or support research to expand the understanding of the causes of, and to develop methods for preventing, cardiovascular diseases in women. Activities under such subsection shall include conducting and supporting the following:

''(1) Research to determine the reasons underlying the prevalence of heart attack, stroke, and other cardiovascular diseases in women, including African-American women and other women who are members of racial or ethnic minority groups.

''(2) Basic research concerning the etiology and causes of cardiovascular diseases in women.

''(3) Epidemiological studies to address the frequency and natural history of such diseases and the differences among men and women, and among racial and ethnic groups, with respect to such diseases.

''(4) The development of safe, efficient, and cost-effective diagnostic approaches to evaluating women with suspected ischemic heart disease.

''(5) Clinical research for the development and evaluation of new treatments for women, including rehabilitation.

''(6) Studies to gain a better understanding of methods of preventing cardiovascular diseases in women, including applications of effective methods for the control of blood pressure, lipids, and obesity.

''(7) Information and education programs for patients and health care providers on risk factors associated with heart attack, stroke, and other cardiovascular diseases in women, and on the importance of the prevention or control of such risk factors and timely referral with appropriate diagnosis and treatment. Such programs shall include information and education on health-related behaviors that can improve such important risk factors as smoking, obesity, high blood cholesterol, and lack of exercise.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $140,000,000 for fiscal year 1998, and such sums as may be necessary for each of the fiscal years 1999 to 2000. The authorization of appropriations established in the preceding sentence is in addition to any other authorization of appropriations that is available for such purpose.''.●

By Mr. THURMOND:

S. 350. A bill to authorize payment of special annuities to surviving spouses of deceased members of the uniformed services who are ineligible for a survivor annuity under transition laws relating to the establishment of the Survivor Benefit Plan under chapter 73 of title 10, United States Code; to the Committee on Armed Services.

ANNUITY LEGISLATION

Mr. THURMOND. Mr. President, I rise today to introduce a bill that would authorize a modest annuity of $165 a month for a group of surviving spouses of former service members who died before March 21, 1974, and were retired from active duty. The bill would also apply to surviving spouses of service members retired from the Reserves between September 21, 1972 and October 1, 1978.

At the time these service members retired from the military, there was no plan to take care of these widows as we have today. The same concerns that moved the Congress to authorize the current survivor benefit plan are true for this group of forgotten widows. The beneficiaries of this plan are all seniors now. For some, this small annuity will make the difference between a life of dependency and a life of dignity and independence. Let us correct this situation and take care of the service members spouses who had the courage to serve their Nation in the troubling time periods of the Korean and Vietnam wars.

I have tried to get this legislation passed in previous Congresses only to be frustrated by budget rules and CBO scoring.

Mr. President, we must not allow bureaucratic rules to stand in our way because, one fact remains true. The

longer we delay, the fewer of these widows there are to benefit from the legislation. I do not want to be remembered as one who forgot this group who have become known as the Forgotten Widows. I urge my colleagues to join me and support this important legislation.

By Mrs. MURRAY:

S. 351. A bill to provide for teacher technology training; to the Committee on Labor and Human Resources.

THE TEACHER TECHNOLOGY TRAINING ACT OF 1997

Mrs. MURRAY. Mr. President, technology is changing our world. It affects the way we communicate, the way we conduct commerce, and the way our children learn in school. Young people today are in the midst of a technology explosion that has really opened up limitless possibilities in the classroom. In order for our students to tap into this potential and be prepared for the 21st century, they have to learn how to use technology. But all too often today, teachers are expected to incorporate technology into their instruction without being given the training to do so.

A recent study by the Office of Technology Assessment shows that a majority of teachers feel they need additional training in order to adequately use a personal computer. In fact, school districts across the country spend less than 15 percent of their technology budgets on teacher training. Hardware, software, access to the Internet are only helpful to the educational process if teachers are equipped with the knowledge to use that technology.

That is why I am introducing today the Teacher Technology Training Act of 1997, which will add technology to the areas of professional development and teacher training on the Elementary and Secondary Schools Act of 1994. My legislation will require States to incorporate technology requirements in teacher training content and performance standards. School districts and local educational agencies that receive Federal funding for professional development have to include technology classes in their programs. In addition, institutions of higher education will be strongly encouraged to include technology in their education programs.

There are two parts to providing students access to technology: putting computers into the schools, and training teachers in how to use them. Last year, I authored and we passed two amendments that would allow surplus computers from Government agencies to be made available to educational institutions across this country. In addition, Congress provided the E-rate in the telecommunications legislation we passed last year that will provide Internet connections to schools at discounted rates. I also fought for a fivefold increase in appropriations for new technology and classrooms.

These are steps toward ensuring that all schools have computer technology. Now I want work to make sure that teachers are properly trained to use these computers.

Recently, the Department of Education reported that only one in five of our Nation's teachers currently use computers in our classrooms—one out of five. Since technology training today focuses primarily on the mechanics of operating equipment, not on integrating technology into the curriculum, this is not surprising.

Washington State, my home State, has become a State synonymous with Microsoft, Boeing, and thousands of other leading high-technology companies. The Information Technology Association of America reports that these information technology companies are short 190,000 employees today. These are employees dependent upon a technology curriculum and trained teachers in our schools.

When I toured my State of Washington last week, I was astounded by the advances made within our classrooms. At Seattle's Nathan Hale High School, I saw a science class that utilized computers to track weather patterns and charts the effects on their region. They have created their own web pages and are able to hourly tap into the National Weather Service. Their final grade was then based on their ability to produce an accurate 5-day weather forecast.

I also saw physically challenged students openly communicate with their teacher through enhanced computer technology. In the city of Bellingham, I spoke with a student-teacher who was concerned that when she and others went out into the field, there would be teachers who did not know how to use the technology. She felt that many of the students are far ahead of the teachers in their ability to use technology. In Grays Harbor County, I toured a facility supported by a public-private partnership. This lifelong learning center takes surplus computers and teaches student how to repair them and maintain their technology. The possibilities for learning are limitless.

Having technology available for instructors does not directly change teaching or learning. What matters is how successfully teachers can incorporate technology into their classrooms.

We know that technology is only one tool the teachers need to be effective in their jobs. My bill seeks to promote technology training. I have received support for this legislation from the National Education Association, the Washington Software and Digital Alliance, University Presidents and Deans, Washington School Principals, and many corporate and educational institutions.

Mr. President, as a former preschool teacher, a parent education instructor, a former school board member, and as a parent, I know the needs of students and teachers have changed dramatically in recent years. My own children have benefit from the use of technology in their classrooms. But a school full of computers is useless if teachers don't have the necessary training to show students how to use them.

As a member of the Labor and Human Resources Committee, I intend to fight for this legislation in Congress. I urge my colleagues' support for this bill so that we can provide teachers with the tools necessary to teach in today's changing classrooms and tomorrow's work force.

By Mr. BIDEN:

S. 352. A bill to require the United States Sentencing Commission to amend the Federal sentencing guidelines to provide an enhanced penalty for follow-on bombings; to the Committee on the Judiciary.

THE POLICE AND RESCUE SQUAD PROTECTION ACT

• Mr. BIDEN. Mr. President, the bombings in Atlanta over the past 2 months—the second of which occurred last weekend—have marked the opening of yet another unfortunate new chapter in the escalation of domestic terrorism.

While the magnitude of these attacks were far less than the World Trade Center and Oklahoma City bombings, they were noteworthy for the pernicious technique this criminal—or criminal organization—used:

First, the terrorists attracted police, firefighters, and rescue workers to the scene by detonating one bomb,

And then, with the unmistakable intent to injure the public safety officers responding to the first explosion, detonated a second explosive device in the parking lot outside the location of the first bombing.

According to the experts, this tactic is one imported from the hotbed of terrorist activity—the Middle East.

On two occasions last year, follow-on bombs were detonated in Southern Lebanon. One almost killed Israel's northern commander—Maj. Gen. Amiram Levine.

Then this January, only 6 days before the Atlanta abortion clinic bombing, two bombs were detonated only 10 minutes apart near a bus station in Tel Aviv. Thirteen people were injured, including one police officer who came to the scene in response to the first bomb and was wounded by the second.

Last month in Atlanta, the first bomb injured no one, but the ''follow-on'' bomb wounded seven people, including two FBI agents, one ATF agent, and two local firefighters. Experts have stated that many more rescue workers would have been injured had the force of the second blast not been deflected by a car, which just happened to be parked in the right spot.

Five people were injured by the bomb that exploded in an Atlanta restaurant last Friday, but fortunately, the police found the second bomb and detonated it with a remote-controlled robot.

Of course, all terrorist acts are horrific. But this follow-on bombing tactic

is especially henious because the technique is designed to do one thing— kill the police, firefighters, paramedics, and all the other professionals who unhesitatingly rush to the scene of a bombing to provide aid to the wounded.

Mark my words: now that this tactic has been employed in Atlanta, covered by the national media, and probably communicated across the country through the Internet, some other devious, sick, individual, somewhere in the United States, will do it again. Mark my words.

I believe that those who employ tactics aimed exclusively at injuring the police, firefighters, and other public safety officers should be punished above and beyond whatever punishment they would receive for destroying property or causing injury.

That is why today I am introducing the Police and Rescue Squad Protection Act.

The bill will increase the punishment for anyone who plants a follow-on bomb with the intent to injure public safety officers. And it clearly states that anyone who detonates, or attempts to detonate one bomb right after another bomb in the same location is acting with the criminal intent to injure law enforcement and emergency medical officials.

In my view, this legislation will send a strong message that we will not tolerate the grotesque tactics that we've seen in the streets of Tel Aviv, and now, in Atlanta.

More importantly, this legislation honors those who, without fear or hesitation, put themselves in jeopardy at a time of crisis.

If this bill deters one terrorist from planting a follow-on bomb and saves the life of one police officer, firefighter, ambulance driver, or paramedic that rushes to the scene of a crime, then it will have been well worth the energy expended to enact it.

I hope my colleagues will join me in this effort.

By Mr. KENNEDY:

S. 353. A bill to amend title XXVII of the Public Health Service Act and part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 to establish standards for protection of consumers in managed care plans and other health plans; to the Committee on Labor and Human Resources.

THE HEALTH INSURANCE BILL OF RIGHTS OF 1997

Mr. KENNEDY. Mr. President, I am introducing today the Health Insurance Bill of Rights Act to provide quality assurance and patient protection. Companion legislation is being introduced in the House of Representatives by Congressman DINGELL, Congressman WAXMAN, Congressman CARDIN, and others.

This legislation is a needed response to the surging growth of managed care and the rapid changes taking place in the health insurance market—changes that too often put insurance industry profits ahead of patients' health needs.

Managed care has mushroomed over the past decade. In 1987, only 13 percent of privately insured Americans were enrolled in HMOs. Today, that figure is 75 percent. At its best, managed care offers the opportunity to achieve both greater efficiency and higher quality in health care. In too many cases, however, the pressure for profits leads to lesser care—not better care. Too many managed care firms and other insurance companies have decided that the shortest route to higher profits and a competitive edge is by denying patients the care they need and deserve.

Some of the most flagrant abuses by insurance plans have been documented in recent months:

Just last year Congress enacted legislation to block drive-by deliveries and prevent new mothers and their babies from being evicted from hospitals in less than 48 hours.

Breast cancer patients are being forced to undergo mastectomies on an outpatient basis, when sound medical advice requires a reasonable hospital stay.

Children are being permanently injured or even losing their lives because their parents are forced to drive past the nearest emergency room to a more distant hospital because it has the contract with their health plan.

Doctors are being subjected to gag rules that keep them from giving their patients their best medical advice.

People with rare and dangerous diseases are being denied access to specialists to treat their conditions.

Patients can't get needed pharmaceutical drugs, because the particular drug they need is not on the list of drugs approved for coverage by their insurance plan; sometimes such lists are developed and administered by pharmaceutical companies bent on selling their own drugs and blocking competition.

Patients are being misdiagnosed, sometimes with fatal results, because insurance plans cut corners on diagnostic tests.

Victims of cancer and other serious diseases are being denied participation in quality clinical trials offering the only hope of cure for otherwise incurable conditions.

Children afflicted with serious, chronic conditions are being denied access to the medical centers with the only available expertise to treat their conditions effectively.

These abuses are not typical of most insurance companies. But they are common enough that an overwhelming 80 percent of Americans now believe that their quality of care is often compromised by their insurance plan to save money. It is time to deal with these festering problems. Good business practices can improve health care, but health care must be more than just another business.

The legislation we are introducing today establishes basic standards for insurance plans in six specific areas:

First, access to care, including specialty care, emergency care, and clinical trials.

Second, standards for quality of care.

Third, information that must be available to patients.

Fourth, expeditious and fair appeal procedures when physicians or patients disagree with plan decisions.

Fifth, protection of the doctor-patient relationship, by banning gag rules and objectionable compensation arrangements.

Sixth, a requirement that plan guidelines may not override good medical practice.

These steps will not eliminate every abuse that occurs in the insurance industry, but they will go a long way to addressing the major problems patients confront.

At the most basic level, the legislation establishes a right to needed care. A patient facing a health emergency should not be required to go to a distant emergency room, or to obtain prior authorization for care. Someone suffering from a serious condition requiring specialty care should not be denied that care because an insurance company thinks it is too expensive. Someone with a condition that cannot be addressed by conventional therapies should have a reasonable opportunity to participate in a quality clinical trial that offers the hope of effective treatment. Plans should set up clear, fair, and timely appeal procedures for cases in which the plan fails to fulfill its obligations.

Historically, patients have relied on their personal physician to be the best source of impartial advice on needed care. This legislation maintains that critical role by prohibiting plans from restricting doctor-patient communications or from establishing compensation plans that bribe or penalize doctors into representing the plan's interest at the expense of their patients' health.

To maintain and improve quality of care, all managed care plans will be required to set up a separate unit dedicated to quality, and to collect data to verify that the plan, in fact, is providing care that meets objective quality standards.

Patients will be guaranteed full information about plan coverage, appeal rights, access to primary care doctors and other specialists, and other needed information. Plans will be required to collect and make available standardized data for consumers to compare plans.

These provisions add up to a health insurance bill of rights that will protect millions of Americans.

I look forward to working with a broad range of physician, patient, and industry groups as Congress considers this legislation. Action is essential and overdue to provide these needed protections. The bottom line in health care must be patient needs, not industry profits. Concerned citizens in all parts of the country are demanding action, and Congress owes them a response.

Mr. President, I ask unanimous consent that additional material be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 353

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Bill of Rights Act of 1997''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

(a) PATIENT PROTECTION STANDARDS.—Title XXVII of the Public Health Service Act is amended—

(1) by redesignating part C as part D, and

(2) by inserting after part B the following new part:

''PART C—PATIENT PROTECTION STANDARDS

''SEC. 2770. NOTICE; ADDITIONAL DEFINITIONS.

''(a) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this part as if such section applied to such issuer and such issuer were a group health plan.

''(b) ADDITIONAL DEFINITIONS.—For purposes of this part:

''(1) NONPARTICIPATING PHYSICIAN OR PROVIDER.—The term 'nonparticipating physician or provider' means, with respect to health care items and services furnished to an enrollee under health insurance coverage, a physician or provider that is not a participating physician or provider for such services.

''(2) PARTICIPATING PHYSICIAN OR PROVIDER.—The term 'participating physician or provider' means, with respect to health care items and services furnished to an enrollee under health insurance coverage, a physician or provider that furnishes such items and services under a contract or other arrangement with the health insurance issuer offering such coverage.

''SUBPART 1—ACCESS TO CARE

''SEC. 2771. ACCESS TO EMERGENCY CARE.

''(a) PROHIBITION OF CERTAIN RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.

''(1) IN GENERAL.—If health insurance coverage provides any benefits with respect to emergency services (as defined in paragraph (2)(B)), the health insurance issuer offering such coverage shall cover emergency services furnished to an enrollee—

''(A) without the need for any prior authorization determination,

''(B) subject to paragraph (3), whether or not the physician or provider furnishing such services is a participating physician or provider with respect to such services, and

''(C) subject to paragraph (3), without regard to any other term or condition of such coverage (other than an exclusion of benefits, or an affiliation or waiting period, permitted under section 2701).

''(2) EMERGENCY SERVICES; EMERGENCY MEDICAL CONDITION.—For purposes of this section—

''(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

''(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(ii) serious impairment to bodily functions, or

''(iii) serious dysfunction of any bodily organ or part.

''(B) EMERGENCY SERVICES.—The term 'emergency services' means—

''(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition (as defined in subparagraph (A)), and

''(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of the Social Security Act to stabilize the patient.

''(C) TRAUMA AND BURN CENTERS.—The provisions of clause (ii) of subparagraph (B) apply to a trauma or burn center, in a hospital, that—

''(i) is designated by the State, a regional authority of the State, or by the designee of the State, or

''(ii) is in a State that has not made such designations and meets medically recognized national standards.

''(3) APPLICATION OF NETWORK RESTRICTION PERMITTED IN CERTAIN CASES.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), if a health insurance issuer in relation to health insurance coverage denies, limits, or otherwise differentiates in coverage or payment for benefits other than emergency services on the basis that the physician or provider of such services is a nonparticipating physician or provider, the issuer may deny, limit, or differentiate in coverage or payment for emergency services on such basis.

''(B) NETWORK RESTRICTIONS NOT PERMITTED IN CERTAIN EXCEPTIONAL CASES.—The denial or limitation of, or differentiation in, coverage or payment of benefits for emergency services under subparagraph (A) shall not apply in the following cases:

''(i) CIRCUMSTANCES BEYOND CONTROL OF ENROLLEE.—The enrollee is unable to go to a participating hospital for such services due to circumstances beyond the control of the enrollee (as determined consistent with guidelines and subparagraph (C)).

''(ii) LIKELIHOOD OF AN ADVERSE HEALTH CONSEQUENCE BASED ON LAYPERSON'S JUDGMENT.—A prudent layperson possessing an average knowledge of health and medicine could reasonably believe that, under the circumstances and consistent with guidelines, the time required to go to a participating hospital for such services could result in any of the adverse health consequences described in a clause of subsection (a)(2)(A).

''(iii) PHYSICIAN REFERRAL.—A participating physician or other person authorized by the plan refers the enrollee to an emergency department of a hospital and does not specify an emergency department of a hospital that is a participating hospital with respect to such services.

''(C) APPLICATION OF 'BEYOND CONTROL' STANDARDS.—For purposes of applying subparagraph (B)(i), receipt of emergency services from a nonparticipating hospital shall be treated under the guidelines as being 'due to circumstances beyond the control of the enrollee' if any of the following conditions are met:

''(i) UNCONSCIOUS.—The enrollee was unconscious or in an otherwise altered mental state at the time of initiation of the services.

''(ii) AMBULANCE DELIVERY.—The enrollee was transported by an ambulance or other emergency vehicle directed by a person other than the enrollee to the nonparticipating hospital in which the services were provided.

''(iii) NATURAL DISASTER.—A natural disaster or civil disturbance prevented the enrollee from presenting to a participating hospital for the provision of such services.

''(iv) NO GOOD FAITH EFFORT TO INFORM OF CHANGE IN PARTICIPATION DURING A CONTRACT YEAR.—The status of the hospital changed from a participating hospital to a nonparticipating hospital with respect to emergency services during a contract year and the plan or issuer failed to make a good faith effort to notify the enrollee involved of such change.

''(v) OTHER CONDITIONS.—There were other factors (such as those identified in guidelines) that prevented the enrollee from controlling selection of the hospital in which the services were provided.

''(b) ASSURING COORDINATED COVERAGE OF MAINTENANCE CARE AND POST-STABILIZATION CARE.—

''(1) IN GENERAL.—In the case of an enrollee who is covered under health insurance coverage issued by a health insurance issuer and who has received emergency services pursuant to a screening evaluation conducted (or

supervised) by a treating physician at a hospital that is a nonparticipating provider with respect to emergency services, if—

''(A) pursuant to such evaluation, the physician identifies post-stabilization care (as defined in paragraph (3)(B)) that is required by the enrollee,

''(B) the coverage provides benefits with respect to the care so identified and the coverage requires (but for this subsection) an affirmative prior authorization determination as a condition of coverage of such care, and

''(C) the treating physician (or another individual acting on behalf of such physician) initiates, not later than 30 minutes after the time the treating physician determines that the condition of the enrollee is stabilized, a good faith effort to contact a physician or other person authorized by the issuer (by telephone or other means) to obtain an affirmative prior authorization determination with respect to the care,

then, without regard to terms and conditions specified in paragraph (2) the issuer shall cover maintenance care (as defined in paragraph (3)(A)) furnished to the enrollee during the period specified in paragraph (4) and shall cover post-stabilization care furnished to the enrollee during the period beginning under paragraph (5) and ending under paragraph (6).

''(2) TERMS AND CONDITIONS WAIVED.—The terms and conditions (of coverage) described in this paragraph that are waived under paragraph (1) are as follows:

''(A) The need for any prior authorization determination.

''(B) Any limitation on coverage based on whether or not the physician or provider furnishing the care is a participating physician or provider with respect to such care.

''(C) Any other term or condition of the coverage (other than an exclusion of benefits, or an affiliation or waiting period, permitted under section 2701 and other than a requirement relating to medical necessity for coverage of benefits).

''(3) MAINTENANCE CARE AND POST-STABILIZATION CARE DEFINED.—In this subsection:

''(A) MAINTENANCE CARE.—The term 'maintenance care' means, with respect to an individual who is stabilized after provision of emergency services, medically necessary items and services (other than emergency services) that are required by the individual to ensure that the individual remains stabilized during the period described in paragraph (4).

''(B) POST-STABILIZATION CARE.—The term 'post-stabilization care' means, with respect to an individual who is determined to be stable pursuant to a medical screening examination or who is stabilized after provision of emergency services, medically necessary items and services (other than emergency services and other than maintenance care) that are required by the individual.

''(4) PERIOD OF REQUIRED COVERAGE OF MAINTENANCE CARE.—The period of required coverage of maintenance care of an individual under this subsection begins at the time of the request (or the initiation of the good faith effort to make the request) under paragraph (1)(C) and ends when—

''(A) the individual is discharged from the hospital;

''(B) a physician (designated by the issuer involved) and with privileges at the hospital involved arrives at the emergency department of the hospital and assumes responsibility with respect to the treatment of the individual; or

''(C) the treating physician and the issuer agree to another arrangement with respect to the care of the individual.

''(5) WHEN POST-STABILIZATION CARE REQUIRED TO BE COVERED.—

''(A) WHEN TREATING PHYSICIAN UNABLE TO COMMUNICATE REQUEST.—If the treating physician or other individual makes the good faith effort to request authorization under paragraph (1)(C) but is unable to communicate the request directly with an authorized person referred to in such paragraph within 30 minutes after the time of initiating such effort, then post-stabilization care is required to be covered under this subsection beginning at the end of such 30-minute period.

''(B) WHEN ABLE TO COMMUNICATE REQUEST, AND NO TIMELY RESPONSE.—

''(i) IN GENERAL.—If the treating physician or other individual under paragraph (1)(C) is able to communicate the request within the 30-minute period described in subparagraph (A), the post-stabilization care requested is required to be covered under this subsection beginning 30 minutes after the time when the issuer receives the request unless a person authorized by the plan or issuer involved communicates (or makes a good faith effort to communicate) a denial of the request for the prior authorization determination within 30 minutes of the time when the issuer receives the request and the treating physician does not request under clause (ii) to communicate directly with an authorized physician concerning the denial.

''(ii) REQUEST FOR DIRECT PHYSICIAN-TO-PHYSICIAN COMMUNICATION CONCERNING DENIAL.—If a denial of a request is communicated under clause (i), the treating physician may request to communicate respecting the denial directly with a physician who is authorized by the issuer to deny or affirm such a denial.

''(C) WHEN NO TIMELY RESPONSE TO REQUEST FOR PHYSICIAN-TO-PHYSICIAN COMMUNICATION.—If a request for physician-to-physician communication is made under subparagraph (B)(ii), the post-stabilization care requested is required to be covered under this subsection beginning 30 minutes after the time when the issuer receives the request from a treating physician unless a physician, who is authorized by the issuer to reverse or affirm the initial denial of the care, communicates (or makes a good faith effort to communicate) directly with the treating physician within such 30-minute period.

''(D) DISAGREEMENTS OVER POST-STABILIZATION CARE.—If, after a direct physician-to-physician communication under subparagraph (C), the denial of the request for the post-stabilization care is not reversed and the treating physician communicates to the issuer involved a disagreement with such decision, the post-stabilization care requested is required to be covered under this subsection beginning as follows:

''(i) DELAY TO ALLOW FOR PROMPT ARRIVAL OF PHYSICIAN ASSUMING RESPONSIBILITY.—If the issuer communicates that a physician (designated by the plan or issuer) with privileges at the hospital involved will arrive promptly (as determined under guidelines) at the emergency department of the hospital in order to assume responsibility with respect to the treatment of the enrollee involved, the required coverage of the post-stabilization care begins after the passage of such time period as would allow the prompt arrival of such a physician.

''(ii) OTHER CASES.—If the issuer does not so communicate, the required coverage of the post-stabilization care begins immediately.

''(6) NO REQUIREMENT OF COVERAGE OF POST-STABILIZATION CARE IF ALTERNATE PLAN OF TREATMENT.—

''(A) IN GENERAL.—Coverage of post-stabilization care is not required under this subsection with respect to an individual when—

''(i) subject to subparagraph (B), a physician (designated by the plan or issuer involved) and with privileges at the hospital involved arrives at the emergency department of the hospital and assumes responsibility with respect to the treatment of the individual; or

''(ii) the treating physician and the issuer agree to another arrangement with respect to the post-stabilization care (such as an appropriate transfer of the individual involved to another facility or an appointment for timely followup treatment for the individual).

''(B) SPECIAL RULE WHERE ONCE CARE INITIATED.—Required coverage of requested post-stabilization care shall not end by reason of subparagraph (A)(i) during an episode of care (as determined by guidelines) if the treating physician initiated such care (consistent with a previous paragraph) before the arrival of a physician described in such subparagraph.

''(7) CONSTRUCTION.—Nothing in this subsection shall be construed as—

''(A) preventing an issuer from authorizing coverage of maintenance care or post-stabilization care in advance or at any time; or

''(B) preventing a treating physician or other individual described in paragraph (1)(C) and an issuer from agreeing to modify any of the time periods specified in paragraphs (5) as it relates to cases involving such persons.

''(c) LIMITS ON COST-SHARING FOR SERVICES FURNISHED IN EMERGENCY DEPARTMENTS.—If health insurance coverage provides any benefits with respect to emergency services, the health insurance issuer offering such coverage may impose cost sharing with respect to such services only if the following conditions are met:

''(1) LIMITATIONS ON COST-SHARING DIFFERENTIAL FOR NONPARTICIPATING PROVIDERS.—

''(A) NO DIFFERENTIAL FOR CERTAIN SERVICES.—In the case of services furnished under the circumstances described in clause (i), (ii), or (iii) of subsection (a)(3)(B) (relating to circumstances beyond the control of the enrollee, the likelihood of an adverse health consequence based on layperson's judgment, and physician referral), the cost-sharing for such services provided by a nonparticipating provider or physician does not exceed the cost-sharing for such services provided by a participating provider or physician.

''(B) ONLY REASONABLE DIFFERENTIAL FOR OTHER SERVICES.—In the case of other emergency services, any differential by which the cost-sharing for such services provided by a nonparticipating provider or physician exceeds the cost-sharing for such services provided by a participating provider or physician is reasonable (as determined under guidelines).

''(2) ONLY REASONABLE DIFFERENTIAL BETWEEN EMERGENCY SERVICES AND OTHER SERVICES.—Any differential by which the cost-sharing for services furnished in an emergency department exceeds the cost-sharing for such services furnished in another setting is reasonable (as determined under guidelines).

''(3) CONSTRUCTION.—Nothing in paragraph (1)(B) or (2) shall be construed as authorizing guidelines other than guidelines that establish maximum cost-sharing differentials.

''(d) INFORMATION ON ACCESS TO EMERGENCY SERVICES.—A health insurance issuer, to the extent a health insurance issuer offers health insurance coverage, shall provide education to enrollees on—

''(1) coverage of emergency services (as defined in subsection (a)(2)(B)) by the issuer in accordance with the provisions of this section,

''(2) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent,

''(3) any cost sharing applicable to emergency services,

''(4) the process and procedures of the plan for obtaining emergency services, and

''(5) the locations of—

''(A) emergency departments, and

''(B) other settings,

in which participating physicians and hospitals provide emergency services and post-stabilization care.

''(e) GENERAL DEFINITIONS.—For purposes of this section:

''(1) COST SHARING.—The term 'cost sharing' means any deductible, coinsurance amount, copayment or other out-of-pocket payment (other than premiums or enrollment fees) that a health insurance issuer offering health insurance issuer imposes on enrollees with respect to the coverage of benefits.

''(2) GOOD FAITH EFFORT.—The term 'good faith effort' has the meaning given such term in guidelines and requires such appropriate documentation as is specified under such guidelines.

''(3) GUIDELINES.—The term 'guidelines' means guidelines established by the Secretary after consultation with an advisory panel that includes individuals representing emergency physicians, health insurance issuers, including at least one health maintenance organization, hospitals, employers, the States, and consumers.

''(4) PRIOR AUTHORIZATION DETERMINATION.—The term 'prior authorization determination' means, with respect to items and services for which coverage may be provided under health insurance coverage, a determination (before the provision of the items and services and as a condition of coverage of the items and services under the coverage) of whether or not such items and services will be covered under the coverage.

''(5) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide (in complying with section 1867 of the Social Security Act) such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from the facility.

''(6) STABILIZED.—The term 'stabilized' means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur before an individual can be transferred from the facility, in compliance with the requirements of section 1867 of the Social Security Act.

''(7) TREATING PHYSICIAN.—The term 'treating physician' includes a treating health care professional who is licensed under State law to provide emergency services other than under the supervision of a physician.

''SEC. 2772. ACCESS TO SPECIALTY CARE.

''(a) OBSTETRICAL AND GYNECOLOGICAL CARE.—

''(1) IN GENERAL.—If a health insurance issuer, in connection with the provision of health insurance coverage, requires or provides for an enrollee to designate a participating primary care provider—

''(A) the issuer shall permit a female enrollee to designate a physician who specializes in obstetrics and gynecology as the enrollee's primary care provider; and

''(B) if such an enrollee has not designated such a provider as a primary care provider, the issuer—

''(i) may not require prior authorization by the enrollee's primary care provider or otherwise for coverage of routine gynecological care (such as preventive women's health examinations) and pregnancy-related services provided by a participating physician who specializes in obstetrics and gynecology to the extent such care is otherwise covered, and

''(ii) may treat the ordering of other gynecological care by such a participating physician as the prior authorization of the primary care provider with respect to such care under the coverage.

''(2) CONSTRUCTION.—Nothing in paragraph (1)(B)(ii) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological care so ordered.

''(b) SPECIALTY CARE.—

''(1) REFERRAL TO SPECIALTY CARE FOR ENROLLEES REQUIRING TREATMENT BY SPECIALISTS.—

''(A) IN GENERAL.—In the case of an enrollee who is covered under health insurance coverage offered by a health insurance issuer and who has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist, the issuer shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease.

''(B) SPECIALIST DEFINED.—For purposes of this subsection, the term 'specialist' means, with respect to a condition, a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

''(C) CARE UNDER REFERRAL.—Care provided pursuant to such referral under subparagraph (A) shall be—

''(i) pursuant to a treatment plan (if any) developed by the specialist and approved by the issuer, in consultation with the designated primary care provider or specialist and the enrollee (or the enrollee's designee), and

''(ii) in accordance with applicable quality assurance and utilization review standards of the issuer.

Nothing in this subsection shall be construed as preventing such a treatment plan for an enrollee from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

''(D) REFERRALS TO PARTICIPATING PROVIDERS.—An issuer is not required under subparagraph (A) to provide for a referral to a specialist that is not a participating provider, unless the issuer does not have an appropriate specialist that is available and accessible to treat the enrollee's condition and that is a participating provider with respect to such treatment.

''(E) TREATMENT OF NONPARTICIPATING PROVIDERS.—If an issuer refers an enrollee to a nonparticipating specialist, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received by such a specialist that is a participating provider.

''(2) SPECIALISTS AS PRIMARY CARE PROVIDERS.—

''(A) IN GENERAL.—A health insurance issuer, in connection with the provision of health insurance coverage, shall have a procedure by which a new enrollee upon enrollment, or an enrollee upon diagnosis, with an ongoing special condition (as defined in subparagraph (C)) may receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the enrollee's primary and specialty care. If such an enrollee's care would most appropriately be coordinated by such a specialist, the issuer shall refer the enrollee to such specialist.

''(B) TREATMENT AS PRIMARY CARE PROVIDER.—Such specialist shall be permitted to treat the enrollee without a referral from the enrollee's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the enrollee's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan (referred to in paragraph (1)(C)(i)).

''(C) ONGOING SPECIAL CONDITION DEFINED.—In this paragraph, the term 'special condition' means a condition or disease that—

''(i) is life-threatening, degenerative, or disabling, and

''(ii) requires specialized medical care over a prolonged period of time.

''(D) TERMS OF REFERRAL.—The provisions of subparagraphs (C) through (E) of paragraph (1) shall apply with respect to referrals under subparagraph (A) of this paragraph in the same manner as they apply to referrals under paragraph (1)(A).

''(3) STANDING REFERRALS.—

''(A) IN GENERAL.—A health insurance issuer, in connection with the provision of health insurance coverage, shall have a procedure by which an enrollee who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the issuer, or the primary care provider in consultation with the medical director of the issuer and the specialist (if any), determines that such a standing referral is appropriate, the issuer shall make such a referral to such a specialist.

''(C) TERMS OF REFERRAL.—The provisions of subparagraphs (C) through (E) of paragraph (1) shall apply with respect to referrals under subparagraph (A) of this paragraph in the same manner as they apply to referrals under paragraph (1)(A).

''SEC. 2773. CONTINUITY OF CARE.

''(a) IN GENERAL.—If a contract between a health insurance issuer, in connection with the provision of health insurance coverage, and a health care provider is terminated (other than by the issuer for failure to meet applicable quality standards or for fraud) and an enrollee is undergoing a course of treatment from the provider at the time of such termination, the issuer shall—

''(1) notify the enrollee of such termination, and

''(2) subject to subsection (c), permit the enrollee to continue the course of treatment with the provider during a transitional period (provided under subsection (b)).

''(b) TRANSITIONAL PERIOD.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend for at least—

''(A) 60 days from the date of the notice to the enrollee of the provider's termination in the case of a primary care provider, or

''(B) 120 days from such date in the case of another provider.

''(2) INSTITUTIONAL CARE.—The transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and shall include reasonable follow-up care related to the institutionalization and shall also include institutional care scheduled prior to the date of termination of the provider status.

''(3) PREGNANCY.—If—

''(A) an enrollee has entered the second trimester of pregnancy at the time of a provider's termination of participation, and

''(B) the provider was treating the pregnancy before date of the termination,

the transitional period under this subsection with respect to provider's treatment of the

pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—

''(A) IN GENERAL.—If—

''(i) an enrollee was determined to be terminally ill (as defined in subparagraph (B)) at the time of a provider's termination of participation, and

''(ii) the provider was treating the terminal illness before the date of termination,

the transitional period under this subsection shall extend for the remainder of the enrollee's life for care directly related to the treatment of the terminal illness.

''(B) DEFINITION.—In subparagraph (A), an enrollee is considered to be 'terminally ill' if the enrollee has a medical prognosis that the enrollee's life expectancy is 6 months or less.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—An issuer may condition coverage of continued treatment by a provider under subsection (a)(2) upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to continue to accept reimbursement from the issuer at the rates applicable prior to the start of the transitional period as payment in full.

''(2) The provider agrees to adhere to the issuer's quality assurance standards and to provide to the issuer necessary medical information related to the care provided.

''(3) The provider agrees otherwise to adhere to the issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan approved by the issuer.

''SEC. 2774. CHOICE OF PROVIDER.

''(a) PRIMARY CARE.—A health insurance issuer that offers health insurance coverage shall permit each enrollee to receive primary care from any participating primary care provider who is available to accept such enrollee.

''(b) SPECIALISTS.—

''(1) IN GENERAL.—Subject to paragraph (2), a health insurance issuer that offers health insurance coverage shall permit each enrollee to receive medically necessary specialty care, pursuant to appropriate referral procedures, from any qualified participating health care provider who is available to accept such enrollee for such care.

''(2) LIMITATION.—Paragraph (1) shall not apply to speciality care if the issuer clearly informs enrollees of the limitations on choice of participating providers with respect to such care.

''(c) LIST OF PARTICIPATING PROVIDERS.—For disclosure of information about participating primary care and specialty care providers, see section 2782(b)(3).

''SEC. 2775. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

''(a) IN GENERAL.—If a health insurance issuer offers health insurance coverage to a qualified enrollee (as defined in subsection (b)), the issuer—

''(1) may not deny the enrollee participation in the clinical trial referred to in subsection (b)(2);

''(2) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

''(3) may not discriminate against the enrollee on the basis of the enrollee's participation in such trial.

''(b) QUALIFIED ENROLLEE DEFINED.—For purposes of subsection (a), the term 'qualified enrollee' means an enrollee under health insurance coverage who meets the following conditions:

''(1) The enrollee has a life-threatening or serious illness for which no standard treatment is effective.

''(2) The enrollee is eligible to participate in an approved clinical trial with respect to treatment of such illness.

''(3) The enrollee and the referring physician conclude that the enrollee's participation in such trial would be appropriate.

''(4) The enrollee's participation in the trial offers potential for significant clinical benefit for the enrollee.

''(c) PAYMENT.—

''(1) IN GENERAL.—Under this section an issuer shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected (as determined by the Secretary) to be paid for by the sponsors of an approved clinical trial.

''(2) PAYMENT RATE.—In the case of covered items and services provided by—

''(A) a participating provider, the payment rate shall be at the agreed upon rate, or

''(B) a nonparticipating provider, the payment rate shall be at the rate the issuer would normally pay for comparable services under subparagraph (A).

''(d) APPROVED CLINICAL TRIAL DEFINED.—In this section, the term 'approved clinical trial' means a clinical research study or clinical investigation approved and funded by one or more of the following:

''(1) The National Institutes of Health.

''(2) A cooperative group or center of the National Institutes of Health.

''(3) The Department of Veterans Affairs.

''(4) The Department of Defense.

''SEC. 2776. ACCESS TO NEEDED PRESCRIPTION DRUGS.

''If a health insurance issuer offers health insurance coverage that provides benefits with respect to prescription drugs but the coverage limits such benefits to drugs included in a formulary, the issuer shall—

''(1) ensure participation of participating physicians in the development of the formulary;

''(2) disclose the nature of the formulary restrictions; and

''(3) provide for exceptions from the formulary limitation when medical necessity, as determined by the enrollee's physician subject to reasonable review by the issuer, dictates that a non-formulary alternative is indicated.

''SUBPART 2—QUALITY ASSURANCE

''SEC. 2777. INTERNAL QUALITY ASSURANCE PROGRAM.

''(a) REQUIREMENT.—A health insurance issuer that offers health insurance coverage shall establish and maintain an ongoing, internal quality assurance and continuous quality improvement program that meets the requirements of subsection (b).

''(b) PROGRAM REQUIREMENTS.—The requirements of this subsection for a quality improvement program of an issuer are as follows:

''(1) ADMINISTRATION.—The issuer has a separate identifiable unit with responsibility for administration of the program.

''(2) WRITTEN PLAN.—The issuer has a written plan for the program that is updated annually and that specifies at least the following:

''(A) The activities to be conducted.

''(B) The organizational structure.

''(C) The duties of the medical director.

''(D) Criteria and procedures for the assessment of quality.

''(E) Systems for ongoing and focussed evaluation activities.

''(3) SYSTEMATIC REVIEW.—The program provides for systematic review of the type of health services provided, consistency of services provided with good medical practice, and patient outcomes.

''(4) QUALITY CRITERIA.—The program—

''(A) uses criteria that are based on performance and clinical outcomes where feasible and appropriate, and

''(B) includes criteria that are directed specifically at meeting the needs of at-risk populations and enrollees with chronic or severe illnesses.

''(5) SYSTEM FOR REPORTING.—The program has procedures for reporting of possible quality concerns by providers and enrollees and for remedial actions to correct quality problems, including written procedures for responding to concerns and taking appropriate corrective action.

''(6) DATA COLLECTION.—The program provides for the collection of systematic, scientifically based data to be used in the measure of quality.

''(c) DEEMING.—For purposes of subsection (a), the requirements of subsection (b) are deemed to be met with respect to a health insurance issuer if the issuer—

''(1) is a qualified health maintenance organization (as defined in section 1310(d)), or

''(2) is accredited by a national accreditation organization that is certified by the Secretary.

''SEC. 2778. COLLECTION OF STANDARDIZED DATA.

''(a) IN GENERAL.—A health insurance issuer that offers health insurance coverage shall collect uniform quality data that include—

''(1) a minimum uniform data set described in subsection (b), and

''(2) additional data that are consistent with the requirements of a nationally recognized body identified by the Secretary.

''(b) MINIMUM UNIFORM DATA SET.—The Secretary shall specify the data required to be included in the minimum uniform data set under subsection (a)(1) and the standard format for such data. Such data shall include at least—

''(1) aggregate utilization data;

''(2) data on the demographic characteristics of enrollees;

''(3) data on disease-specific and age-specific mortality rates of enrollees;

''(4) data on enrollee satisfaction, including data on enrollee disenrollment and grievances; and

''(5) data on quality indicators.

''(c) AVAILABILITY.—A summary of the data collected under subsection (a) shall be disclosed under section 2782(b)(4).

''SEC. 2779. PROCESS FOR SELECTION OF PROVIDERS.

''(a) IN GENERAL.—A health insurance issuer that offers health insurance coverage shall have a written process for the selection of participating health care professionals, including minimum professional requirements.

''(b) VERIFICATION OF BACKGROUND.—Such process shall include verification of a health care provider's license, a history of suspension or revocation, and liability claim history.

''(c) RESTRICTION.—Such process shall not use a high-risk patient base or location of a provider in an area with residents with poorer health status as a basis for excluding providers from participation.

''SEC. 2780. DRUG UTILIZATION PROGRAM.

''A health insurance issuer that provides health insurance coverage that includes benefits for prescription drugs shall establish and maintain a drug utilization program which—

''(1) encourages appropriate use of prescription drugs by enrollees and providers,

''(2) monitors illnesses arising from improper drug use or from adverse drug reactions or interactions, and

''(3) takes appropriate action to reduce the incidence of improper drug use and adverse drug reactions and interactions.

"SEC. 2781. STANDARDS FOR UTILIZATION REVIEW ACTIVITIES.

''(a) COMPLIANCE WITH REQUIREMENTS.—

''(1) IN GENERAL.—A health insurance issuer shall conduct utilization review activities in connection with the provision of health insurance coverage only in accordance with a utilization review program that meets the requirements of this section.

''(2) USE OF OUTSIDE AGENTS.—Nothing in this section shall be construed as preventing a health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

''(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms 'utilization review' and 'utilization review activities' mean procedures used to monitor or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes ambulatory review, prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

''(b) WRITTEN POLICIES AND CRITERIA.—

''(1) WRITTEN POLICIES.—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

''(2) USE OF WRITTEN CRITERIA.—

''(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed pursuant to the program with the input of appropriate physicians.

''(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for an enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

''(C) NO ADVERSE DETERMINATION BASED ON REFUSAL TO OBSERVE SERVICE.—Such a program shall not base an adverse determination on—

''(i) a refusal to consent to observing any health care service, or

''(ii) lack of reasonable access to a health care provider's medical or treatment records, unless the program has provided reasonable notice to the enrollee.

''(c) CONDUCT OF PROGRAM ACTIVITIES.—

''(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions. In this subsection, the term 'health care professional' means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with State law.

''(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

''(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and, to the extent required, who have received appropriate training in the conduct of such activities under the program.

''(B) PEER REVIEW OF ADVERSE CLINICAL DETERMINATIONS.—Such a program shall provide that clinical peers shall evaluate the clinical appropriateness of adverse clinical determinations. In this subsection, the term 'clinical peer' means, with respect to a review, a physician or other health care professional who holds a non-restricted license in a State and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

''(C) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that—

''(i) provides incentives, direct or indirect, for such persons to make inappropriate review decisions, or

''(ii) is based, directly or indirectly, on the quantity or type of adverse determinations rendered.

''(D) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who provides health care services to an enrollee to perform utilization review activities in connection with the health care services being provided to the enrollee.

''(3) TOLL-FREE TELEPHONE NUMBER.—Such a program shall provide that—

''(A) appropriate personnel performing utilization review activities under the program are reasonably accessible by toll-free telephone not less than 40 hours per week during normal business hours to discuss patient care and allow response to telephone requests, and

''(B) the program has a telephone system capable of accepting, recording, or providing instruction to incoming telephone calls during other than normal business hours and to ensure response to accepted or recorded messages not less than one business day after the date on which the call was received.

''(4) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilization review activities with respect to a class of services furnished to an enrollee more frequently than is reasonably required to assess whether the services under review are medically necessary.

''(5) LIMITATION ON INFORMATION REQUESTS.—Under such a program, information shall be required to be provided by health care providers only to the extent it is necessary to perform the utilization review activity involved.

''(d) DEADLINE FOR DETERMINATIONS.—

''(1) PRIOR AUTHORIZATION SERVICES.—Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the enrollee or the enrollee's designee and the enrollee's health care provider by telephone and in writing, as soon as possible in accordance with the medical exigencies of the cases, and in no event later than 3 business days after the date of receipt of the necessary information respecting such determination.

''(2) CONTINUED CARE.—In the case of a utilization review activity involving authorization for continued or extended health care services, or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the enrollee or the enrollee's designee and the enrollee's health care provider by telephone and in writing, within 1 business day of the date of receipt of the necessary information respecting such determination. Such notice shall include, with respect to continued or extended health care services, the number of extended services approved, the new total of approved services, the date of onset of services, and the next review date.

''(3) PREVIOUSLY PROVIDED SERVICES.—In the case of a utilization review activity involving retrospective review of health care services previously provided, the utilization review program shall make a the determination concerning such services, and provide notice of the determination to the enrollee or the enrollee's designee and the enrollee's health care provider by telephone and in writing, within 30 days of the date of receipt of the necessary information respecting such determination.

''(4) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, AND POST-STABILIZATION CARE.—For waiver of prior authorization requirements in certain cases involving emergency services and maintenance care and post-stabilization care, see sections 2771(a)(1)(A) and 2771(a)(2)(A), respectively.

''(e) NOTICE OF ADVERSE DETERMINATIONS.—

''(1) IN GENERAL.—Notice of an adverse determination under a utilization review program (including as a result of a reconsideration under subsection (f)) shall be in writing and shall include—

''(A) the reasons for the determination (including the clinical rationale);

''(B) instructions on how to initiate an appeal under section 2785; and

''(C) notice of the availability, upon request of the enrollee (or the enrollee's designee) of the clinical review criteria relied upon to make such determination.

''(2) SPECIFICATION OF ANY ADDITIONAL INFORMATION.—Such a notice shall also specify what (if any) additional necessary information must be provided to, or obtained by, person making the determination in order to make a decision on such an appeal.

''(f) RECONSIDERATION.—

''(1) AT REQUEST OF PROVIDER.—In the event that a utilization review program provides for an adverse determination without attempting to discuss such matter with the enrollee's health care provider who specifically recommended the health care service, procedure, or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination under this subsection.

''(2) TIMING AND CONDUCT.—Except in cases of retrospective reviews, such reconsideration shall occur as soon as possible in accordance with the medical exigencies of the cases, and in no event later than 1 business day after the date of receipt of the request and shall be conducted by the enrollee's health care provider and the health care professional making the initial determination or a designated qualified health care professional if the original professional cannot be available.

''(3) NOTICE.—In the event that the adverse determination is upheld after reconsideration, the utilization review program shall provide notice as required under subsection (e).

''(4) CONSTRUCTION.—Nothing in this subsection shall preclude the enrollee from initiating an appeal from an adverse determination under section 2785.

''SUBPART 3—PATIENT INFORMATION

"SEC. 2782. PATIENT INFORMATION.

''(a) DISCLOSURE REQUIREMENT.—A health insurance issuer in connection with the provision of health insurance coverage shall submit to the applicable State authority, provide to enrollees (and prospective enrollees), and make available to the public, in writing the information described in subsection (b).

''(b) INFORMATION.—The information described in this subsection includes the following:

''(1) DESCRIPTION OF COVERAGE.—A description of coverage provisions, including health care benefits, benefit limits, coverage exclusions, coverage of emergency care, and the definition of medical necessity used in determining whether benefits will be covered.

''(2) ENROLLEE FINANCIAL RESPONSIBILITY.—An explanation of an enrollee's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, including limits on such responsibility and responsibility for health care services that are provided by nonparticipating providers or are furnished without meeting applicable utilization review requirements.

''(3) INFORMATION ON PROVIDERS.—A description—

''(A) of procedures for enrollees to select, access, and change participating primary and specialty providers,

''(B) of the rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers, and

''(C) in the case of each participating provider, of the name, address, and telephone number of the provider, the credentials of the provider, and the provider's availability to accept new patients.

''(4) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and rights to reconsideration and appeal) under any utilization review program under section 2781 or any drug utilization program under section 2780, as well as a summary of the minimum uniform data collected under section 2778(a)(1).

''(5) GRIEVANCE PROCEDURES.—Information on the grievance procedures under sections 2784 and 2785, including information describing—

''(A) the grievance procedures used by the issuer to process and resolve disputes between the issuer and an enrollee (including method for filing grievances and the time frames and circumstances for acting on grievances);

''(B) written complaints and appeals, by type of complaint or appeal, received by the issuer relating to its coverage; and

''(C) the disposition of such complaints and appeals.

''(6) PAYMENT METHODOLOGY.—A description of the types of methodologies the issuer uses to reimburse different classes of providers and, as specified by the Secretary, the financial arrangements or contractual provisions with providers.

''(7) INFORMATION ON ISSUER.—Notice of appropriate mailing addresses and telephone numbers to be used by enrollees in seeking information or authorization for treatment.

''(8) ASSURING COMMUNICATIONS WITH ENROLLEES.—A description of how the issuer addresses the needs of non-English-speaking enrollees and others with special communications needs, including the provision of information described in this subsection to such enrollees.

''(c) FORM OF DISCLOSURE.—

''(1) UNIFORMITY.—Information required to be disclosed under this section shall be provided in accordance with uniform, national reporting standards specified by the Secretary, after consultation with applicable State authorities, so that prospective enrollees may compare the attributes of different issuers and coverage offered within an area.

''(2) INFORMATION INTO HANDBOOK.—Nothing in this section shall be construed as preventing an issuer from making the information under subsection (b) available to enrollees through an enrollee handbook or similar publication.

''(3) UPDATING.—The information on participating providers described in subsection (a)(3)(C) shall be updated not less frequently than monthly. Nothing in this section shall prevent an issuer from changing or updating other information made available under this section.

''(4) CONSTRUCTION.—Nothing in subsection (a)(6) shall be construed as requiring disclosure of individual contracts or financial arrangements between an issuer and any provider. Nothing in this subsection shall be construed as preventing the information described in subsection (a)(3)(C) from being provided in a separate document.

''SEC. 2783. PROTECTION OF PATIENT CONFIDENTIALITY.

''A health insurance issuer that offers health insurance coverage shall establish appropriate policies and procedures to ensure that all applicable State and Federal laws to protect the confidentiality of individually identifiable medical information are followed.

''SUBPART 4—GRIEVANCE PROCEDURES

''SEC. 2784. ESTABLISHMENT OF COMPLAINT AND APPEALS PROCESS.

''(a) ESTABLISHMENT OF SYSTEM.—A health insurance issuer in connection with the provision of health insurance coverage shall establish and maintain a system to provide for the presentation and resolution of complaints and appeals brought by enrollees, designees of enrollees, or by health care providers acting on behalf of an enrollee and with the enrollee's consent, regarding any aspect of the issuer's health care services, including complaints regarding quality of care, choice and accessibility of providers, network adequacy, and compliance with the requirements of this part.

''(b) COMPONENTS OF SYSTEM.—Such system shall include the following components (which shall be consistent with applicable requirements of section 2785):

''(1) Written notification to all enrollees and providers of the telephone numbers and business addresses of the issuer employees responsible for resolution of complaints and appeals.

''(2) A system to record and document, over a period of at least 3 years, all complaints and appeals made and their status.

''(3) The availability of an enrollee services representative to assist enrollees, as requested, with complaint and appeal procedures.

''(4) Establishment of a specified deadline (not to exceed 30 days after the date of receipt of a complaint or appeal) for the issuer to respond to complaints or appeals.

''(5) A process describing how complaints and appeals are processed and resolved.

''(6) Procedures for follow-up action, including the methods to inform the complainant or appellant of the resolution of a complaint or appeal.

''(7) Notification to the continuous quality improvement program under section 2777(a) of all complaints and appeals relating to quality of care.

''(c) NO REPRISAL FOR EXERCISE OF RIGHTS.—A health insurance issuer shall not take any action with respect to an enrollee or a health care provider that is intended to penalize the enrollee, a designee of the enrollee, or the health care provider for discussing or exercising any rights provided under this part (including the filing of a complaint or appeal pursuant to this section).

''SEC. 2785. PROVISIONS RELATING TO APPEALS OF UTILIZATION REVIEW DETERMINATIONS AND SIMILAR DETERMINATIONS.

''(a) RIGHT OF APPEAL.—

''(1) IN GENERAL.—An enrollee in health insurance coverage offered by a health insurance issuer, and any provider acting on behalf of the enrollee with the enrollee's consent, may appeal any appealable decision (as defined in paragraph (2)) under the procedures described in this section and (to the extent applicable) section 2784. Such enrollees and providers shall be provided with a written explanation of the appeal process upon the conclusion of each stage in the appeal process and as provided in section 2782(a)(5)

''(2) APPEALABLE DECISION DEFINED.—In this section, the term 'appealable decision' means any of the following:

''(A) An adverse determination under a utilization review program under section 2781.

''(B) Denial of access to specialty and other care under section 2772.

''(C) Denial of continuation of care under section 2773.

''(D) Denial of a choice of provider under section 2774.

''(E) Denial of coverage of routine patient costs in connection with an approval clinical trial under section 2775.

''(F) Denial of access to needed drugs under section 2776(3).

''(G) The imposition of a limitation that is prohibited under section 2789.

''(H) Denial of payment for a benefit,

''(b) INFORMAL INTERNAL APPEAL PROCESS (STAGE 1).—

''(1) IN GENERAL.—Each issuer shall establish and maintain an informal internal appeal process (an appeal under such process in this section referred to as a 'stage 1 appeal') under which any enrollee or any provider acting on behalf of an enrollee with the enrollee's consent, who is dissatisfied with any appealable decision has the opportunity to discuss and appeal that decision with the medical director of the issuer or the health care professional who made the decision.

''(2) TIMING.—All appeals under this paragraph shall be concluded as soon as possible in accordance with the medical exigencies of the cases, and in no event later than 72 hours in the case of appeals from decisions regarding urgent care and 5 days in the case of all other appeals.

''(3) FURTHER REVIEW.—If the appeal is not resolved to the satisfaction of the enrollee at this level by the deadline under paragraph (2), the issuer shall provide the enrollee and provider (if any) with a written explanation of the decision and the right to proceed to a stage 2 appeal under subsection (c).

''(c) FORMAL INTERNAL APPEAL PROCESS (STAGE 2).—

''(1) IN GENERAL.—Each issuer shall establish and maintain a formal internal appeal process (an appeal under such process in this section referred to as a 'stage 2 appeal') under which any enrollee or provider acting on behalf of an enrollee with the enrollee's consent, who is dissatisfied with the results of a stage 1 appeal has the opportunity to appeal the results before a panel that includes a physician or other health care professional (or professionals) selected by the issuer who have not been involved in the appealable decision at issue in the appeal.

''(2) AVAILABILITY OF CLINICAL PEERS.—The panel under subparagraph (A) shall have available either clinical peers (as defined in section 2781(c)(2)(B)) who have not been involved in the appealable decision at issue in the appeal or others who are mutually agreed upon by the parties. If requested by the enrollee or enrollee's provider with the enrollee's consent, such a peer shall participate in the panel's review of the case.

''(3) TIMELY ACKNOWLEDGMENT.—The issuer shall acknowledge the enrollee or provider involved of the receipt of a stage 2 appeals upon receipt of the appeal.

''(4) DEADLINE.—

''(A) IN GENERAL.—The issuer shall conclude each stage 2 appeal as soon as possible after the date of the receipt of the appeal in accordance with medical exigencies of the case involved, but in no event later than 72 hours in the case of appeals from decisions

regarding urgent care and (except as provided in subparagraph (B)) 20 business days in the case of all other appeals.

''(B) EXTENSION.—An issuer may extend the deadline for an appeal that does not relate to a decision regarding urgent or emergency care up to an additional 20 business days where it can demonstrate to the applicable State authority reasonable cause for the delay beyond its control and where it provides, within the original deadline under subparagraph (A), a written progress report and explanation for the delay to such authority and to the enrollee and provider involved.

''(5) NOTICE.—If an issuer denies a stage 2 appeal, the issuer shall provide the enrollee and provider involved with written notification of the denial and the reasons therefore, together with a written notification of rights to any further appeal

''(d) DIRECT USE OF FURTHER APPEALS.—In the event that the issuer fails to comply with any of the deadlines for completion of appeals under this section or in the event that the issuer for any reason expressly waives its rights to an internal review of an appeal under subsection (b) or (c), the enrollee and provider involved shall be relieved of any obligation to complete the appeal stage involved and may, at the enrollee's or provider's option, proceed directly to seek further appeal through any applicable external appeals process.

''(e) EXTERNAL APPEAL PROCESS IN CASE OF USE OF EXPERIMENTAL TREATMENT TO SAVE LIFE OF PATIENT.—

''(1) IN GENERAL.—In the case of an enrollee described in paragraph (2), the health insurance issuer shall provide for an external independent review process respecting the issuer's decision not to cover the experimental therapy (described in paragraph (2)(B)(ii)).

''(2) ENROLLEE DESCRIBED.—An enrollee described in this paragraph is an enrollee who meets the following requirements:

''(A) The enrollee has a terminal condition that is highly likely to cause death within 2 years.

''(B) The enrollee's physician certifies that—

''(i) there is no standard, medically appropriate therapy for successfully treating such terminal condition, but

''(ii) based on medical and scientific evidence, there is a drug, device, procedure, or therapy (in this section referred to as the 'experimental therapy') that is more beneficial than any available standard therapy.

''(C) The issuer has denied coverage of the experimental therapy on the basis that it is experimental or investigational.

''(3) DESCRIPTION OF PROCESS AND DECISION.—The process under this subsection shall provide for a determination on a timely basis, by a panel of independent, impartial physicians appointed by a State authority or by an independent review organization certified by the State, of the medical appropriateness of the experimental therapy. The decision of the panel shall be in writing and shall be accompanied by an explanation of the basis for the decision. A decision of the panel that is favorable to the enrollee may not be appealed by the issuer except in the case of misrepresentation of a material fact by the enrollee or a provider. A decision of the panel that is not favorable to the enrollee may be appealed by the enrollee.

''(4) ISSUER COVERING PROCESS COSTS.—Direct costs of the process under this subsection shall be borne by the issuer, and not by the enrollee.

''(f) OTHER INDEPENDENT OR EXTERNAL REVIEW.—

''(1) IN GENERAL.—In the case of appealable decision described in paragraph (2), the health insurance issuer shall provide for—

''(A) an external review process for such decisions consistent with the requirements of paragraph (3), or

''(B) an internal independent review process for such decisions consistent with the requirements of paragraph (4).

''(2) APPEALABLE DECISION DESCRIBED.—An appealable decision described in this paragraph is decision that does not involve a decision described in subsection (e)(1) but involves—

''(A) a claim for benefits involving costs over a significant threshold, or

''(B) assuring access to care for a serious condition.

''(3) EXTERNAL REVIEW PROCESS.—The requirements of this subsection for an external review process are as follows:

''(A) The process is established under State law and provides for review of decisions on stage 2 appeals by an independent review organization certified by the State.

''(B) If the process provides that decisions in such process are not binding on issuers, the process must provide for public methods of disclosing frequency of noncompliance with such decisions and for sanctioning issuers that consistently refuse to take appropriate actions in response to such decisions.

''(C) Results of all such reviews under the process are disclosed to the public, along with at least annual disclosure of information on issuer compliance.

''(D) All decisions under the process shall be in writing and shall be accompanied by an explanation of the basis for the decision.

''(E) Direct costs of the process shall be borne by the issuer, and not by the enrollee.

''(F) The issuer shall provide for publication at least annually of information on the numbers of appeals and decisions considered under the process.

''(4) INTERNAL, INDEPENDENT REVIEW PROCESS.—The requirements of this subsection for an internal, independent review process are as follows:

''(A)(i) The process must provide for the participation of persons who are independent of the issuer in conducting reviews and (ii) the Secretary must have found (through reviews conducted no less often than biannually) the process to be fair and impartial.

''(B) If the process provides that decisions in such process are not binding on issuers, the process must provide for public methods of disclosing frequency of noncompliance with such decisions and for sanctioning issuers that consistently refuse to take appropriate actions in response to such decisions.

''(C) Results of all such reviews under the process are disclosed to the public, along with at least annual disclosure of information on issuer compliance.

''(D) All decisions under the process shall be in writing and shall be accompanied by an explanation of the basis for the decision.

''(E) Direct costs of the process shall be borne by the issuer, and not by the enrollee.

''(F) The issuer shall provide for publication at least annually of information on the numbers of appeals and decisions considered under the process.

The Secretary may delegate the authority under subparagraph (A)(ii) to applicable State authorities.

''(5) OVERSIGHT.—The Secretary (and applicable State authorities in the case of delegation of Secretarial authority under paragraph (4)) shall conduct reviews not less often than biannually of the fairness and impartiality issuers who desired to use an internal, independent review process described in paragraph (4) to satisfy the requirement of paragraph (1).

''(6) REPORT.—The Secretary shall provide for periodic reports on the effectiveness of this subsection in assuring fair and impartial reviews of stage 2 appeals. Such reports shall include information on the number of stage 2 appeals (and decisions), for each of the types of review processes described in paragraph (2), by health insurance coverage.

''(g) CONSTRUCTION.—Nothing in this part shall be construed as removing any legal rights of enrollees under State or Federal law, including the right to file judicial actions to enforce rights.

''SEC. 2786. STATE HEALTH INSURANCE OMBUDSMEN.

''(a) IN GENERAL.—Each State that obtains a grant under subsection (c) shall establish and maintain a Health Insurance Ombudsman. Such Ombudsman may be part of a independent, nonprofit entity, and shall be responsible for at least the following:

''(1) To assist consumers in the State in choosing among health insurance coverage.

''(2) To provide counseling and assistance to enrollees dissatisfied with their treatment by health insurance issuers in regard to such coverage and in the filing of complaints and appeals regarding determinations under such coverage.

''(3) To investigate instances of poor quality or improper treatment of enrollees by health insurance issuers in regard to such coverage and to bring such instances to the attention of the applicable State authority.

''(b) FEDERAL ROLE.—In the case of any State that does not establish and maintain such an Ombudsman under subsection (a), the Secretary shall provide for the establishment and maintenance of such an official as will carry out with respect to that State the functions otherwise provided under subsection (a) by a Health Insurance Ombudsman.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary such amounts as may be necessary to provide for grants to States to establish and operate Health Insurance Ombudsmen under subsection (a) or for the operation of Ombudsmen under subsection (b).

''SUBPART 5—PROTECTION OF PROVIDERS AGAINST INTERFERENCE WITH MEDICAL COMMUNICATIONS AND IMPROPER INCENTIVE ARRANGEMENTS

''SEC. 2787. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

''(a) PROHIBITION.—

''(1) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or restrict the provider from engaging in medical communications with the provider's patient.

''(2) NULLIFICATION.—Any contract provision or agreement described in paragraph (1) shall be null and void.

''(3) PROHIBITION ON PROVISIONS.—A contract or agreement described in paragraph (1) shall not include a provision that violates paragraph (1).

''(b) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) to prohibit the enforcement, as part of a contract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by a health insurance issuer to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to

guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider) but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers and their patients; or

''(2) to permit a health care provider to misrepresent the scope of benefits covered under health insurance coverage or to otherwise require a health insurance issuer to reimburse providers for benefits not covered under the coverage.

''(c) PROTECTION OF RELIGIOUS OR MORAL EXPRESSION.—

''(1) IN GENERAL.—An health insurance issuer may fully advise—

''(A) licensed or certified health care providers at the time of their employment with the issuer or at any time during such employment, or

''(B) enrollees at the time of their enrollment for health insurance coverage with the issuer or at any time during which such enrollees have such coverage,

of the coverage's limitations on providing particular medical services (including limitations on referrals for care provided outside of the coverage) based on the religious or moral convictions of the issuer.

''(2) HEALTH CARE PROVIDERS.—Nothing in this section shall be construed to alter the rights and duties of a health care provider to determine what medical communications are appropriate with respect to each patient, except as provided for in subsection (a).

''(d) MEDICAL COMMUNICATION DEFINED.—

''(1) IN GENERAL.—In this section, the term 'medical communication' means any communication made by a health care provider with a patient of the health care provider (or the guardian or legal representative of such patient) with respect to—

''(A) the patient's health status, medical care, or treatment options;

''(B) any utilization review requirements that may affect treatment options for the patient; or

''(C) any financial incentives that may affect the treatment of the patient.

''(2) MISREPRESENTATION.—The term 'medical communication' does not include a communication by a health care provider with a patient of the health care provider (or the guardian or legal representative of such patient) if the communication involves a knowing or willful misrepresentation by such provider.

''SEC. 2788. PROHIBITION AGAINST TRANSFER OF INDEMNIFICATION OR IMPROPER INCENTIVE ARRANGEMENTS.

''(a) PROHIBITION OF TRANSFER OF INDEMNIFICATION.—No contract or agreement between a health insurance issuer (or any agent acting on behalf of such an issuer) and a health care provider shall contain any clause purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions, or omissions of the issuer or agent (as opposed to the provider).

''(b) PROHIBITION OF IMPROPER PHYSICIAN INCENTIVE PLANS.—

''(1) IN GENERAL.—A health insurance issuer offering health insurance coverage may not operate any physician incentive plan unless the following requirements are met:

''(A) No specific payment is made directly or indirectly by the issuer to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the issuer.

''(B) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the issuer—

''(i) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the issuer who receive services from the physician or the physician group, and

''(ii) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the issuer to determine the degree of access of such individuals to services provided by the issuer and satisfaction with the quality of such services.

''(C) The issuer provides the applicable State authority (or the Secretary if such authority is implementing this section) with descriptive information regarding the plan, sufficient to permit the authority (or the Secretary in such case) to determine whether the plan is in compliance with the requirements of this paragraph.

''(2) PHYSICIAN INCENTIVE PLAN DEFINED.—In this section, the term 'physician incentive plan' means any compensation arrangement between a health insurance issuer and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the issuer.

''(3) APPLICATION OF MEDICARE RULES.—The Secretary shall provide for the application of rules under this subsection that are substantially the same as the rules established to carry out section 1876(i)(8) of the Social Security Act.

''SUBPART 6—PROMOTING GOOD MEDICAL PRACTICE AND PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

''SEC. 2789. PROMOTING GOOD MEDICAL PRACTICE.

''(a) PROHIBITING ARBITRARY LIMITATIONS OR CONDITIONS FOR THE PROVISION OF SERVICES.—A health insurance issuer, in connection with the provision of health insurance coverage, may not impose limits on the manner in which particular services are delivered if the services are medically necessary and appropriate for the treatment or diagnosis of an illness or injury to the extent that such treatment or diagnosis is otherwise a covered benefit.

''(b) MEDICAL NECESSITY AND APPROPRIATENESS DEFINED.—In subsection (a), the term 'medically necessary and appropriate' means, with respect to a service or benefit, a service or benefit determined by the treating physician participating in the health insurance coverage after consultation with the enrollee, to be required, accordingly to generally accepted principles of good medical practice, for the diagnosis or direct care and treatment of an illness or injury of the enrollee.

''(c) CONSTRUCTION.—Subsection (a) shall not be construed as requiring coverage of particular services the coverage of which is otherwise not covered under the terms of the coverage.''.

(b) APPLICATION TO GROUP HEALTH INSURANCE COVERAGE.—

(1) Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2706. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under part C with respect to group health insurance coverage it offers.

''(b) ASSURING COORDINATION.—The Secretary of Health and Human Services and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding between such Secretaries, that—

''(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under part C (and this section) and section 713 of the Employee Retirement Income Security Act of 1974 are administered so as to have the same effect at all times; and

''(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.''.''.

(2) Section 2792 of such Act (42 U.S.C. 300gg–92) is amended by inserting ''and section 2706(b)'' after ''of 1996''.

(c) APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.—Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2751 the following new section:

''SEC. 2752. PATIENT PROTECTION STANDARDS.

''Each health insurance issuer shall comply with patient protection requirements under part C with respect to individual health insurance coverage it offers.''.

(d) MODIFICATION OF PREEMPTION STANDARDS.—

(1) GROUP HEALTH INSURANCE COVERAGE.—Section 2723 of such Act (42 U.S.C. 300gg–23) is amended—

(A) in subsection (a)(1), by striking ''subsection (b)'' and inserting ''subsections (b) and (c)'';

(B) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(C) by inserting after subsection (b) the following new subsection:

''(c) SPECIAL RULES IN CASE OF PATIENT PROTECTION REQUIREMENTS.—Subject to subsection (a)(2), the provisions of section 2706 and part C (other than section 2771), and part D insofar as it applies to section 2706 or part C, shall not prevent a State from establishing requirements relating to the subject matter of such provisions (other than section 2771) so long as such requirements are at least as stringent on health insurance issuers as the requirements imposed under such provisions. Subsection (a) shall apply to the provisions of section 2771 (and section 2706 insofar as it relates to such section).''.

(2) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Section 2762 of such Act (42 U.S.C. 300gg–62), as added by section 605(b)(3)(B) of Public Law 104–204, is amended—

(A) in subsection (a), by striking ''subsection (b), nothing in this part'' and inserting ''subsections (b) and (c)'', and

(B) by adding at the end the following new subsection:

''(c) SPECIAL RULES IN CASE OF MANAGED CARE REQUIREMENTS.—Subject to subsection (b), the provisions of section 2752 and part C (other than section 2771), and part D insofar as it applies to section 2752 or part C, shall not prevent a State from establishing requirements relating to the subject matter of such provisions so long as such requirements are at least as stringent on health insurance issuers as the requirements imposed under such section. Subsection (a) shall apply to the provisions of section 2771 (and section 2752 insofar as it relates to such section).''.

(e) ADDITIONAL CONFORMING AMENDMENTS.—

(1) Section 2723(a)(1) of such Act (42 U.S.C. 300gg–23(a)(1)) is amended by striking ''part C'' and inserting ''parts C and D''.

(2) Section 2762(b)(1) of such Act (42 U.S.C. 300gg–62(b)(1)) is amended by striking ''part C'' and inserting ''part D''.

(f) EFFECTIVE DATES.—(1)(A) Subject to subparagraph (B), the amendments made by subsections (a), (b), (d)(1), and (e) shall apply with respect to group health insurance coverage for group health plan years beginning on or after July 1, 1998 (in this subsection referred to as the ''general effective date'') and

also shall apply to portions of plan years occurring on and after January 1, 1999.

(B) In the case of group health insurance coverage provided pursuant to a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by subsections (a), (b), (d)(1), and (e) shall not apply to plan years beginning before the later of—

(i) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(ii) the general effective date.

For purposes of clause (i), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by subsection (a) or (b) shall not be treated as a termination of such collective bargaining agreement.

(2) The amendments made by subsections (a), (c), (d)(2), and (e) shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

SEC. 3. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 713. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), 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 part C (other than section 2786) of title XXVII of the Public Health Service Act.

''(b) APPLICATION.—In applying subsection (a) under this part, any reference in such subpart C—

''(1) to a health insurance issuer and health insurance coverage offered by such an issuer is deemed to include a reference to a group health plan and coverage under such plan, respectively;

''(2) to the Secretary is deemed a reference to the Secretary of Labor;

''(3) to an applicable State authority is deemed a reference to the Secretary of Labor; and

''(4) to an enrollee with respect to health insurance coverage is deemed to include a reference to a participant or beneficiary with respect to a group health plan.

''(c) GROUP HEALTH PLAN OMBUDSMAN.—With respect to group health plans that provide benefits other than through health insurance coverage, the Secretary shall provide for the establishment and maintenance of such a Federal Group Health Plan Ombudsman that will carry out with respect to such plans the functions described in section 2786(a) of the Public Health Service Act with respect to health insurance issuers that offer group health insurance coverage.

''(d) ASSURING COORDINATION.—The Secretary of Health and Human Services and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding between such Secretaries, that—

''(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under such part C (and section 2706 of the Public Health Service Act) and this section are administered so as to have the same effect at all times; and

''(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.''.

(b) MODIFICATION OF PREEMPTION STANDARDS.—Section 731 of such Act (42 U.S.C. 1191) is amended—

(1) in subsection (a)(1), by striking ''subsection (b)'' and inserting ''subsections (b) and (c)'';

(2) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(3) by inserting after subsection (b) the following new subsection:

''(c) SPECIAL RULES IN CASE OF PATIENT PROTECTION REQUIREMENTS.—Subject to subsection (a)(2), the provisions of section 713 and part C of title XXVII of the Public Health Service Act (other than section 2771 of such Act), and subpart C insofar as it applies to section 713 or such part, shall not prevent a State from establishing requirements relating to the subject matter of such provisions (other than section 2771 of such Act) so long as such requirements are at least as stringent on health insurance issuers as the requirements imposed under such provisions. Subsection (a) shall apply to the provisions of section 2771 of such Act (and section 713 of this Act insofar as it relates to such section).''.

(c) CONFORMING AMENDMENTS.— (1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 713''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 712 the following new item:

''Sec. 713. Patient protection standards.''.

(3) Section 734 of such Act (29 U.S.C. 1187) is amended by inserting ''and section 713(d)'' after ''of 1996''.

(d) EFFECTIVE DATE.—(1) Subject to paragraph (2), the amendments made by this section shall apply with respect to group health plans for plan years beginning on or after July 1, 1998 (in this subsection referred to as the ''general effective date'') and also shall apply to portions of plan years occurring on and after January 1, 1999.

(2) In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) the general effective date.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by subsection (a) shall not be treated as a termination of such collective bargaining agreement.

SUMMARY OF THE QUALITY ASSURANCE AND PATIENT PROTECTION ACT

Subpart 1: Access to care.
Subpart 2: Quality Assurance.
Subpart 3. Patient Information.
Subpart 4: Grievance Procedures.
Subpart 5: Protection of providers against interference with medical communications and improper incentive arrangements.
Subpart 6: Promoting good medical practice and protecting the doctor-patient relationship.

SUBPART 1: ACCESS TO CARE

Emergency care.—A plan may not deny coverage for emergency care assessment and stabilization if a prudent layperson would seek such care given the symptoms experienced. Prior authorization for such care is not required. After assessment and stabilization, further needed care is covered if medically necessary.

Access to specialty care.—Obstetrician/gynecologist care.—If a plan requires patients to designate a primary care physician, women have the right to choose an obstetrician/gynecologist as their primary care provider. In any case, they have the right to direct access to an obstetrician/gynecologist for routine gynecological care and pregnancy services without prior authorization from their primary care provider.

Other specialty care.—Enrollees with life-threatening, chronic, degenerative or other serious conditions which require specialty care must be provided access to the appropriate specialists or centers of excellence capable of providing quality care for the condition. If a plan does not have a participating specialist for a condition covered under the plan, the plan must refer the patient to a non-participating specialist at no additional cost.

A plan must have a procedure to allow individuals with a serious illness and ongoing need for specialty care to receive care from a specialist who will coordinate all care for that individual.

A plan must have a procedure for standing referrals for individuals requiring on-going specialty care if a primary care provider, in consultation with the patient, the medical director of the plan and specialist (if any) determine that a standing referral is needed.

Continuity of Care.—If a plan or provider terminates a contract for reasons other than failure to meet quality requirements, the plan must allow an enrollee continued treatment with the provider for a transitional period. Time frames vary depending upon type of care being provided (e.g. primary, institutional, pregnancy, terminal, etc.)

Participation in clinical trials.—If an enrollee has a serious condition for which there is no effective standard treatment and is eligible for an approved clinical trial that offers the potential for substantial clinical benefit, the plan must pay for the routine patient costs of participation in the trial.

Choice of Provider.—A plan must provide an updated list of all participating providers and their ability to accept additional patients. Enrollees must be permitted to obtain services from any provider within the plan identified in the plan documents as available to the enrollee.

Prescription Drugs.—If a plan provides benefits for prescription drugs within a formulary, the plan must allow physicians to participate in the development of the plan formulary, disclose the nature of formulary restrictions, and provide for exceptions when medically necessary.

SUBPART 2: QUALITY ASSURANCE

Internal quality assurance program.—Every plan is required to establish and maintain a quality assurance and improvement program that uses data based on both performance and patient outcomes.

Collection of standardized data.—Plans must report certain standard information to state agencies and the public. The information must be reported in accordance with uniform national standards to be specified by the Secretary. This information will include at least utilization data, demographic data, mortality rates, disenrollment statistics and satisfaction surveys, and quality indicators.

Selection of providers.—The plan must have a written process for selection of providers including a listing of the professional

requirements. The process must include verification of the provider's credentials. Plans may not use a high risk patient base or a provider's location in an area serving residents with poor health status as a basis for exclusion.

Drug utilization program.—If the plan covers prescription medications, it must have a plan to encourage appropriate drug use and monitor and reduce illness arising from improper use.

Standards for utilization review activities.—Utilization review refers to the plan's review of requests for care. It is defined as evaluation of clinical necessity and efficacy. Written clinical review criteria are required. Utilization review must be supervised by a licensed physician. Its activities must be executed by appropriately qualified staff. There can be no incentives to render adverse determinations. Deadlines for response to requests for authorization of care are established. Adverse determinations must be in writing and include the reasons for the determination. Such notices must also include instructions for making an appeal.

SUBPART 3: PATIENT INFORMATION

Patient Information.—Plans must describe and make available to current and prospective enrollees procedures for providing emergency care and care outside normal business hours, for selecting and changing physicians, and for obtaining consultations. They must also list participating providers by category and make clear which members of that list are available to a prospective or current enrollee. The plan must provide information which describes coverage, financial responsibilities of enrollees, methods of obtaining referrals, utilization review processes, and grievance procedures and must include a description of how the plan addresses the needs of non-English speaking enrollees and others with special communication needs. It must describe how providers are paid.

Protection of patient confidentiality.—A program to assure compliance with state and federal confidentiality requirements must be in place.

SUBPART 4: GRIEVANCE PROCEDURES

Provisions relating to appeals of utilization review determination and similar determinations.—A plan must establish and maintain a system to handle and resolve complaints brought against the plan by enrollees and providers. The system should address all aspects of the plan's services, including complaints regarding quality of care, choice and accessibility of providers, and network adequacy. The legislation specifies several components of such a system, including provisions for staffing and staff accessibility, information about appeal procedures, and the time frame within which the plan must respond to complaints. The bill provides for a two stage appeal process, with requirements for a review panel of non-involved providers and consultants employed by the plan in the second phase. Written explanation of each stage of an appeal must be provided. Timely decisions are required. Examples of adverse determinations include denial for emergency care, access to specialists, choice of provider, continuity of care, or payment for routine costs in connection with an approved clinical trial. In the case of experimental therapy to save the life of a patient, an external independent review process with mandatory decision powers is available if the plan chooses not to provide coverage for the treatment. For appeals of other important issues, the plan must either (1) participate in an independent review process established by the state (or the Secretary of Labor for self-insured plans) to make advisory determinations; or (2) establish a third stage of appeal within the plan certified by the Secretary as fair, impartial, and involving independent reviewers to make advisory decisions.

Health Insurance Ombudsman.—A Health Insurance Ombudsman will be established in each state to assist consumers in choosing health insurance, and to provide assistance to patients dissatisfied with their treatment. Assistance includes aiding enrollees in filing complaints and appeals, investigating poor quality or improper treatment, and bringing such instances to the attention of the applicable state authority or, in the case of self-insured insurance plans, to the attention of the Secretary of Labor. The legislation authorizes funds to be appropriated to the Secretary to provide grants to state authorities to establish the program.

SUBPART 5: PROTECTION OF PROVIDERS AGAINST INTERFERENCE WITH MEDICAL COMMUNICATIONS AND IMPROPER INCENTIVES

Prohibition of interference with certain medical communications.—The plan may not prohibit or restrict the provider from engaging in medical communications with the enrollee. Such communications may include discussion of the enrollee's health status, medical care, or treatment options; provisions of the plan's utilization review requirements; or any financial incentives that may affect the treatment of the enrollee.

Ban on improper incentive arrangements.—There may be no incentives to limit medically necessary services. Provider risk is limited. The Secretary shall apply the same rules which apply to the Medicare program. The plan may not have a contract which requires transfer of liability for malpractice caused by the plan from the plan to the provider.

SUBPART 6: PROMOTING GOOD MEDICAL PRACTICE AND PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

Plans are prohibited from denying coverage for medically necessary and appropriate care otherwise covered by the plan, as determined by the treating physician and consistent with generally accepted principles of good medical practice. This provision would prohibit plans from arbitrarily limiting care provided, for example, by requiring that mastectomies be provided on an outpatient basis.

By Mr. KENNEDY (for himself and Mr. KERRY):

S. 354. A bill to amend the Federal Property and Administrative Services Act of 1949 to prohibit executive agencies from awarding contracts that contain a provision allowing for the acquisition by the contractor, at Government expense, of certain equipment or facilities to carry out the contract if the principal purpose of such provision is to increase competition by establishing an alternative source of supply for property or services; to the Committee on Governmental Affairs.

THE FAIR COMPETITION IN FEDERAL PROCUREMENT ACT OF 1997

Mr. KENNEDY. Mr. President, Senator KERRY and I are offering legislation today to present a serious injustice in Federal procurement. Congressman JOHN OLVER is introducing identical legislation in the House of Representatives. This issue has come to our attention in the context of the Bureau of Engraving and Printing's contract for U.S. currency paper production, but it could arise in other contexts that would pose similar inequities.

A respected, long-standing family-owned business in Dalton, MA, Crane and Company, has supplied currency paper for the Treasury for the past 117 years. Crane has been a trusted supplier to the Federal Government, providing high quality products on a timely basis. It has negotiated reasonable terms with the Government, keeping its price increases below the rate of inflation. And it has made substantial investments over the years to ensure that it has the sophisticated equipment needed to produce the currency, including the special security features now built into the paper itself.

This year, however, the Bureau of Engraving and Printing has proposed to go to extraordinary lengths to create alternate sources for currency paper production. The Bureau has proposed subsidies to other companies to help them become competitive and buy the state-of-the-art equipment that Crane bought on its own. This is not fair competition. It's a misguided policy that will give other companies an unfair advantage and create an unlevel playing field.

Our legislation is straightforward. It amends section 303 of the Federal Property and Administrative Services Act of 1949 to prohibit nondefense agencies in the executive branch from financing equipment or facilities to help a contractor compete against an existing contractor in Federal procurement. With all the pressures of the deficit, we should not be spending taxpayer money on this sort of sham competition. It's unfair to leading-edge firms like Crane that have invested their own resources to obtain Government contracts, and it's hard to see how any taxpayers will benefit. Crane is in a class by itself. There is no suggestion of antitrust problems. Crane wins these contracts fair and square against potential competitors, and it should not have to compete with Uncle Sam.

I urge the Congress to enact this legislation and prevent an extremely unfair and unwise policy from moving forward at the Treasury Department or other Federal agencies.

By Mr. GRAMM (for himself, and Mrs. HUTCHISON):

S. 355. A bill to amend the Internal Revenue Code of 1986 to make the research credit permanent; to the Committee on Finance.

RESEARCH CREDIT LEGISLATION

● Mr. GRAMM. Mr. President, today Senator HUTCHISON and I are introducing a bill to permanently extend the research and development tax credit. The R&D tax credit was originally enacted as a part of President Reagan's Economic Recovery and Tax Act of 1981 in order to encourage greater private sector investment in research and development. Since its creation, the credit has been extended seven times, and it is currently set to expire on May 31, 1997.

Since its enactment in 1981, the benefits of the R&D credit have been enormous. Studies show that in the short

run, every dollar of the R&D credit stimulates a dollar of additional private R&D spending, and in the long run, each dollar of the credit yields up to $2 in additional private R&D spending. Furthermore, the rate of return from R&D spending to society as a whole is estimated to be as high as 60 percent.

Given these facts, we can easily expect that the benefits of the credit will only be enhanced if it is extended permanently. A permanent extension of the R&D credit would encourage companies to take on additional research and development projects by allowing them to be certain that the credit will be in effect during these long-run initiatives. In fact, the ratio of R&D spending to output rose over 40 percent in the 1980's when the R&D credit was in effect for the longest period of time.

The R&D credit is an effective and proven incentive for companies to increase investment in U.S.-based research and development. The continued existence of the R&D credit is particularly important given the substantial tax incentives provided by many of our international competitors to their domestic R&D industries. The jobs created by R&D expenditures are exactly the kind of jobs we all claim to vote. In my home State of Texas alone, the average high-technology job pays $47,019 a year—almost $20,000 more per year than the average private sector salary of $27,147.

The need to make the credit permanent is only further highlighted by the fact that in 1996, for the first time in its history, the R&D credit was allowed to lapse—there was a gap in the law between July 1, 1995, through July 1, 1996. Haphazard and unpredictable temporary extensions of the credit, combined with this recent lapse, have set a negative precedent for the research community.

Businesses cannot and do not ignore the possibility of future gaps in the R&D credit, and will be understandably driven to scale back new long-term projects if they cannot be certain that the credit will continue. We should permanently extend the R&D tax credit to finally remove this unnecessary barrier to long-term research and development which has been created by the stop-and-go extension process.

Finally, Mr. President, I want to point out that the R&D credit has a long history of bipartisan support. The President has signaled his support for the credit, not only by signing last year's extension as a part of the Small Business Job Protection Act, but also by proposing a further extension as a part of his fiscal year 1998 budget. Unfortunately, his proposal follows the ill-advised precedent of merely temporarily extending the credit.

I believe that this credit must be made permanent, and I am proud to have joined 17 members of the Texas delegation in a letter to Chairman ARCHER and Chairman ROTH calling for a permanent extension of the R&D tax credit. I ask unanimous consent that the text of this letter and the text of the bill be printed in the RECORD at the conclusion of my remarks. The time has come for us to demonstrate our long-term commitment to research and development, and I urge my colleagues to join me and Senator HUTCHISON in sponsoring this bill.

Mr. President, I ask unanimous consent that additional material be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 355

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. EXTENSION OF RESEARCH CREDIT.

(a) CREDIT MADE PERMANENT.—

(1) IN GENERAL.—Section 41 of the Internal Revenue Code of 1986 is amended by striking subsection (h).

(2) CONFORMING AMENDMENT.—Section 45C(b)(1) of such Code is amended by striking subparagraph (D).

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to amounts paid or incurred after May 31, 1997, in taxable years ending after such date.

———

CONGRESS OF THE UNITED STATES,
Washington, DC, February 13, 1997.

Hon WILLIAM ROTH,
U.S. Senate, Washington, DC.

Hon. BILL ARCHER,
Washington, DC.

DEAR GENTLEMEN: We want to thank you for your leadership last year in extending the Research and Development (R&D) tax credit, and to solicit your further support. As you know, the R&D credit will expire on May 31, 1997. We would like to express out strong support for a prompt, permanent extension of the credit.

There are a number of excellent reasons why Congress should permanently extend the credit. According to a recent study, each dollar of tax benefits generates as much as two dollars of long-term investment spending by the private sector. Also, the ''spillover effects'' of R&D are outstanding; the rate of return derived by society generally from R&D spending is estimated to be as much as sixty percent.

The R&D credit enjoys broad, bipartisan support and provides a critical, effective and proven incentive for companies to increase their investment in U.S.-based research and development. The continued encouragement of private sector led R&D is particularly important in light of the substantial tax and other financial incentives offered by many of our major foreign trade competitors. Moreover, targeted almost exclusively at wages and salaries paid to employees engaged in direct U.S.-based research and development, the credit promotes the creation of new, high-skilled jobs.

Texas companies lead the nation in many areas of research and development and the growth of high wage jobs. Continued growth of our economy is closely tied to the ability of our companies to make a sustained commitment to long-term high cost research. Again, thank you for your outstanding effort on Texas' behalf in the past, and we look forward to working with you to continue our shared commitment in research and development.

Sincerely,

PHIL GRAMM
(and 17 other Members).●

By Mr. GRAHAM (for himself, Mr. HUTCHINSON, Ms. MIKULSKI, and Mr. CHAFEE):

S. 356. A bill to amend the Internal Revenue Code of 1986, the Public Health Service Act, the Employee Retirement Income Security Act of 1974, the title XVIII and XIX of the Social Security Act to assure access to emergency medical services under group health plans, health insurance coverage, and the Medicare and Medicaid Programs; to the Committee on Finance.

THE ACCESS TO EMERGENCY MEDICAL SERVICES ACT

Ms. MIKULSKI. Mr. President, I am proud to join Senator GRAHAM in introducing the Access to Emergency Medical Services Act of 1997. This bill prohibits health plans from denying coverage and payment for emergency room visits. I support this bill for three reasons. It protects patients and patients' pocketbooks. It respects medical decisions made by doctors and nurses. It gives HMO's the opportunity to do the right thing.

Personal health is not something to take chances with. That's why many people seek emergency assistance when they think something may be seriously wrong with their health. They go to the emergency room thinking their insurance company covers emergency room treatment. But when the problem turns out to be a nonemergency, the insurance company denies payment. This is called retrospective denial. I want to end retrospective denials. No family should have to second guess getting the care they need because they are worried about being stuck with an enormous bill.

Last week my office received a phone call from a woman in Frederick, MD. She was distraught. She had begged her husband not to take her to the emergency room when she complained of serious chest pains. She knew their insurance company wouldn't pay. It had happened before. But her husband insisted she go. He was worried about her and wanted her to see a doctor. She cried all the way to the hospital. A few weeks later she got the notice—her claim was denied. She was stuck with the bill.

She was right to go to the emergency room. There are approximately 200 medical problems that could cause the type of chest pain she experienced ranging from a heart attack to pulmonary emboli to simple indigestion. The point is, no one knows for sure what problem they are having until they get treatment from an emergency room physician.

Maryland already has laws in place to guarantee that HMO's will cover to emergency services. But we can't practice good emergency medicine one patient, one ER room, or one State at a time. That's why we need a national law that ensures that medical decisions are made in the ER room, not the corporate boardroom.

This bill will set a new national definition for the term ''emergency'' without preempting stronger State laws. The ''Prudent Layperson Standard'' means that a person with average knowledge of health and medicine can seek emergency treatment when they think they have a serious medical condition. Quite often, patients do not know when they go to an emergency room whether their illness is life-threatening or not. With this standard, they are not required to know—they can use their own best judgment. After all, we can't expect the average person to be able to diagnose like a doctor.

I am proud that the State of Maryland was the first State to enact legislation to counter these unfair practices. They passed their first law in 1993. But it took two follow-up laws to clarify the intent of the first one. Work still needs to be done to make sure the law is enforced. I salute the Maryland emergency physicians who took this issue on, and continue to fight for fair play on behalf of their patients.

I want to see managed care, but I don't want to see doctors managed. There is a fundamental distinction. We have to start getting our priorities straight and decide where we are going to be making our decisions. And in the case of emergencies—I believe the decisions need to be made in the emergency room and not the boardroom.

By Mr. BENNETT (for himself, Mr. HATCH, Mr. MURKOWSKI, Mr. CRAIG, Mr. BURNS, and Mr. THOMAS):

S. 357. A bill to authorize the Bureau of Land Management to manage the Grand Staircase-Escalante National Monument, and for other purposes; to the Committee on Energy and Natural Resources.

THE GRAND STAIRCASE-ESCALANTE RESOURCE PROTECTION ACT

Mr. BENNETT. Mr. President, in the last Congress, by coincidence, on my birthday, President Clinton announced the creation of the Grand Staircase-Escalante National Monument, taking 1.7 million acres in the State of Utah and creating a national monument under the authority of the Antiquities Act of 1906. This, frankly, caught a number of us by complete surprise—well, maybe not complete surprise, because we had seen reports in the newspaper that this might be coming. But whenever we spoke to anybody in the administration about it, we were constantly told that no decision has been made.

Congressman Orton, the Democratic Congressman in the district in which this land was located, was told ''nothing is imminent.'' Even 24 hours before the announcement was made, people in the White House were insisting that nothing was coming down on this particular subject. And then, as I say, on the morning of my birthday, I received a phone call from Leon Panetta, not to wish me happy birthday, but to inform me that the President would indeed be creating a new national monument in Utah under his authority as outlined in the Antiquities Act.

The process by which the monument was put together was entirely closed to any elected official. No one from the State of Utah who holds elected office—not the Governor, neither of the Members of this body, not the Members of the other body, no one—was allowed to make comments or be involved in the process of creating the monument. We now know, however, from press reports that members of what is called the environmental community were involved in writing this proclamation. They had access to the White House, to the Department of Interior, and to administration officials that the rest of us were denied.

Out of this closed process came the national monument and, with it, frankly, Mr. President, considerable antagonism and disappointment on the part of many people in Utah—if polls can be believed, a large majority of the people of Utah—at the way they were treated in this matter. ''Not to worry,'' we were assured by the President at the Grand Canyon. And I was assured personally on the phone by Leon Panetta that there would be protections of the rights of ordinary citizens written into the pattern of the way this monument would be managed.

Mr. Panetta outlined those to me, and I wrote them down. Then, when the President appeared on national television, I followed my list and saw that the President was going down the same list. That is, he made exactly the same promises that Mr. Panetta had made as to the way things would be handled in the monument.

Mr. President, today I am introducing a bill. It will be known as the Grand Staircase-Escalante Resource Protection Act. Its sole purpose is to codify the promises the President made when he created the monument. I said to my staff, ''Do not put everything in this bill you think we must have. Just make sure the act is entirely just what the President promised he would do.''

Let me give you some examples of what I mean. On this chart we have the President's statement made on September 18 when he said: ''Families will be able to use this canyon as they always have. The land will remain open for multiple uses, including hunting, fishing, hiking, camping, and grazing.''

Many of the people who have reacted to the creation of the monument have made it clear that there should never be multiple uses on this land. They say that this would be incompatible with its designation as ''wilderness.'' But the President did not designate the land as wilderness. He designated it as a national monument, and he specifically promised—these are his words—that ''The land will remain open for multiple use . . .'' This was taken off the transcript that was available to us the day the President made his statement.

Another promise the President made is on this chart. It is a little bit longer, but to the people in Utah it may be even more important. He said, ''Mining revenues from Federal and State land help to support your schools.''

He was speaking to the people of Utah.

> I know the children of Utah have a big stake in school lands located within the boundaries of the monument that I am designating today . . . creating this national monument should not and will not come at the expense of Utah's children.

That is a very important commitment made by the President. It has to do with the fact that almost 200,000 acres in this monument are owned by a trust that administers these lands for the benefit of Utah's schoolchildren. Under the monument designation, conceivably the trust would lose that ownership unless there can be a pattern of swapping out school acres for other acres outside the boundaries of the monument.

These are a few of the President's promises.

There was another one which I do not have on the chart but that struck me personally. The President said, ''We will appoint an exchange working group, including Congressman Orton and the two Senators as well as the Governor and others, that will examine this issue of school trust land.''

It has now been 6 months since the President made that statement, and no such group has been proposed by anybody. It has been 6 months since the President made that proclamation, and we don't see any indication that he intends to instruct people to follow through on the promise that the people will be able to use the canyon as they always have. And we see no indication that the people in the administration are taking any steps to make Utah's schoolchildren whole for the income that they will lose as a result of the creation of this monument.

If I were to pick up the phone and call the White House today and ask for Leon Panetta to remind him of the pledge he made to me, I would be told, ''Mr. Panetta doesn't work here anymore.'' So I have decided to take the promises that the President made in this speech, which was before the entire country on national television, and write those promises into law. Many people have said, ''Oh, you are going to do terrible things if you write those into law. You are going to undo every protection that is important to this monument.'' To them I say, if you do not like these promises, argue with William Jefferson Clinton. Don't argue with me because they were his pledges; not mine.

Some groups have seized on some language that I have in the bill describing what will be permitted in the monument and say, ''You go far beyond the President in the things you allow. Where did you get the idea that mining and timber and those kinds of things should be allowed?'' My answer is, I took the definition of ''multiple use''

that is in the FLPMA handbook produced by the Department of the Interior and reproduced it, neither subtracting nor adding anything. I made no attempt to put my judgment as to what ''multiple use'' means. I used the manual that is produced by the Department of the Interior to define what ''multiple use'' means.

By virtue of the introduction of this bill, we will now have hearings. There will be hearings both in the House and the Senate. I am told that a companion bill will be introduced on the other side of the Capitol.

I myself point out that these hearings are open, unlike the process the President followed, which was closed. These hearings will allow those who disagree with me—and I heard from some people this afternoon who disagreed with me quite vehemently—an opportunity to come before the Congress and tell the Congress what they think the President meant when he used these words. These hearings will give the Department of the Interior the opportunity to come before the Congress and tell the Congress what they think the President meant when he used these words. If they can make a plausible case to the Congress, I am perfectly willing to amend the bill and accept changes. The thing I am not willing to do is to accept, as some have said, that ''This was merely a campaign speech. The President should not be held to honor any commitment he made in that speech because it was in the heat of the campaign.''

We are talking, Mr. President, about 1.7 million acres of land in my State. That is a land mass bigger than some of the States represented by Senators who sit here in this Chamber. We are talking about a major action that impacts the future of the people of southern Utah. That being the case, we must codify what the President said so that these commitments are kept whether they were made in a campaign speech or not.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 357

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Grand Staircase-Escalante Resource Protection Act''.

SEC. 2. FINDINGS.

Congress finds that—

(1) the designation of the Grand Staircase-Escalante National Monument applies only to Federal land within the boundary of the Monument;

(2) multiple use has been and continues to be the guiding principle in the management of public land;

(3) in accordance with Proclamation 6920, issued by the President on September 18, 1996 (61 Fed. Reg. 50223 (1996), Federal land within the Monument should remain open for multiple uses;

(4) the United States should not lay claim to Federal water rights in lands within the Monument except in accordance with the substantive and procedural requirements of the State of Utah, and designation of the Monument and enactment of this Act should not impair exercise of water rights by the State of Utah;

(5) mining revenues from Federal and State School and Institutional Trust Lands have generated considerable revenues for Utah schools;

(6) an estimated 176,000 acres of surface land containing significant coal and other resources managed by the School and Institutional Trust Lands Administration for the benefit of Utah's school children are located within the boundary of the Monument;

(7) the creation of the Monument must not come at the expense of Utah's school children;

(8) designation of the Monument will produce a considerable loss of future Federal royalties, State royalties, and school trust royalties resulting in significant revenue loss to Utah's school children; and

(9) the lack of congressional, State, and local consultation prior to designation of the Monument and the failure of the Proclamation to establish a specific boundary for the Monument are certain to give rise to disputes that will require boundary adjustments.

SEC. 3. DEFINITIONS.

In this Act:

(1) ADVISORY COMMITTEE.—The term ''advisory committee'' means the Grand Staircase-Escalante National Monument Advisory Committee established under section 12.

(2) DIRECTOR.—The term ''Director'' means the Director of the Bureau of Land Management.

(3) EXISTING.—The term ''existing'' means in existence as of September 18, 1996.

(4) MANAGEMENT PLAN.—The term ''management plan'' means the management plan for the Monument submitted to Congress under section 9.

(5) MONUMENT.—The term ''Monument'' means the Grand Staircase-Escalante National Monument established by Proclamation of the President on September 18, 1996.

(6) MULTIPLE USE.—The term ''multiple use'' has the meaning given in section 103 of the Federal Land Policy and Management Act of 1976 (43 U.S.C. 1702).

(7) SECRETARY.—The term ''Secretary'' means the Secretary of the Interior.

(8) SPECIAL MANAGEMENT AREA.—The term ''special management area'' means an area that is managed by the Secretary in accordance with the principles of multiple use and sustained yield in accordance with this Act.

(9) SUSTAINED YIELD.—The term ''sustained yield'' has the meaning given in section 103 of the Federal Land Policy and Management Act of 1976 (43 U.S.C. 1702).

SEC. 4. MANAGEMENT OF THE MONUMENT.

(a) SPECIAL MANAGEMENT AREA.—

(1) IN GENERAL.—The Monument shall be managed by the Secretary as a special management area in accordance with this Act.

(2) MULTIPLE USE AND SUSTAINED YIELD.—The Secretary shall manage the resources within the Monument in accordance with the principles of multiple use and sustained yield (including recreation, range, timber, minerals, oil and gas, watershed, wildlife, fish, and natural scenic, scientific, and historical values), using principles of economic and ecologic sustainability.

(3) PROTECTION OF RESOURCES.—The Secretary shall provide for the protection, interpretation, and responsible use of Monument resources.

(4) ECONOMIC SUSTAINABILITY.—The Secretary shall manage the Monument resources in a way that provides for economic sustainability of local communities.

(b) MANAGEMENT AUTHORITY.—

(1) DELEGATION TO THE DIRECTOR.—The Secretary shall delegate authority to manage the Monument to the Director.

(2) LEAD AGENCY.—The Bureau of Land Management shall be the lead agency in all management decisions concerning the Monument, pursuant to all applicable legal authorities, and shall act in consultation with other Federal agencies, State and local government authorities, and the advisory committee.

(c) FUTURE ACTION.—Nothing in this Act precludes the revocation of the Proclamation 6920 by Act of Congress or by Executive order, but, so long as land within the Monument remains subject to designation as a national monument under Proclamation 6920, any successor proclamation, or an Act of Congress, the Monument shall be managed in accordance with this Act.

SEC. 5. VALID EXISTING RIGHTS AND USES.

(a) EXERCISE OF VALID EXISTING RIGHTS.—

(1) IN GENERAL.—The Secretary shall recognize and give due deference to the exercise of any valid existing right, lease, permit, or authorization under any law, including—

(A) the Federal Land Policy and Management Act of 1976 (43 U.S.C. 1701 et seq.);

(B)(i) sections 2319–28, 2331, 2333-2337, and 2344 of the Revised Statutes (commonly known as the ''General Mining Law of 1872'') (30 U.S.C. 22-24, 26-28, 29-30, 33-35, 37, 39-42, 47); and

(ii) the Act entitled ''An Act to promote the mining of coal, phosphate, oil, oil shale, gas, and sodium on the public domain'', approved February 25, 1920 (commonly known as the ''Mineral Lands Leasing Act of 1920'') (30 U.S.C. 181 et seq.);

(C) section 2477 of the Revised Statutes (43 U.S.C. 932) (to the extent of any rights-of-way existing on October 21, 1976);

(D) the Act of June 28, 1934 (48 Stat. 1269, chapter 865; 43 U.S.C. 315 et seq.) (commonly known as the ''Taylor Grazing Act'');

(E) the Surface Mining Control and Reclamation Act of 1977 (30 U.S.C. 1201 et seq.); and

(F) any other applicable law.

(2) NO RESTRICTION.—Neither designation of the Monument nor adoption and implementation of the applicable management plan shall restrict or prevent the exercise of valid existing rights by persons that exercise those rights in compliance with all applicable laws.

(b) ROADS AND RIGHTS-OF-WAY.—The Secretary shall permit routine maintenance and improvement of roads and rights-of-way within Monument boundaries to ensure public safety and a high-quality visitor experience.

(c) TAKINGS.—Any valid existing right determined to be taken as a result of designation of the Monument shall be subject to compensation by the Secretary.

SEC. 6. RANGE MANAGEMENT.

(a) GRAZING OF LIVESTOCK.—Grazing of livestock within the Monument shall continue and shall not be curtailed by reason of designation of the Monument. Designation of the Monument shall not affect existing grazing leases, grazing permits, and levels of livestock grazing within the Monument.

(b) WATER RIGHTS.—The Secretary shall not require a grazing permittee or grazing lessee to transfer or relinquish any part of the permittee's or lessee's water right to another person (including the United States) as a condition of granting, renewing, or transferring a grazing permit or grazing lease.

SEC. 7. WITHDRAWALS.

No existing withdrawal, reservation, or appropriation shall be revoked except in accordance with section 204 of the Federal

Land Policy and Management Act of 1976 (43 U.S.C. 1714).

SEC. 8. NO FEDERAL RESERVATION OF WATER RIGHT.

(a) NO FEDERAL RESERVATION.—Nothing in this Act, any other Act, or any action taken under any Act creates an expressed or implied reservation of water rights in the United States for any purpose.

(b) ACQUISITION AND EXERCISE OF WATER RIGHTS UNDER UTAH LAW.—

(1) ACQUISITION.—The United States may acquire such water rights as the Secretary considers to be necessary to carry out responsibilities of the Secretary with respect to any land within the Monument only in accordance with the substantive and procedural requirements of the law of the State of Utah.

(2) EXERCISE.—Any rights to water granted under the law of the State of Utah may be exercised only in accordance with the substantive and procedural requirements of the law of the State of Utah.

(3) EMINENT DOMAIN.—Nothing in this Act authorizes the use of the power of eminent domain by the United States to acquire water rights on land within the Monument.

(c) FACILITIES NOT AFFECTED.—Nothing in this Act or any other Act relating to management of land within the Monument authorizes any action to be taken that may affect the capacity, operation, repair, construction, maintenance, modification, or repair of municipal, agricultural, livestock, or wildlife water facilities within or outside the Monument or water resources that flow through the Monument.

(d) WATER RESOURCE PROJECTS.—Nothing in this Act or any other Act relating to management of land within the Monument limits, or establishes any matter to be taken into consideration in connection with approval or denial by any Federal official of access to, or use of, the Federal land within or outside the Monument for development and operation of water resource projects (including reservoir projects).

SEC. 9. MANAGEMENT PLAN.

(a) MANAGEMENT IN ACCORDANCE WITH FLPMA.—

(1) IN GENERAL.—Not later than September 18, 1999, the Secretary shall submit to Congress a management plan for the Monument.

(2) MULTIPLE USE AND SUSTAINED YIELD.—In the development and revision of the management plan, the Secretary shall use and observe the principles of multiple use and sustained yield and shall use a systematic interdisciplinary approach to achieve integrated consideration of physical, biological, economic, and other sciences.

(b) REQUIREMENTS.—In the management plan, the Secretary shall specifically address—

(1) the multiple uses of all of the resources of the Monument (including recreation, range, timber, mineral, oil and gas, watershed, wildlife, fish, and natural scenic, scientific, and historical resources) in a responsible manner, under all applicable laws and authorities; and

(2) the economic impacts of the Monument on the economies of local communities.

(c) NOTICE AND COMMENT.—The management plan shall be made available for public review and comment as required by law.

(d) UTILIZATION OF MONUMENT RESOURCES.—Development and utilization of resources within the Monument shall be authorized if—

(1) the President or Congress determines it to be in the interests of the United States; or

(2) in case of a national emergency.

(e) INTERIM MANAGEMENT PLAN.—

(1) IN GENERAL.—Not later than 45 days after the date of enactment of this Act, the Secretary shall modify any guidelines in existence on the date of enactment of this Act regarding management of the Monument to conform to the requirements of this Act.

(2) PENDING APPLICATIONS.—No lease on land within the Monument with respect to which an application of any kind was pending on September 18, 1996, or is pending on the date of enactment of this Act shall expire if the Secretary has not acted on the application.

SEC. 10. STATE JURISDICTION WITH RESPECT TO FISH AND WILDLIFE.

Nothing in this Act—

(1) affects the jurisdiction or responsibilities of the State of Utah with respect to fish and wildlife management activities (including hunting, fishing, trapping, predator control, and the stocking or transplanting of fish and wildlife); or

(2) precludes the State of Utah from developing water resources for fish and wildlife purposes under State law.

SEC. 11. SCHOOL TRUST LANDS EXCHANGE.

(a) EXPEDITION OF EXCHANGES.—The Secretary shall provide necessary resources to expedite all exchanges of school trust lands within the Monument when sought by the School and Institutional Trust Lands Administration of the State of Utah.

(b) VALUATION.—The Secretary shall value school trust land sections as if surrounding unencumbered Federal lands were available for mineral development, and all reasonable differences in valuation shall be resolved in favor of the school trust.

(c) ANALYSIS OF LOST ROYALTIES.—Not later than 45 days after the date of enactment of this Act, the Secretary shall submit to Congress an analysis of the loss of Federal royalties that can be expected to result from designation of the Monument, based on research compiled by the United States Geological Survey.

(d) ACCESS TO STATE SECTIONS.—The Secretary shall not deny access to school trust lands within the Monument by agencies of the State of Utah and designated permittees of those agencies.

SEC. 12. ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—Not later than 90 days after the date of enactment of this Act, the Secretary shall establish and convene a meeting of an advisory committee to be known as the ''Grand Staircase-Escalante National Monument Advisory Committee''.

(b) DUTIES AND RESPONSIBILITIES.—The advisory committee shall advise the Secretary, the Director, and the Governor of the State of Utah concerning the development, management, and interpretation of Monument resources and the development, exchange, or disposal of State school trust lands.

(c) MEMBERSHIP.—The advisory committee shall consist of—

(1) the Secretary, the Governor of the State of Utah, the member of the House of Representatives from the third congressional district, and the 2 members of the Senate from the State of Utah; and

(2) 10 members appointed by the Secretary of the Interior from among persons recommended by the Governor of Utah, including—

(A) 1 representative of agricultural interests;

(B) 1 representative of mining and oil and gas interests;

(C) 1 representative of recreational interests;

(D) 1 representative of environmental interests;

(E) 1 representative of the School Institutional Trust Lands Administration of the State of Utah;

(F) 1 representative of the Department of Natural Resources of the State of Utah;

(G) 1 representative of other agencies of the State of Utah;

(H) 1 representative of local communities;

(I) 1 representative of Native Americans; and

(J) 1 representative of the public at large.

(d) TERMS.—A member of the advisory committee shall serve for a term not to exceed 5 years, determined by the Secretary in consultation with the Governor of the State of Utah, and may serve more than 1 term.

(e) VACANCIES.—A vacancy on the advisory committee shall be filled in the same manner as the original appointment is made. A member of the advisory committee may serve until a successor is appointed.

(f) CHAIRPERSON.—The advisory committee shall select 1 member to serve as chairperson.

(g) MEETINGS.—The advisory committee shall meet regularly.

(h) QUORUM.—A majority of members shall constitute a quorum.

(i) COMPENSATION.—Members of the advisory committee shall serve without compensation, except that members shall be entitled to reimbursement of travel expenses including per diem while engaged in the business of the advisory committee, in accordance with section 5703 of title 5, United States Code.

SEC. 13. MONUMENT PLANNING TEAM.

The Secretary shall provide that the Monument planning team formed by the Secretary to prepare the management plan for the Monument includes at least 5 persons appointed by the Governor of the State of Utah to represent the State and local governments.

SEC. 14. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as are necessary to—

(1) provide for development and implementation of management plans, protection of Monument resources, visitor services and facilities, law enforcement, public safety, additional payments in lieu of taxes to impacted counties, economic mitigation, and the operation of the Monument advisory committee; and

(2) facilitate the exchange of school trust lands.

ADDITIONAL COSPONSORS

S. 5

At the request of Mr. ASHCROFT, the name of the Senator from Oklahoma [Mr. INHOFE] was added as a cosponsor of S. 5, a bill to establish legal standards and procedures for product liability litigation, and for other purposes.

S. 6

At the request of Mr. SANTORUM, the name of the Senator from Tennessee [Mr. FRIST] was added as a cosponsor of S. 6, a bill to amend title 18, United States Code, to ban partial-birth abortions.

S. 191

At the request of Mr. HELMS, the name of the Senator from Oklahoma [Mr. INHOFE] was added as a cosponsor of S. 191, a bill to throttle criminal use of guns.

S. 197

At the request of Mr. ROTH, the names of the Senator from California [Mrs. FEINSTEIN], the Senator from Colorado [Mr. ALLARD], the Senator from Florida [Mr. MACK], the Senator from Missouri [Mr. ASHCROFT], the Senator