(1) congratulates the United States women's soccer team for winning the 1999 Women's World Cup;

(2) recognizes the important contribution of each individual team member to the United States and to the advancement of women's sports; and

(3) invites the members of the United States women's soccer team to the United States Capitol to be honored and recognized by the Senate for their achievements.

SEC. 2. TRANSMISSION OF ENROLLED RESOLUTION.

The Secretary of the Senate shall transmit an enrolled copy of this resolution to the United States women's soccer team.

Mr. CAMPBELL. Mr. President, today I submit a resolution in honor of the Women's World Cup Soccer Champions, the U.S. Women's Soccer Team.

From the first game of the Women's World Cup in New Jersey, which was played before a sold-out crowd, to the final game at the Rose Bowl filled with 90,185 screaming fans, setting the women's sports record for attendance, this U.S. Women's Soccer Team has inspired us all. The U.S. Women's Soccer Team had an outstanding run during the 1999 Women's World Cup which culminated in an amazing victory against the Chinese in the final game.

After 120 minutes of exciting soccer, the game came down to a shoot-out where the U.S. Women's Team prevailed 5 to 4 to become the champions. From Briana Scurry's game winning save to the nail-biting seconds before Brandi Chastain made the winning goal, they had us all sitting on the edge of our chairs.

As a former Olympic athlete, I know the dedication and determination that these women must have in order to achieve this tremendous accomplishment. I want to point out that every member of this team either has a college degree or is pursuing one. I can't think of better role models for today's youth than this World Cup Team.

I want to congratulate and recognize each and every member of this team and I ask unanimous consent that their names and the resolution be printed in the RECORD. I would also like to thank my good friend and former Olympian Donna de Varona, the Chairwoman of the Women's World Cup, for her hard work and dedication to ensure that women's soccer is finally given the recognition it deserves. I urge my colleagues to join in strong support of passage of this resolution.

There being no objection, the names were ordered to be printed in the RECORD, as follows:

U.S. WOMEN'S SOCCER TEAM

Michelle Akers, Brandi Chastain, Tracy Ducar, Lorrie Fair, Joy Fawcett, Danielle Fotopoulos, Julie Foudy, Mia Hamm, Kristine Lilly, Shannon MacMillan, Tiffeny Milbrett, Carla Overbeck, Cindy Parlow, Christie Pearce, Tiffany Roberts, Briana Scurry, Kate Sobrero, Tisha Venturini, Saskia Webber, Sara Whalen.

AMENDMENTS SUBMITTED

PATIENTS' BILL OF RIGHTS ACT OF 1999

SNOWE (AND OTHERS) AMENDMENT NO. 1241

Ms. SNOWE (for herself, Mr. ABRAHAM, Mr. FITZGERALD, Mr. CRAPO, Ms. COLLINS, Mr. JEFFORDS, Mr. MURKOWSKI, and Mr. DEWINE) proposed an amendment to amendment No. 1239 proposed by Mr. DODD to the bill (S. 1344) to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage; as follows:

Strike section 152 of the bill, and insert the following:

WOMEN'S HEALTH AND CANCER RIGHTS.

(a) SHORT TITLE.—This section may be cited as the ''Women's Health and Cancer Rights Act of 1999''.

(b) FINDINGS.—Congress finds that—

(1) the offering and operation of health plans affect commerce among the States;

(2) health care providers located in a State serve patients who reside in the State and patients who reside in other States; and

(3) in order to provide for uniform treatment of health care providers and patients among the States, it is necessary to cover health plans operating in 1 State as well as health plans operating among the several States.

(c) AMENDMENTS TO ERISA.—

(1) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 301, is further amended by adding at the end the following:

''SEC. 715. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following—

''(A) a mastectomy;

''(B) a lumpectomy; or

''(C) a lymph node dissection for the treatment of breast cancer.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

''(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

''(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 2000;

whichever is earlier.

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (d).''.

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 714 the following new item:

''Sec. 715. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.''.

(d) AMENDMENTS TO PHSA RELATING TO THE GROUP MARKET.—Subpart 2 of part A of title XXVII of the Public Health Service Act, as amended by section 201, is further amended by adding at the end the following new section:

"SEC. 2708. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following—

''(A) a mastectomy;

''(B) a lumpectomy; or

''(C) a lymph node dissection for the treatment of breast cancer.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

''(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

''(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 2000;

whichever is earlier.

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (d).''.

(e) AMENDMENTS TO PHSA RELATING TO THE INDIVIDUAL MARKET.—Subpart 2 of part B of title XXVII of the Public Health Service Act, as amended by section 202, is further amended by adding at the end the following new section:

"SEC. 2754. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND SECONDARY CONSULTATIONS.

''The provisions of section 2708 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(f) AMENDMENTS TO THE IRC.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 401, is further amended—

(A) in the table of sections, by inserting after the item relating to section 9813 the following new item:

''Sec. 9814. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.''; and

(B) by inserting after section 9813 the following:

"SEC. 9814. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following—

''(A) a mastectomy;

''(B) a lumpectomy; or

''(C) a lymph node dissection for the treatment of breast cancer.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

''(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

''(c) NOTICE.—A group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan and shall be transmitted—

''(1) in the next mailing made by the plan to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 2000;

whichever is earlier.

''(d) SECONDARY CONSULTATIONS.—

''(1) IN GENERAL.—A group health plan that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation is based on a positive or negative initial diagnosis. In any case in which the attending physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under the plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that coverage is provided with respect to the services necessary for the secondary consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which the individual would have paid if the specialist was participating in the network of the plan.

''(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

''(e) PROHIBITION ON PENALTIES.—A group health plan may not—

''(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

''(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to keep the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations; or

''(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan involved under subsection (d).''.

(2) CLERICAL AMENDMENT.—The table of contents for chapter 100 of such Code is

amended by inserting after the item relating to section 9813 the following new item:

''Sec. 9814. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.''.

KENNEDY (AND OTHERS) AMENDMENT NO. 1242

Mr. DASCHLE (for Mr. KENNEDY (for himself, Mr. REID, Mr. DURBIN, Mr. WELLSTONE, Mr. WYDEN, Mr. REED, Mrs. MURRAY, Mr. DASCHLE, Mr. CHAFEE, and Mrs. FEINSTEIN)) proposed an amendment to amendment No. 1239 to the bill, S. 1344, supra; as follows:

At the appropriate place, insert the following:

SEC. ___. APPLICATION TO ALL HEALTH PLANS.

(a) ERISA.—Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as added by section 101(a)(2) of this Act, is amended by adding at the end the following:

''SEC. 730A. APPLICATION OF PROVISIONS.

''(a) APPLICATION TO GROUP HEALTH PLANS.—The provisions of this subpart, and sections 714 and 503, shall apply to group health plans and health insurance issuers offering health insurance coverage in connection with a group health plan.

''(b) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a group health plan that provides benefits under 2 or more coverage options, the requirements of this subpart, other than section 722, shall apply separately with respect to each coverage option.

''(c) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of this Act with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) section 721 (relating to access to emergency care).

''(B) Section 722 (relating to choice of coverage options), but only insofar as the plan is meeting such requirement through an agreement with the issuer to offer the option to purchase point-of-service coverage under such section.

''(C) Section 723, 724 and 725 (relating to access to specialty care).

''(D) Section 726) (relating to continuity in case of termination of provider (or, issuer in connection with health insurance coverage) contract) but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(E) Section 727 (relating to patient-provider communications).

''(F) Section 728 (relating to prescription drugs).

''(G) Section 729 (relating to self-payment for certain services).

''(2) INFORMATION.—With respect to information required to be provided or made available under section 714, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer's failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

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

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

''(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of section 727, the group health plan shall not be liable for such violation unless the plan caused such violation.

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(d) CONFORMING REGULATIONS.—The Secretary may issue regulations to coordinate the requirements on group health plans under this section with the requirements imposed under the other provisions of this title.''.

(b) APPLICATION TO GROUP MARKET UNDER PUBLIC HEALTH SERVICE ACT.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.), as amended by section 203(a)(1)(B), is further amended by adding at the end the following new section:

''SEC. 2708. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each group health plan shall comply with the following patient protection requirements, and each health insurance issuer shall comply with such patient protection requirements with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection:

''(1) The requirements of subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) The requirements of section 714 of the Employee Retirement Income Security Act of 1974.

''(3) The requirements of subsections (b) through (g) of section 503 of the Employee Retirement Income Security Act of 1974.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 104(b)(1) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

(c) APPLICATION TO INDIVIDUAL MARKET UNDER PUBLIC HEALTH SERVICE ACT.—Subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-51 et seq.), as amended by section 203(b)(2), is further amended by adding at the end the following new section:

''SEC. 2754. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with the following patient protection requirements with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection:

''(1) The requirements of subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) The requirements of section 714 of the Employee Retirement Income Security Act of 1974.

''(3) The requirements of section 503 of the Employee Retirement Income Security Act of 1974.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 104(b)(1) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such subtitle as if such section applied to such issuer and such issuer were a group health plan.

''(c) NONAPPLICATION OF CERTAIN PROVISION.—Section 2763(a) shall not apply to the provisions of this section.''.

(d) APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Standard relating to patients' bill of rights.''; and

(2) by inserting after section 9812 the following:

''SEC. 9813. STANDARD RELATING TO PATIENTS' BILL OF RIGHTS.

''A group health plan shall comply with the following requirements (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section:

''(1) The requirements of subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) The requirements of section 714 of the Employee Retirement Income Security Act of 1974.

''(3) The requirements of section 503 of the Employee Retirement Income Security Act of 1974.''.

(e) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of the Public Health Service Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2708)'' after ''requirements of such subparts''.

(f) NO IMPACT ON SOCIAL SECURITY TRUST FUND.—

(1) IN GENERAL.—Nothing in the amendments made by this section shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

(2) TRANSFERS.—

(A) ESTIMATE OF SECRETARY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this section has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

(B) TRANSFER OF FUNDS.—If, under subparagraph (A), the Secretary of the Treasury estimates that the enactment of this section has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer, not less frequently than quarterly, from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of such section.

(g) INFORMATION REQUIREMENTS.—

(1) INFORMATION FROM GROUP HEALTH PLANS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following:

''(7) INFORMATION FROM GROUP HEALTH PLANS.—

''(A) PROVISION OF INFORMATION BY GROUP HEALTH PLANS.—The administrator of a group health plan subject to the requirements of paragraph (1) shall provide to the Secretary such of the information elements described in subparagraph (C) as the Secretary specifies, and in such manner and at such times as the Secretary may specify (but not more frequently than 4 times per year), with respect to each individual covered under the plan who is entitled to any benefits under this title.

''(B) PROVISION OF INFORMATION BY EMPLOYERS AND EMPLOYEE ORGANIZATIONS.—An employer (or employee organization) that maintains or participates in a group health plan subject to the requirements of paragraph (1) shall provide to the administrator of the plan such of the information elements required to be provided under subparagraph (A), and in such manner and at such times as the Secretary may specify, at a frequency consistent with that required under subparagraph (A) with respect to each individual described in subparagraph (A) who is covered under the plan by reason of employment with that employer or membership in the organization.

''(C) INFORMATION ELEMENTS.—The information elements described in this subparagraph are the following:

''(i) ELEMENTS CONCERNING THE INDIVIDUAL.—

''(I) The individual's name.

''(II) The individual's date of birth.

''(III) The individual's sex.

''(IV) The individual's social security insurance number.

''(V) The number assigned by the Secretary to the individual for claims under this title.

''(VI) The family relationship of the individual to the person who has or had current or employment status with the employer.

''(ii) ELEMENTS CONCERNING THE FAMILY MEMBER WITH CURRENT OR FORMER EMPLOYMENT STATUS.—

''(I) The name of the person in the individual's family who has current or former employment status with the employer.

''(II) That person's social security insurance number.

''(III) The number or other identifier assigned by the plan to that person.

''(IV) The periods of coverage for that person under the plan.

''(V) The employment status of that person (current or former) during those periods of coverage.

''(VI) The classes (of that person's family members) covered under the plan.

''(iii) PLAN ELEMENTS.—

''(I) The items and services covered under the plan.

''(II) The name and address to which claims under the plan are to be sent.

''(iv) ELEMENTS CONCERNING THE EMPLOYER.—

''(I) The employer's name.

''(II) The employer's address.

''(III) The employer identification number of the employer.

''(D) USE OF IDENTIFIERS.—The administrator of a group health plan shall utilize a unique identifier for the plan in providing information under subparagraph (A) and in other transactions, as may be specified by the Secretary, related to the provisions of this subsection. The Secretary may provide to the administrator the unique identifier described in the preceding sentence.

''(E) PENALTY FOR NONCOMPLIANCE.—Any entity that knowingly and willfully fails to comply with a requirement imposed by the previous subparagraphs shall be subject to a civil money penalty not to exceed $1,000 for each incident of such failure. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as those provisions apply to a penalty or proceeding under section 1128A(a).''

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect 180 days after the date of the enactment of this Act.

(h) MODIFICATION TO FOREIGN TAX CREDIT CARRYBACK AND CARRYOVER PERIODS.—

(1) IN GENERAL.—Section 904(c) of the Internal Revenue Code of 1986 (relating to limitation on credit) is amended—

(A) by striking ''in the second preceding taxable year,'', and

(B) by striking ''or fifth'' and inserting ''fifth, sixth, or seventh''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to credits arising in taxable years beginning after December 31, 2001.

(i) LIMITATIONS ON WELFARE BENEFIT FUNDS OF 10 OR MORE EMPLOYER PLANS.—

(1) BENEFITS TO WHICH EXCEPTION APPLIES.—Section 419A(f)(6)(A) of the Internal Revenue Code of 1986 (relating to exception for 10 or more employer plans) is amended to read as follows:

''(A) IN GENERAL.—This subpart shall not apply to a welfare benefit fund which is part of a 10 or more employer plan if the only benefits provided through the fund are 1 or more of the following:

''(i) Medical benefits.

''(ii) Disability benefits.

''(iii) Group term life insurance benefits which do not provide for any cash surrender value or other money that can be paid, assigned, borrowed, or pledged for collateral for a loan.

The preceding sentence shall not apply to any plan which maintains experience-rating arrangements with respect to individual employers.''

(2) LIMITATION ON USE OF AMOUNTS FOR OTHER PURPOSES.—Section 4976(b) of such Act (defining disqualified benefit) is amended by adding at the end the following new paragraph:

''(5) SPECIAL RULE FOR 10 OR MORE EMPLOYER PLANS EXEMPTED FROM PREFUNDING LIMITS.—For purposes of paragraph (1)(C), if—

''(A) subpart D of part I of subchapter D of chapter 1 does not apply by reason of section 419A(f)(6) to contributions to provide 1 or more welfare benefits through a welfare benefit fund under a 10 or more employer plan, and

''(B) any portion of the welfare benefit fund attributable to such contributions is used for a purpose other than that for which the contributions were made,

then such portion shall be treated as reverting to the benefit of the employers maintaining the fund.''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to contributions paid or accrued after the date of the enactment of this Act, in taxable years ending after such date.

(j) MODIFICATION OF INSTALLMENT METHOD AND REPEAL OF INSTALLMENT METHOD FOR ACCRUAL METHOD TAXPAYERS.—

(1) REPEAL OF INSTALLMENT METHOD FOR ACCRUAL BASIS TAXPAYERS.—

(A) IN GENERAL.—Subsection (a) of section 453 of the Internal Revenue Code of 1986 (relating to installment method) is amended to read as follows:

''(a) USE OF INSTALLMENT METHOD.—

''(1) IN GENERAL.—Except as otherwise provided in this section, income from an installment sale shall be taken into account for purposes of this title under the installment method.

''(2) ACCRUAL METHOD TAXPAYER.—The installment method shall not apply to income from an installment sale if such income would be reported under an accrual method of accounting without regard to this section. The preceding sentence shall not apply to a disposition described in subparagraph (A) or (B) of subsection (l)(2).''

(B) CONFORMING AMENDMENTS.—Sections 453(d)(1), 453(i)(1), and 453(k) of such Act are each amended by striking ''(a)'' each place it appears and inserting ''(a)(1)''.

(2) MODIFICATION OF PLEDGE RULES.—Paragraph (4) of section 453A(d) of such Act (relating to pledges, etc., of installment obligations) is amended by adding at the end the following: ''A payment shall be treated as directly secured by an interest in an installment obligation to the extent an arrangement allows the taxpayer to satisfy all or a portion of the indebtedness with the installment obligation.''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to sales or other dispositions occurring on or after the date of the enactment of this Act.

COLLINS (AND OTHERS) AMENDMENT NO. 1243

Ms. COLLINS (for herself, Mr. HUTCHINSON, Mr. JEFFORDS, Mr. FRIST, Mr. GRAMS, Mr. GRASSLEY, and Mr. ABRAHAM) proposed an amendment to amendment No. 1232 proposed by Mr. DASCHLE to the bill, S. 1344, supra; as follows:

In the language proposed to be stricken, at the appropriate place, insert the following:

SEC. ___. INCLUSION OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS IN CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND HEALTH FLEXIBLE SPENDING ACCOUNTS.

(a) IN GENERAL.—Section 125(f) of the Internal Revenue Code of 1986 (defining qualified benefits) is amended by striking the last sentence and inserting the following: ''Such term includes any qualified long-term care insurance contract.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. ___. DEDUCTION FOR PREMIUMS FOR LONG-TERM CARE INSURANCE.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions) is amended by redesignating section 222 as section 223 and by inserting after section 221 the following:

''SEC. 222. PREMIUMS FOR LONG-TERM CARE INSURANCE.

''(a) IN GENERAL.—In the case of an eligible individual, there shall be allowed as a deduction an amount equal to 100 percent of the amount paid during the taxable year for any coverage for qualified long-term care services (as defined in section 7702B(c)) or any qualified long-term care insurance contract (as defined in section 7702B(b)) which constitutes medical care for the taxpayer, his spouse, and dependents.

''(b) LIMITATIONS.—

''(1) DEDUCTION NOT AVAILABLE TO INDIVIDUALS ELIGIBLE FOR EMPLOYER-SUBSIDIZED COVERAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), subsection (a) shall not apply to any taxpayer for any calendar month for which the taxpayer is eligible to participate in any plan which includes coverage for qualified long-term care services

(as so defined) or is a qualified long-term care insurance contract (as so defined) maintained by any employer (or former employer) of the taxpayer or of the spouse of the taxpayer.

''(B) CONTINUATION COVERAGE.—Coverage shall not be treated as subsidized for purposes of this paragraph if—

''(i) such coverage is continuation coverage (within the meaning of section 4980B(f)) required to be provided by the employer, and

''(ii) the taxpayer or the taxpayer's spouse is required to pay a premium for such coverage in an amount not less than 100 percent of the applicable premium (within the meaning of section 4980B(f)(4)) for the period of such coverage.

''(2) LIMITATION ON LONG-TERM CARE PREMIUMS.—In the case of a qualified long-term care insurance contract (as so defined), only eligible long-term care premiums (as defined in section 213(d)(10)) shall be taken into account under subsection (a)(2).

''(c) SPECIAL RULES.—For purposes of this section—

''(1) COORDINATION WITH MEDICAL DEDUCTION, ETC.—Any amount paid by a taxpayer for insurance to which subsection (a) applies shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a).

''(2) DEDUCTION NOT ALLOWED FOR SELF-EMPLOYMENT TAX PURPOSES.—The deduction allowable by reason of this section shall not be taken into account in determining an individual's net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2.''

(b) CONFORMING AMENDMENTS.—

(1) Subsection (a) of section 62 of the Internal Revenue Code of 1986 is amended by inserting after paragraph (17) the following:

''(18) LONG-TERM CARE INSURANCE COSTS OF CERTAIN INDIVIDUALS.—The deduction allowed by section 222.''

(2) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

''Sec. 222. Premiums for long-term care insurance.

''Sec. 223. Cross reference.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. ___. PATIENT RIGHT TO MEDICAL ADVICE AND CARE.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.) is amended—

(1) by redesignating subpart C as subpart D; and

(2) by inserting after subpart B the following:

''SEC. 723. PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE

(1) GENERAL RIGHTS.—

(A) WAIVER OF PLAN REFERRAL REQUIREMENT.—If a group health plan described in paragraph (2) requires a referral to obtain coverage for speciality care, the plan shall waive the referral requirement in the case of a female participant or beneficiary who seeks coverage for obstetrical care or routine gynecological care (such as preventive gynecological care).

(B) RELATED ROUTINE CARE.—With respect to a participant or beneficiary described in subparagraph (A), a group health plan described in paragraph (2) may treat the ordering of other care that is related to obstetric or routine gynecologic care, by a physician who specializes in obstetrics and gynecology as the authorization of the primary care provider for such other care.

(2) APPLICATION OF SECTION.—A group health plan described in this paragraph is a group health plan (other than a fully insured group health plan), that—

(A) provides coverage for obstetric care (such as pregnancy-related services) or routine gynecologic care (such as preventive women's health examinations); and

(B) requires the designation by a participant or beneficiary of a participating primary care provider who is not a physician who specializes in obstetrics or gynecology.

(3) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed—

(A) as waiving any coverage requirement relating to medical necessity or appropriateness with respect to the coverage of obstetric or gynecologic care described in paragraph (1);

(B) to preclude the plan from requiring that the physician who specializes in obstetrics or gynecology notify the designated primary care provider or the plan of treatment decisions;

(C) to preclude a group health plan from allowing health care professionals other than physicians to provide routine obstetric or routine gynecologic care; or

(D) to preclude a group health plan from permitting a physician who specializes in obstetrics and gynecology from being a primary care provider under the plan.

(4) APPLICATION OF PROVISIONS.—

(A) IN GENERAL.—Notwithstanding any other provision of this Act (or an amendment made by this Act), the provisions of this subsection shall only apply to group health plans (other than fully insured group health plans).

(B) FULLY INSURED GROUP HEALTH PLAN.—In this subsection, the term ''fully insured group health plan'' means a group health plan where benefits under the plan are provided pursuant to the terms of an arrangement between a group health plan and a health insurance issuer and are guaranteed by the health insurance issuer under a contract or policy of insurance.

''SEC. 725. TIMELY ACCESS TO SPECIALISTS.

''(a) TIMELY ACCESS.—

''(1) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall ensure that participants and beneficiaries have timely, in accordance with the medical exigencies of the case, access to primary and speciality health care professionals who are appropriate to the condition of the participant or beneficiary, when such care is covered under the plan. Such access may be provided through contractual arrangements with specialized providers outside of the network of the plan.

''(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

''(A) to require the coverage under a group health plan of particular benefits or services or to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's participants or beneficiaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan; or

''(B) to override any State licensure or scope-of-practice law.

''(b) TREATMENT PLANS.—

''(1) IN GENERAL.—Nothing in this section shall be construed to prohibit a group health plan (other than a fully insured group health plan) from requiring that speciality care be provided pursuant to a treatment plan so long as the treatment plan is—

''(A) developed by the specialist, in consultation with the case manager or primary care provider, and the participant or beneficiary;

''(B) approved by the plan in a timely manner in accordance with the medical exigencies of the case; and

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

''(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan from requiring the specialist to provide the case manager or primary care provider with regular updates on the specialty care provided, as well as all other necessary medical information.

''(c) REFERRALS.—Nothing in this section shall be construed to prohibit a plan from requiring an authorization by the case manager or primary care provider of the participant or beneficiary in order to obtain coverage for speciality services so long as such authorization is for an adequate number of referrals.

''(d) SPECIALITY CARE DEFINED.—For purposes of this subsection, the term 'speciality care' means, with respect to a condition, care and treatment provided by a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise (including age-appropriate expertise) through appropriate training and experience.

SEC. . PATIENT ACCESS TO EMERGENCY MEDICAL CARE.

(a) COVERAGE OF EMERGENCY CARE.—

(1) IN GENERAL.—To the extent that the group health plan (other than a fully insured group health plan) provides coverage for benefits consisting of emergency medical care (as defined in subsection (c)) or emergency ambulance services, except for items or services specifically excluded—

(A) the plan shall provide coverage for benefits, without requiring preauthorization, for emergency medical screening examinations or emergency ambulance services, to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations or emergency ambulance services to be necessary to determine whether emergency medical care (as so defined) is necessary; and

(B) the plan shall provide coverage for benefits, without requiring preauthorization, for additional emergency medical care to stabilize an emergency medical condition following an emergency medical screening examination (if determined necessary under subparagraph (A)), pursuant to the definition of stabilize under section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(2) REIMBURSEMENT FOR CARE TO MAINTAIN MEDICAL STABILITY.—

(A) IN GENERAL.—In the case of services provided to a participant or beneficiary by a nonparticipating provider in order to maintain the medical stability of the participant or beneficiary, the group health plan involved shall provide for reimbursement with respect to such services if—

(i) coverage for services of the type furnished is available under the group health plan;

(ii) the services were provided for care related to an emergency medical condition and in an emergency department in order to maintain the medical stability of the participant or beneficiary; and

(iii) the nonparticipating provider contacted the plan regarding approval for such services.

(B) FAILURE TO RESPOND.—If a group health plan fails to respond within 1 hours of being contacted in accordance with subparagraph (A)(iii), then the plan shall be liable for the cost of services provided by the nonparticipating provider in order to maintain the stability of the participant or beneficiary.

(C) LIMITATION.—The liability of a group health plan to provide reimbursement under subparagraph (A) shall terminate when the

plan has contacted the nonparticipating provider to arrange for discharge or transfer.

(D) LIABILITY OF PARTICIPANT.—A participant or beneficiary shall not be liable for the costs of services to which subparagraph (A) in an amount that exceeds the amount of liability that would be incurred if the services were provided by a participating health care provider with prior authorization by the plan.

(b) IN-NETWORK UNIFORM COSTS-SHARING AND OUT-OF-NETWORK CARE.—

(1) IN-NETWORK UNIFORM COST-SHARING.—Nothing in this section shall be construed as preventing a group health plan (other than a fully insured group health plan) from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to coverage for benefits described in subsection (a), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in subsection (c)) provided to such similarly situated participants and beneficiaries under the plan, and such cost-sharing is disclosed in accordance with section 714.

(2) OUT-OF-NETWORK CARE.—If a group health plan (other than a fully insured group health plan) provides any benefits with respect to emergency medical care (as defined in subsection (c)), the plan shall cover emergency medical care under the plan in a manner so that, if such care is provided to a participant or beneficiary by a nonparticipating health care provider, the participant or beneficiary is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating provider.

(c) DEFINITION OF EMERGENCY MEDICAL CARE.—In this section:

(1) IN GENERAL.—The term ''emergency medical care'' means, with respect to a participant or beneficiary under a group health plan (other than a fully insured group health plan), covered inpatient and outpatient services that—

(A) are furnished by any provider, including a nonparticipating provider, that is qualified to furnish such services; and

(B) are needed to evaluate or stabilize (as such term is defined in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd)(e)(3)) an emergency medical condition (as defined in paragraph (2)).

(2) EMERGENCY MEDICAL CONDITION.—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—

(A) placing the health of the participant or beneficiary (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(d) APPLICATION OF PROVISIONS.—

(1) IN GENERAL.—Notwithstanding any other provision of this Act (or an amendment made by this Act), the provisions of this section shall only apply to group health plans (other than fully insured group health plans).

(2) FULLY INSURED GROUP HEALTH PLAN.—In this section, the term ''fully insured group health plan'' means a group health plan where benefits under the plan are provided pursuant to the terms of an arrangement between a group health plan and a health insurance issuer and are guaranteed by the health insurance issuer under a contract or policy of insurance.

AGRICULTURE, RURAL DEVELOPMENT, FOOD AND DRUG ADMINISTRATION AND RELATED AGENCIES APPROPRIATIONS ACT, 2000

CONRAD AMENDMENT NO. 1244

(Ordered to lie on the table.)

Mr. CONRAD submitted an amendment intended to be proposed by him to the bill (S. 1233) making appropriations for Agriculture, Rural Development, Food and Drug Administration, and Related Agencies programs for the fiscal year ending September 30, 2000, and for other purposes; as follows:

On page 76, between lines 6 and 7, insert the following:

TITLE ____—RURAL ECONOMY EMERGENCY STABILIZATION

SEC. ___01. SHORT TITLE.

This title may be cited as the ''Rural Economy Emergency Stabilization Act of 1999''.

SEC. ___02. MARKET LOSS ASSISTANCE.

(a) IN GENERAL.—Except as provided in subsections (d) and (e), the Secretary of Agriculture (referred to in this title as the ''Secretary'') shall use not more than $5,600,000,000 of funds of the Commodity Credit Corporation to provide assistance to owners and producers on a farm that are eligible for payments for fiscal year 1999 under a production flexibility contract for the farm under the Agricultural Market Transition Act (7 U.S.C. 7201 et seq.) to partially compensate the owners and producers for the loss of markets for the 1999 crop of a commodity.

(b) AMOUNT.—Except as provided in subsections (d) and (e), the amount of assistance made available to owners and producers on a farm under this section shall be proportionate to the amount of the contract payment received by the owners and producers for fiscal year 1999 under a production flexibility contract for the farm under the Agricultural Market Transition Act.

(c) TIME FOR PAYMENT.—The assistance made available under this section for an eligible owner or producer shall be provided as soon as practicable after the date of enactment of this Act.

(d) DAIRY PRODUCERS.—

(1) IN GENERAL.—Of the total amount made available under subsection (a), $200,000,000 shall be available to provide assistance to dairy producers in a manner determined by the Secretary.

(2) FEDERAL MILK MARKETING ORDERS.—Payments made under this subsection shall not affect any decision with respect to rulemaking activities under section 143 of the Agricultural Market Transition Act (7 U.S.C. 7253).

(e) PEANUTS.—

(1) IN GENERAL.—Of the total amount made available under subsection (a), the Secretary shall use not to exceed $45,000,000 to provide payments to producers of quota peanuts or additional peanuts to partially compensate the producers for the loss of markets for the 1998 crop of peanuts.

(2) AMOUNT.—The amount of a payment made to producers on a farm of quota peanuts or additional peanuts under paragraph (1) shall be equal to the product obtained by multiplying—

(A) the quantity of quota peanuts or additional peanuts produced or considered produced by the producers under section 155 of the Agricultural Market Transition Act (7 U.S.C. 7271); by

(B) an amount equal to 5 percent of the loan rate established for quota peanuts or additional peanuts, respectively, under section 155 of that Act.

SEC. ___03. CROP INSURANCE PREMIUM REFUNDS.

The Secretary, acting through the Federal Crop Insurance Corporation, shall use not more than $400,000,000 of funds of the Commodity Credit Corporation to provide premium refunds or other assistance to purchasers of crop insurance for their 2000 or preceding insured crops.

SEC. ___04. CROP LOSS ASSISTANCE.

(a) IN GENERAL.—In addition to amounts that have been made available before the date of enactment of this Act to carry out section 1102 of the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 1999 (7 U.S.C. 1421 note; Public Law 105–277) under other law, the Secretary shall use not more than $360,000,000 of funds of the Commodity Credit Corporation to provide crop loss assistance in accordance with that section in a manner that, to the maximum extent practicable—

(1) fully compensates agricultural producers for crop losses in accordance with that section (including regulations promulgated to carry out that section); and

(2) provides equitable treatment under that section for agricultural producers described in subsections (b) and (c) of that section.

(b) CITRUS CROP LOSSES.—Notwithstanding any other provision of law (including regulations), for the purposes of section 1102 of that Act, a loss of a citrus crop caused by a disaster in 1998 shall be considered to be a loss of the 1998 crop of the citrus crop, without regard to the time of harvest.

(c) COMPENSATION FOR DENIAL OF CROP LOSS ASSISTANCE BASED ON TAXPAYER IDENTIFICATION NUMBERS.—The Secretary shall use not more than $70,000,000 of funds of the Commodity Credit Corporation to make payments to producers on a farm that were denied crop loss assistance under section 1102 of the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 1999 (7 U.S.C. 1421 note; Public Law 105–277), as the result of a change in the taxpayer identification numbers of the producers if the Secretary determines that the change was not made to create an advantage for the producers in the crop insurance program through lower premiums or higher actual production histories.

SEC. ___05. EMERGENCY LIVESTOCK FEED ASSISTANCE.

For an additional amount to provide emergency livestock feed assistance in accordance with section 1103 of the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 1999 (7 U.S.C. 1421 note; Public Law 105–277), there is appropriated, out of any money in the Treasury not otherwise appropriated, $295,000,000.

SEC. ___06. FUNDS FOR STRENGTHENING MARKETS, INCOME, AND SUPPLY (SECTION 32).

For an additional amount for the fund maintained for funds made available under section 32 of the Act of August 24, 1935 (7 U.S.C. 612c), there is appropriated, out of any money in the Treasury not otherwise appropriated, $355,000,000.

SEC. ___07. DISASTER RESERVE.

(a) IN GENERAL.—For the disaster reserve established under section 813 of the Agricultural Act of 1970 (7 U.S.C. 1427a), there is appropriated, out of any money in the Treasury not otherwise appropriated, $500,000,000.