''(1) IN GENERAL.—The reasonable costs of the electric reliability organization, and the reasonable costs of each affiliated regional reliability entity that are related to implementation or enforcement of organization standards or other requirements contained in a delegation agreement approved under subsection (h), shall be assessed by the electric reliability organization and each affiliated regional reliability entity, respectively, taking into account the relationship of costs to each region and based on an allocation that reflects an equitable sharing of the costs among all electric energy consumers.

''(2) RULES.—The Commission shall provide by rule for the review of costs and allocations under paragraph (1) in accordance with the standards in this subsection and subsection (d)(4)(F).

''(m) APPLICATION OF ANTITRUST LAWS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the following activities are rebuttably presumed to be in compliance with the antitrust laws of the United States:

''(A) Activities undertaken by the electric reliability organization under this section or affiliated regional reliability entity operating under a delegation agreement under subsection (h).

''(B) Activities of a member of the electric reliability organizations or affiliated regional reliability entity in pursuit of the objectives of the electric reliability organization or affiliated regional reliability entity under this section undertaken in good faith under the rules of the organization of the electric reliability organization or affiliated regional reliability entity.

''(2) AVAILABILITY OF DEFENSES.—In a civil action brought by any person or entity against the electric reliability organization or an affiliated regional reliability entity alleging a violation of an antitrust law based on an activity under this Act, the defenses of primary jurisdiction and immunity from suit and other affirmative defenses shall be available to the extent applicable.

''(n) REGIONAL ADVISORY ROLE.—

''(1) ESTABLISHMENT OF REGIONAL ADVISORY BODY.—The Commission shall establish a regional advisory body on the petition of the Governors of at least two-thirds of the States within a region that have more than one-half of their electrical loads served within the region.

''(2) MEMBERSHIP.—A regional advisory body—

''(A) shall be composed of 1 member from each State in the region, appointed by the Governor of the State; and

''(B) may include representatives of agencies, States, and Provinces outside the United States, on execution of an appropriate international agreement described in subsection (f).

''(3) FUNCTIONS.—A regional advisory body may provide advice to the electric reliability organization, an affiliated regional reliability entity, or the Commission regarding—

''(A) the governance of an affiliated regional reliability entity existing or proposed within a region;

''(B) whether a standard proposed to apply within the region is just, reasonable, not unduly discriminatory or preferential, and in the public interest; and

''(C) whether fees proposed to be assessed within the region are—

''(i) just, reasonable, not unduly discriminatory or preferential, and in the public interest; and

''(ii) consistent with the requirements of subsection (l).

''(4) DEFERENCE.—In a case in which a regional advisory body encompasses an entire interconnection, the Commission may give deference to advice provided by the regional advisory body under paragraph (3).

''(o) APPLICABILITY OF SECTION.—This section does not apply outside the 48 contiguous States.

''(p) REHEARINGS; COURT REVIEW OF ORDERS.—Section 313 applies to an order of the Commission issued under this section.

''(q) PRESERVATION OF STATE AUTHORITY.—

''(1) The electric reliability organization shall have authority to develop, implement, and enforce compliance with standards for the reliable operation of only the bulk-power system.

''(2) This section does not provide the electric reliability organization or the Commission with the authority to set and enforce compliance with standards for adequacy or safety of electric facilities or services.

''(3) Nothing in this section shall be construed to preempt any authority of any State to take action to ensure the safety, adequacy, and reliability of electric service within that State, as long as such action is not inconsistent with any organization standard.

''(4) Not later than 90 days after the application of the electric reliability organization or other affected party, the Commission shall issue a final order determining whether a State action is inconsistent with an organization standard, after notice and opportunity for comment, taking into consideration any recommendations of the electric reliability organization.

''(5) The Commission, after consultation with the electric reliability organization, may stay the effectiveness of any State action, pending the Commission's issuance of a final order.''.

(b) ENFORCEMENT.—

(1) GENERAL PENALTIES.—Section 316(c) of the Federal Power Act (16 U.S.C. 825o(c)) is amended—

(A) by striking ''subsection'' and inserting ''section''; and

(B) by striking ''or 214'' and inserting ''214 or 215''.

(2) CERTAIN PROVISIONS.—Section 316A of the Federal Power Act (16 U.S.C. 825o–1) is amended by striking ''or 214'' each place it appears and inserting ''214, or 215''.

THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS, 2001

On June 30, 2000, the Senate amended and passed H.R. 4577, as follows:

Resolved, That the bill from the House of Representatives (H.R. 4577) entitled ''An Act making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2001, and for other purposes.'', do pass with the following amendment:

Strike out all after the enacting clause and insert:

DIVISION A—DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES

That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2001, and for other purposes, namely:

TITLE I—DEPARTMENT OF LABOR

EMPLOYMENT AND TRAINING ADMINISTRATION

TRAINING AND EMPLOYMENT SERVICES

For necessary expenses of the Workforce Investment Act, including the purchase and hire of passenger motor vehicles, the construction, alteration, and repair of buildings and other facilities, and the purchase of real property for training centers as authorized by the Workforce Investment Act and the National Skill Standards Act of 1994; $2,990,141,000 plus reimbursements, of which $1,718,801,000 is available for obligation for the period July 1, 2001 through June 30, 2002, of which $1,250,965,000 is available for obligation for the period April 1, 2001 through June 30, 2002, including $1,000,965,000 to carry out chapter 4 of the Workforce Investment Act and $250,000,000 to carry out section 169 of such Act; and of which $20,375,000 is available for the period July 1, 2001 through June 30, 2004 for necessary expenses of construction, rehabilitation, and acquisition of Job Corps centers: Provided, That $9,098,000 shall be for carrying out section 172 of the Workforce Investment Act, and $3,500,000 shall be for carrying out the National Skills Standards Act of 1994: Provided further, That no funds from any other appropriation shall be used to provide meal services at or for Job Corps centers: Provided further, That funds provided to carry out section 171(d) of such Act may be used for demonstration projects that provide assistance to new entrants in the workforce and incumbent workers: Provided further, That funding provided to carry out projects under section 171 of the Workforce Investment Act of 1998 that are identified in the Conference Agreement, shall not be subject to the requirements of section 171(b)(2)(B) of such Act, the requirements of section 171(c)(4)(D) of such Act, or the joint funding requirements of sections 171(b)(2)(A) and 171(c)(4)(A) of such Act: Provided further, That funding appropriated herein for Dislocated Worker Employment and Training Activities under section 132(a)(2)(A) of the Workforce Investment Act of 1998 may be distributed for Dislocated Worker Projects under section 171(d) of the Act without regard to the 10 percent limitation contained in section 171(d) of the Act.

For necessary expenses of the Workforce Investment Act, including the purchase and hire of passenger motor vehicles, the construction, alteration, and repair of buildings and other facilities, and the purchase of real property for training centers as authorized by the Workforce Investment Act; $2,463,000,000 plus reimbursements, of which $2,363,000,000 is available for obligation for the period October 1, 2001 through June 30, 2002, and of which $100,000,000 is available for the period October 1, 2001 through June 30, 2004, for necessary expenses of construction, rehabilitation, and acquisition of Job Corps centers.

COMMUNITY SERVICE EMPLOYMENT FOR OLDER AMERICANS

To carry out the activities for national grants or contracts with public agencies and public or private nonprofit organizations under paragraph (1)(A) of section 506(a) of title V of the Older Americans Act of 1965, as amended, or to carry out older worker activities as subsequently authorized, $343,356,000.

To carry out the activities for grants to States under paragraph (3) of section 506(a) of title V of the Older Americans Act of 1965, as amended, or to carry out older worker activities as subsequently authorized, $96,844,000.

FEDERAL UNEMPLOYMENT BENEFITS AND ALLOWANCES

For payments during the current fiscal year of trade adjustment benefit payments and allowances under part I; and for training, allowances for job search and relocation, and related State administrative expenses under part II, subchapters B and D, chapter 2, title II of the Trade Act of 1974, as amended, $406,550,000, together with such amounts as may be necessary to be charged to the subsequent appropriation for payments for any period subsequent to September 15 of the current year.

STATE UNEMPLOYMENT INSURANCE AND EMPLOYMENT SERVICE OPERATIONS

For authorized administrative expenses, $153,452,000, together with not to exceed $3,095,978,000 (including not to exceed $1,228,000 which may be used for amortization payments to States which had independent retirement plans in their State employment service agencies prior to 1980), which may be expended from the Employment Security Administration account in the Unemployment Trust Fund including the cost of administering section 51 of the Internal Revenue Code of 1986, as amended, section 7(d) of the Wagner-Peyser Act, as amended, the Trade Act of 1974, as amended, the Immigration Act of 1990, and the Immigration and Nationality Act, as amended, and of which the sums available in the allocation for activities authorized by title III of the Social Security Act, as amended (42 U.S.C. 502–504), and the sums available in the allocation for necessary administrative expenses for carrying out 5 U.S.C. 8501–8523, shall be available for obligation by the States through December 31, 2001, except that funds used for automation acquisitions shall be available for obligation by the States through September 30, 2003; and of which $153,452,000, together with not to exceed $763,283,000 of the amount which may be expended from said trust fund, shall be available for obligation for the period July 1, 2001 through June 30, 2002, to fund activities under the Act of June 6, 1933, as amended, including the cost of penalty mail authorized under 39 U.S.C. 3202(a)(1)(E) made available to States in lieu of allotments for such purpose: Provided, That to the extent that the Average Weekly Insured Unemployment (AWIU) for fiscal year 2001 is projected by the Department of Labor to exceed 2,396,000, an additional $28,600,000 shall be available for obligation for every 100,000 increase in the AWIU level (including a pro rata amount for any increment less than 100,000) from the Employment Security Administration Account of the Unemployment Trust Fund: Provided further, That funds appropriated in this Act which are used to establish a national one-stop career center system, or which are used to support the national activities of the Federal-State unemployment insurance programs, may be obligated in contracts, grants or agreements with non-State entities: Provided further, That funds appropriated under this Act for activities authorized under the Wagner-Peyser Act, as amended, and title III of the Social Security Act, may be used by the States to fund integrated Employment Service and Unemployment Insurance automation efforts, notwithstanding cost allocation principles prescribed under Office of Management and Budget Circular A–87.

ADVANCES TO THE UNEMPLOYMENT TRUST FUND AND OTHER FUNDS

For repayable advances to the Unemployment Trust Fund as authorized by sections 905(d) and 1203 of the Social Security Act, as amended, and to the Black Lung Disability Trust Fund as authorized by section 9501(c)(1) of the Internal Revenue Code of 1954, as amended; and for nonrepayable advances to the Unemployment Trust Fund as authorized by section 8509 of title 5, United States Code, and to the ''Federal unemployment benefits and allowances'' account, to remain available until September 30, 2002, $435,000,000.

In addition, for making repayable advances to the Black Lung Disability Trust Fund in the current fiscal year after September 15, 2001, for costs incurred by the Black Lung Disability Trust Fund in the current fiscal year, such sums as may be necessary.

PROGRAM ADMINISTRATION

For expenses of administering employment and training programs, $107,651,000, including $6,431,000 to support up to 75 full-time equivalent staff, the majority of which will be term Federal appointments lasting no more than 1 year, to administer welfare-to-work grants, together with not to exceed $48,507,000, which may be expended from the Employment Security Administration account in the Unemployment Trust Fund.

PENSION AND WELFARE BENEFITS ADMINISTRATION

SALARIES AND EXPENSES

For necessary expenses for the Pension and Welfare Benefits Administration, $103,342,000.

PENSION BENEFIT GUARANTY CORPORATION

PENSION BENEFIT GUARANTY CORPORATION FUND

The Pension Benefit Guaranty Corporation is authorized to make such expenditures, including financial assistance authorized by section 104 of Public Law 96–364, within limits of funds and borrowing authority available to such Corporation, and in accord with law, and to make such contracts and commitments without regard to fiscal year limitations as provided by section 104 of the Government Corporation Control Act, as amended (31 U.S.C. 9104), as may be necessary in carrying out the program through September 30, 2001, for such Corporation: Provided, That not to exceed $11,652,000 shall be available for administrative expenses of the Corporation: Provided further, That expenses of such Corporation in connection with the termination of pension plans, for the acquisition, protection or management, and investment of trust assets, and for benefits administration services shall be considered as non-administrative expenses for the purposes hereof, and excluded from the above limitation.

EMPLOYMENT STANDARDS ADMINISTRATION

SALARIES AND EXPENSES

For necessary expenses for the Employment Standards Administration, including reimbursement to State, Federal, and local agencies and their employees for inspection services rendered, $350,779,000, together with $1,985,000 which may be expended from the Special Fund in accordance with sections 39(c), 44(d) and 44(j) of the Longshore and Harbor Workers' Compensation Act: Provided, That $2,000,000 shall be for the development of an alternative system for the electronic submission of reports required to be filed under the Labor-Management Reporting and Disclosure Act of 1959, as amended, and for a computer database of the information for each submission by whatever means, that is indexed and easily searchable by the public via the Internet: Provided further, That the Secretary of Labor is authorized to accept, retain, and spend, until expended, in the name of the Department of Labor, all sums of money ordered to be paid to the Secretary of Labor, in accordance with the terms of the Consent Judgment in Civil Action No. 91–0027 of the United States District Court for the District of the Northern Mariana Islands (May 21, 1992): Provided further, That the Secretary of Labor is authorized to establish and, in accordance with 31 U.S.C. 3302, collect and deposit in the Treasury fees for processing applications and issuing certificates under sections 11(d) and 14 of the Fair Labor Standards Act of 1938, as amended (29 U.S.C. 211(d) and 214) and for processing applications and issuing registrations under title I of the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C. 1801 et seq.).

SPECIAL BENEFITS

(INCLUDING TRANSFER OF FUNDS)

For the payment of compensation, benefits, and expenses (except administrative expenses) accruing during the current or any prior fiscal year authorized by title 5, chapter 81 of the United States Code; continuation of benefits as provided for under the heading ''Civilian War Benefits'' in the Federal Security Agency Appropriation Act, 1947; the Employees' Compensation Commission Appropriation Act, 1944; sections 4(c) and 5(f) of the War Claims Act of 1948 (50 U.S.C. App. 2012); and 50 percent of the additional compensation and benefits required by section 10(h) of the Longshore and Harbor Workers' Compensation Act, as amended, $56,000,000 together with such amounts as may be necessary to be charged to the subsequent year appropriation for the payment of compensation and other benefits for any period subsequent to August 15 of the current year: Provided, That amounts appropriated may be used under section 8104 of title 5, United States Code, by the Secretary of Labor to reimburse an employer, who is not the employer at the time of injury, for portions of the salary of a reemployed, disabled beneficiary: Provided further, That balances of reimbursements unobligated on September 30, 2000, shall remain available until expended for the payment of compensation, benefits, and expenses: Provided further, That in addition there shall be transferred to this appropriation from the Postal Service and from any other corporation or instrumentality required under section 8147(c) of title 5, United States Code, to pay an amount for its fair share of the cost of administration, such sums as the Secretary determines to be the cost of administration for employees of such fair share entities through September 30, 2001: Provided further, That of those funds transferred to this account from the fair share entities to pay the cost of administration, $30,510,000 shall be made available to the Secretary as follows: (1) for the operation of and enhancement to the automated data processing systems, including document imaging, medical bill review, and periodic roll management, in support of Federal Employees' Compensation Act administration, $19,971,000; (2) for conversion to a paperless office, $7,005,000; (3) for communications redesign, $750,000; (4) for information technology maintenance and support, $2,784,000; and (5) the remaining funds shall be paid into the Treasury as miscellaneous receipts: Provided further, That the Secretary may require that any person filing a notice of injury or a claim for benefits under chapter 81 of title 5, United States Code, or 33 U.S.C. 901 et seq., provide as part of such notice and claim, such identifying information (including Social Security account number) as such regulations may prescribe.

BLACK LUNG DISABILITY TRUST FUND

(INCLUDING TRANSFER OF FUNDS)

Beginning in fiscal year 2001 and thereafter, such sums as may be necessary from the Black Lung Disability Trust Fund, to remain available until expended, for payment of all benefits authorized by section 9501(d)(1) (2) (4) and (7) of the Internal Revenue Code of 1954, as amended; and interest on advances as authorized by section 9501(c)(2) of that Act. In addition, the following amounts shall be available from the Fund for fiscal year 2001 for expenses of operation and administration of the Black Lung Benefits program as authorized by section 9501(d)(5) of that Act: $30,393,000 for transfer to the Employment Standards Administration, ''Salaries and Expenses''; $21,590,000 for transfer to Departmental Management, ''Salaries and Expenses''; $318,000 for transfer to Departmental Management, ''Office of Inspector General''; and $356,000 for payments into Miscellaneous Receipts for the expenses of the Department of Treasury.

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

SALARIES AND EXPENSES

For necessary expenses for the Occupational Safety and Health Administration, $425,983,000, including not to exceed $88,493,000 which shall be the maximum amount available for grants to States under section 23(g) of the Occupational Safety and Health Act, which grants shall be no less than 50 percent of the costs of State occupational safety and health programs required to be incurred under plans approved by the Secretary under section 18 of the Occupational Safety and Health Act of 1970; and, in addition, notwithstanding 31 U.S.C. 3302, the Occupational Safety and Health Administration may retain up to $750,000 per fiscal year of training institute

course tuition fees, otherwise authorized by law to be collected, and may utilize such sums for occupational safety and health training and education grants: Provided, That of the amount appropriated under this heading that is in excess of the amount appropriated for such purposes for fiscal year 2000, at least $22,200,000 shall be used to carry out education, training, and consultation activities as described in subsections (c) and (d) of section 21 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 670(c) and (d)): Provided further, That, notwithstanding 31 U.S.C. 3302, the Secretary of Labor is authorized, during the fiscal year ending September 30, 2001, to collect and retain fees for services provided to Nationally Recognized Testing Laboratories, and may utilize such sums, in accordance with the provisions of 29 U.S.C. 9a, to administer national and international laboratory recognition programs that ensure the safety of equipment and products used by workers in the workplace: Provided further, That none of the funds appropriated under this paragraph shall be obligated or expended to prescribe, issue, administer, or enforce any standard, rule, regulation, or order under the Occupational Safety and Health Act of 1970 which is applicable to any person who is engaged in a farming operation which does not maintain a temporary labor camp and employs 10 or fewer employees: Provided further, That no funds appropriated under this paragraph shall be obligated or expended to administer or enforce any standard, rule, regulation, or order under the Occupational Safety and Health Act of 1970 with respect to any employer of 10 or fewer employees who is included within a category having an occupational injury lost workday case rate, at the most precise Standard Industrial Classification Code for which such data are published, less than the national average rate as such rates are most recently published by the Secretary, acting through the Bureau of Labor Statistics, in accordance with section 24 of that Act (29 U.S.C. 673), except—

(1) to provide, as authorized by such Act, consultation, technical assistance, educational and training services, and to conduct surveys and studies;

(2) to conduct an inspection or investigation in response to an employee complaint, to issue a citation for violations found during such inspection, and to assess a penalty for violations which are not corrected within a reasonable abatement period and for any willful violations found;

(3) to take any action authorized by such Act with respect to imminent dangers;

(4) to take any action authorized by such Act with respect to health hazards;

(5) to take any action authorized by such Act with respect to a report of an employment accident which is fatal to one or more employees or which results in hospitalization of two or more employees, and to take any action pursuant to such investigation authorized by such Act; and

(6) to take any action authorized by such Act with respect to complaints of discrimination against employees for exercising rights under such Act:

Provided further, That the foregoing proviso shall not apply to any person who is engaged in a farming operation which does not maintain a temporary labor camp and employs 10 or fewer employees.

MINE SAFETY AND HEALTH ADMINISTRATION

SALARIES AND EXPENSES

For necessary expenses for the Mine Safety and Health Administration, $244,747,000, including purchase and bestowal of certificates and trophies in connection with mine rescue and first-aid work, and the hire of passenger motor vehicles; including up to $1,000,000 for mine rescue and recovery activities, which shall be available only to the extent that fiscal year 2001 obligations for these activities exceed $1,000,000; in addition, not to exceed $750,000 may be collected by the National Mine Health and Safety Academy for room, board, tuition, and the sale of training materials, otherwise authorized by law to be collected, to be available for mine safety and health education and training activities, notwithstanding 31 U.S.C. 3302; and, in addition, the Administration may retain up to $1,000,000 from fees collected for the approval and certification of equipment, materials, and explosives for use in mines, and may utilize such sums for such activities; the Secretary is authorized to accept lands, buildings, equipment, and other contributions from public and private sources and to prosecute projects in cooperation with other agencies, Federal, State, or private; the Mine Safety and Health Administration is authorized to promote health and safety education and training in the mining community through cooperative programs with States, industry, and safety associations; and any funds available to the department may be used, with the approval of the Secretary, to provide for the costs of mine rescue and survival operations in the event of a major disaster.

BUREAU OF LABOR STATISTICS

SALARIES AND EXPENSES

For necessary expenses for the Bureau of Labor Statistics, including advances or reimbursements to State, Federal, and local agencies and their employees for services rendered, $369,327,000, together with not to exceed $67,257,000, which may be expended from the Employment Security Administration account in the Unemployment Trust Fund; and $10,000,000 which shall be available for obligation for the period July 1, 2001 through June 30, 2002, for Occupational Employment Statistics.

DEPARTMENTAL MANAGEMENT

SALARIES AND EXPENSES

For necessary expenses for Departmental Management, including the hire of three sedans, and including the management or operation, through contracts, grants or other arrangements, of Departmental bilateral and multilateral foreign technical assistance, of which the funds designated to carry out bilateral assistance under the international child labor initiative shall be available for obligation through September 30, 2002, $30,000,000 for the acquisition of Departmental information technology, architecture, infrastructure, equipment, software and related needs which will be allocated by the Department's Chief Information Officer in accordance with the Department's capital investment management process to assure a sound investment strategy; $337,964,000: Provided, That no funds made available by this Act may be used by the Solicitor of Labor to participate in a review in any United States court of appeals of any decision made by the Benefits Review Board under section 21 of the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 921) where such participation is precluded by the decision of the United States Supreme Court in Director, Office of Workers' Compensation Programs v. Newport News Shipbuilding, 115 S. Ct. 1278 (1995), notwithstanding any provisions to the contrary contained in Rule 15 of the Federal Rules of Appellate Procedure: Provided further, That no funds made available by this Act may be used by the Secretary of Labor to review a decision under the Longshore and Harbor Workers' Compensation Act (33 U.S.C. 901 et seq.) that has been appealed and that has been pending before the Benefits Review Board for more than 12 months: Provided further, That any such decision pending a review by the Benefits Review Board for more than 1 year shall be considered affirmed by the Benefits Review Board on the 1-year anniversary of the filing of the appeal, and shall be considered the final order of the Board for purposes of obtaining a review in the United States courts of appeals: Provided further, That these provisions shall not be applicable to the review or appeal of any decision issued under the Black Lung Benefits Act (30 U.S.C. 901 et seq.): Provided further, That beginning in fiscal year 2001, there is established in the Department of Labor an office of disability employment policy which shall, under the overall direction of the Secretary, provide leadership, develop policy and initiatives, and award grants furthering the objective of eliminating barriers to the training and employment of people with disabilities. Such office shall be headed by an assistant secretary: Provided further, That of amounts provided under this head, not more than $23,002,000 is for this purpose.

VETERANS EMPLOYMENT AND TRAINING

Not to exceed $186,913,000 may be derived from the Employment Security Administration account in the Unemployment Trust Fund to carry out the provisions of 38 U.S.C. 4100–4110A, 4212, 4214, and 4321–4327, and Public Law 103–353, and which shall be available for obligation by the States through December 31, 2001. To carry out the Stewart B. McKinney Homeless Assistance Act and section 168 of the Workforce Investment Act of 1998, $19,800,000, of which $7,300,000 shall be available for obligation for the period July 1, 2001, through June 30, 2002.

OFFICE OF INSPECTOR GENERAL

For salaries and expenses of the Office of Inspector General in carrying out the provisions of the Inspector General Act of 1978, as amended, $50,015,000, together with not to exceed $4,770,000, which may be expended from the Employment Security Administration account in the Unemployment Trust Fund.

GENERAL PROVISIONS

SEC. 101. None of the funds appropriated in this title for the Job Corps shall be used to pay the compensation of an individual, either as direct costs or any proration as an indirect cost, at a rate in excess of Executive Level II.

(TRANSFER OF FUNDS)

SEC. 102. Not to exceed 1 percent of any discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended) which are appropriated for the current fiscal year for the Department of Labor in this Act may be transferred between appropriations, but no such appropriation shall be increased by more than 3 percent by any such transfer: Provided, That the Appropriations Committees of both Houses of Congress are notified at least 15 days in advance of any transfer.

SEC. 103. EXTENDED DEADLINE FOR EXPENDITURE. Section 403(a)(5)(C)(viii) of the Social Security Act (42 U.S.C. 603(a)(5)(C)(viii)) (as amended by section 806(b) of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2000 (as enacted into law by section 1000(a)(4) of Public Law 106–113)) is amended by striking ''3 years'' and inserting ''5 years''.

SEC. 104. ELIMINATION OF SET-ASIDE OF PORTION OF WELFARE-TO-WORK FUNDS FOR PERFORMANCE BONUSES. (a) IN GENERAL.—Section 403(a)(5) of the Social Security Act (as amended by section 806(b) of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2000 (as enacted into law by section 1000(a)(4) of Public Law 106–113)) is amended by striking subparagraph (E) and redesignating subparagraphs (F) through (K) as subparagraphs (E) through (J), respectively.

(b) CONFORMING AMENDMENTS.—The Social Security Act (as amended by section 806(b) of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2000 (as enacted into law by section 1000(a)(4) of Public Law 106–113)) is further amended as follows:

(1) Section 403(a)(5)(A)(i) (42 U.S.C. 603(a)(5)(A)(i)) is amended by striking ''subparagraph (I)'' and inserting ''subparagraph (H)''.

(2) Subclause (I) of each of subparagraphs (A)(iv) and (B)(v) of section 403(a)(5) (42 U.S.C. 603(a)(5)(A)(iv)(I) and (B)(v)(I)) is amended—

(A) in item (aa)—

(i) by striking ''(I)'' and inserting ''(H)''; and

(ii) by striking ''(G), and (H)'' and inserting ''and (G)''; and

(B) in item (bb), by striking ''(F)'' and inserting ''(E)''.

(3) Section 403(a)(5)(B)(v) (42 U.S.C. 603(a)(5)(B)(v)) is amended in the matter preceding subclause (I) by striking ''(I)'' and inserting ''(H)''.

(4) Subparagraphs (E), (F), and (G)(i) of section 403(a)(5) (42 U.S.C. 603(a)(5)), as so redesignated by subsection (a) of this section, are each amended by striking ''(I)'' and inserting ''(H)''.

(5) Section 412(a)(3)(A) (42 U.S.C. 612(a)(3)(A)) is amended by striking ''403(a)(5)(I)'' and inserting ''403(a)(5)(H)''.

(c) FUNDING AMENDMENT.—Section 403(a)(5)(H)(i)(II) of such Act (42 U.S.C. 603(a)(5)(H)(i))(II) (as redesignated by subsection (a) of this section and as amended by section 806(b) of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2000 (as enacted into law by section 1000(a)(4) of Public Law 106–113)) is further amended by striking ''$1,450,000,000'' and inserting ''$1,400,000,000''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) of this section shall take effect on October 1, 2000.

SEC. 105. None of the funds made available in this Act may be used by the Occupational Safety and Health Administration to promulgate, issue, implement, administer, or enforce any proposed, temporary, or final standard on ergonomic protection.

TITLE II—DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICES ADMINISTRATION

HEALTH RESOURCES AND SERVICES

For carrying out titles II, III, VII, VIII, X, XII, XIX, and XXVI of the Public Health Service Act, section 427(a) of the Federal Coal Mine Health and Safety Act, title V and section 1820 of the Social Security Act, the Health Care Quality Improvement Act of 1986, as amended, and the Native Hawaiian Health Care Act of 1988, as amended, $4,572,424,000, of which $150,000 shall remain available until expended for interest subsidies on loan guarantees made prior to fiscal year 1981 under part B of title VII of the Public Health Service Act, of which $10,000,000 shall be available for the construction and renovation of health care and other facilities, of which $25,000,000 from general revenues, notwithstanding section 1820(j) of the Social Security Act, shall be available for carrying out the Medicare rural hospital flexibility grants program under section 1820 of such Act, and of which $4,000,000 shall be provided to the Rural Health Outreach Office of the Health Resources and Services Administration for the awarding of grants to community partnerships in rural areas for the purchase of automated external defibrillators and the training of individuals in basic cardiac life support: Provided, That the Division of Federal Occupational Health may utilize personal services contracting to employ professional management/administrative and occupational health professionals: Provided further, That of the funds made available under this heading, $250,000 shall be available until expended for facilities renovations at the Gillis W. Long Hansen's Disease Center: Provided further, That in addition to fees authorized by section 427(b) of the Health Care Quality Improvement Act of 1986, fees shall be collected for the full disclosure of information under the Act sufficient to recover the full costs of operating the National Practitioner Data Bank, and shall remain available until expended to carry out that Act: Provided further, That fees collected for the full disclosure of information under the ''Health Care Fraud and Abuse Data Collection Program'', authorized by section 221 of the Health Insurance Portability and Accountability Act of 1996, shall be sufficient to recover the full costs of operating the Program, and shall remain available to carry out that Act until expended: Provided further, That no more than $5,000,000 is available for carrying out the provisions of Public Law 104–73: Provided further, That of the funds made available under this heading, $253,932,000 shall be for the program under title X of the Public Health Service Act to provide for voluntary family planning projects: Provided further, That amounts provided to said projects under such title shall not be expended for abortions, that all pregnancy counseling shall be nondirective, and that such amounts shall not be expended for any activity (including the publication or distribution of literature) that in any way tends to promote public support or opposition to any legislative proposal or candidate for public office: Provided further, That $538,000,000 shall be for State AIDS Drug Assistance Programs authorized by section 2616 of the Public Health Service Act.

RICKY RAY HEMOPHILIA RELIEF FUND PROGRAM

For payment to the Ricky Ray Hemophilia Relief Fund, as provided by Public Law 105–369, $85,000,000, of which $10,000,000 shall be for program management.

HEALTH EDUCATION ASSISTANCE LOANS PROGRAM ACCOUNT

Such sums as may be necessary to carry out the purpose of the program, as authorized by title VII of the Public Health Service Act, as amended. For administrative expenses to carry out the guaranteed loan program, including section 709 of the Public Health Service Act, $3,679,000.

VACCINE INJURY COMPENSATION PROGRAM TRUST FUND

For payments from the Vaccine Injury Compensation Program Trust Fund, such sums as may be necessary for claims associated with vaccine-related injury or death with respect to vaccines administered after September 30, 1988, pursuant to subtitle 2 of title XXI of the Public Health Service Act, to remain available until expended: Provided, That for necessary administrative expenses, not to exceed $2,992,000 shall be available from the Trust Fund to the Secretary of Health and Human Services.

CENTERS FOR DISEASE CONTROL AND PREVENTION

DISEASE CONTROL, RESEARCH, AND TRAINING

To carry out titles II, III, VII, XI, XV, XVII, XIX and XXVI of the Public Health Service Act, sections 101, 102, 103, 201, 202, 203, 301, and 501 of the Federal Mine Safety and Health Act of 1977, sections 20, 21, and 22 of the Occupational Safety and Health Act of 1970, title IV of the Immigration and Nationality Act and section 501 of the Refugee Education Assistance Act of 1980; including insurance of official motor vehicles in foreign countries; and hire, maintenance, and operation of aircraft, $3,204,496,000, of which $20,000,000 shall be made available to carry out children's asthma programs and $4,000,000 of such $20,000,000 shall be utilized to carry out improved asthma surveillance and tracking systems and the remainder shall be used to carry out diverse community-based childhood asthma programs including both school- and community-based grant programs, except that not to exceed 5 percent of such funds may be used by the Centers for Disease Control and Prevention for administrative costs or reprogramming, and of which $175,000,000 shall remain available until expended for the facilities master plan for equipment and construction and renovation of facilities, and in addition, such sums as may be derived from authorized user fees, which shall be credited to this account, and of which $25,000,000 shall be made available through such Centers for the establishment of partnerships between the Federal Government and academic institutions and State and local public health departments to carry out pilot programs for antimicrobial resistance detection, surveillance, education and prevention and to conduct research on resistance mechanisms and new or more effective antimicrobial compounds, and of which $10,000,000 shall remain available until expended to carry out the Fetal Alcohol Syndrome prevention and services program: Provided, That in addition to amounts provided herein, up to $91,129,000 shall be available from amounts available under section 241 of the Public Health Service Act: Provided further, That none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used to advocate or promote gun control: Provided further, That the Director may redirect the total amount made available under authority of Public Law 101–502, section 3, dated November 3, 1990, to activities the Director may so designate: Provided further, That the Congress is to be notified promptly of any such transfer: Provided further, That not to exceed $10,000,000 may be available for making grants under section 1509 of the Public Health Service Act to not more than 15 States: Provided further, That notwithstanding any other provision of law, a single contract or related contracts for development and construction of facilities may be employed which collectively include the full scope of the project: Provided further, That the solicitation and contract shall contain the clause ''availability of funds'' found at 48 CFR 52.232–18: Provided further, That in addition to amounts made available under this heading for the National Program of Cancer Registries, an additional $15,000,000 shall be made available for such Program and special emphasis in carrying out such Program shall be given to States with the highest number of the leading causes of cancer mortality: Provided further, That amounts made available under this Act for the administrative and related expenses of the Centers for Disease Control and Prevention shall be reduced by $15,000,000: Provided further, That the funds made available under this heading for section 317A of the Public Health Service Act may be made available for programs operated in accordance with a strategy (developed and implemented by the Director for the Centers for Disease Control and Prevention) to identify and target resources for childhood lead poisoning prevention to high-risk populations, including ensuring that any individual or entity that receives a grant under that section to carry out activities relating to childhood lead poisoning prevention may use a portion of the grant funds awarded for the purpose of funding screening assessments and referrals at sites of operation of the Early Head Start programs under the Head Start Act.

NATIONAL INSTITUTES OF HEALTH

NATIONAL CANCER INSTITUTE

For carrying out section 301 and title IV of the Public Health Service Act with respect to cancer, $3,804,084,000.

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

For carrying out section 301 and title IV of the Public Health Service Act with respect to cardiovascular, lung, and blood diseases, and blood and blood products, $2,328,102,000.

NATIONAL INSTITUTE OF DENTAL AND CRANIOFACIAL RESEARCH

For carrying out section 301 and title IV of the Public Health Service Act with respect to dental disease, $309,923,000.

NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES

For carrying out section 301 and title IV of the Public Health Service Act with respect to diabetes and digestive and kidney disease, $1,318,106,000.

NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE

For carrying out section 301 and title IV of the Public Health Service Act with respect to neurological disorders and stroke, $1,189,425,000.

NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

For carrying out section 301 and title IV of the Public Health Service Act with respect to allergy and infectious diseases, $2,066,526,000.

NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES

For carrying out section 301 and title IV of the Public Health Service Act with respect to general medical sciences, $1,554,176,000.

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

For carrying out section 301 and title IV of the Public Health Service Act with respect to child health and human development, $986,069,000.

NATIONAL EYE INSTITUTE

For carrying out section 301 and title IV of the Public Health Service Act with respect to eye diseases and visual disorders, $516,605,000.

NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES

For carrying out sections 301 and 311 and title IV of the Public Health Service Act with respect to environmental health sciences, $508,263,000.

NATIONAL INSTITUTE ON AGING

For carrying out section 301 and title IV of the Public Health Service Act with respect to aging, $794,625,000.

NATIONAL INSTITUTE OF ARTHRITIS AND MUSCULOSKELETAL AND SKIN DISEASES

For carrying out section 301 and title IV of the Public Health Service Act with respect to arthritis and musculoskeletal and skin diseases, $401,161,000.

NATIONAL INSTITUTE ON DEAFNESS AND OTHER COMMUNICATION DISORDERS

For carrying out section 301 and title IV of the Public Health Service Act with respect to deafness and other communication disorders, $303,541,000.

NATIONAL INSTITUTE OF NURSING RESEARCH

For carrying out section 301 and title IV of the Public Health Service Act with respect to nursing research, $106,848,000.

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

For carrying out section 301 and title IV of the Public Health Service Act with respect to alcohol abuse and alcoholism, $336,848,000.

NATIONAL INSTITUTE ON DRUG ABUSE

For carrying out section 301 and title IV of the Public Health Service Act with respect to drug abuse, $790,038,000.

NATIONAL INSTITUTE OF MENTAL HEALTH

For carrying out section 301 and title IV of the Public Health Service Act with respect to mental health, $1,117,928,000.

NATIONAL HUMAN GENOME RESEARCH INSTITUTE

For carrying out section 301 and title IV of the Public Health Service Act with respect to human genome research, $385,888,000.

NATIONAL CENTER FOR RESEARCH RESOURCES

For carrying out section 301 and title IV of the Public Health Service Act with respect to research resources and general research support grants, $775,212,000: Provided, That none of these funds shall be used to pay recipients of the general research support grants program any amount for indirect expenses in connection with such grants: Provided further, That $75,000,000 shall be for extramural facilities construction grants.

NATIONAL CENTER FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE

For carrying out section 301 and title IV of the Public Health Service Act with respect to complementary and alternative medicine, $100,089,000.

JOHN E. FOGARTY INTERNATIONAL CENTER

For carrying out the activities at the John E. Fogarty International Center, $61,260,000.

NATIONAL LIBRARY OF MEDICINE

For carrying out section 301 and title IV of the Public Health Service Act with respect to health information communications, $256,953,000, of which $4,000,000 shall be available until expended for improvement of information systems: Provided, That in fiscal year 2001, the Library may enter into personal services contracts for the provision of services in facilities owned, operated, or constructed under the jurisdiction of the National Institutes of Health.

OFFICE OF THE DIRECTOR

(INCLUDING TRANSFER OF FUNDS)

For carrying out the responsibilities of the Office of the Director, National Institutes of Health, $352,165,000, of which $48,271,000 shall be for the Office of AIDS Research: Provided, That funding shall be available for the purchase of not to exceed 20 passenger motor vehicles for replacement only: Provided further, That the Director may direct up to 1 percent of the total amount made available in this or any other Act to all National Institutes of Health appropriations to activities the Director may so designate: Provided further, That no such appropriation shall be decreased by more than 1 percent by any such transfers and that the Congress is promptly notified of the transfer: Provided further, That the National Institutes of Health is authorized to collect third party payments for the cost of clinical services that are incurred in National Institutes of Health research facilities and that such payments shall be credited to the National Institutes of Health Management Fund: Provided further, That all funds credited to the National Institutes of Health Management Fund shall remain available for one fiscal year after the fiscal year in which they are deposited: Provided further, That up to $500,000 shall be available to carry out section 499 of the Public Health Service Act: Provided further, That, notwithstanding section 499(k)(10) of the Public Health Service Act, funds from the Foundation for the National Institutes of Health may be transferred to the National Institutes of Health.

BUILDINGS AND FACILITIES

For the study of, construction of, and acquisition of equipment for, facilities of or used by the National Institutes of Health, including the acquisition of real property, $148,900,000, to remain available until expended, of which $47,300,000 shall be for the neuroscience research center: Provided, That notwithstanding any other provision of law, a single contract or related contracts for the development and construction of the first phase of the National Neuroscience Research Center may be employed which collectively include the full scope of the project: Provided further, That the solicitation and contract shall contain the clause ''availability of funds'' found at 48 CFR 52.232–18.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

For carrying out titles V and XIX of the Public Health Service Act with respect to substance abuse and mental health services, the Protection and Advocacy for Mentally Ill Individuals Act of 1986, and section 301 of the Public Health Service Act with respect to program management, $2,730,757,000, of which $15,000,000 shall remain available until expended to carry out the Fetal Alcohol Syndrome prevention and services program, of which $10,000,000 shall be used to provide grants to local non-profit private and public entities to enable such entities to develop and expand activities to provide substance abuse services to homeless individuals: Provided, That in addition to amounts provided herein, $12,000,000 shall be available from amounts available under section 241 of the Public Health Services Act, to carry out the National Household Survey on Drug Abuse: Provided further, That within the amounts provided herein, $3,000,000 shall be available for the Center for Mental Health Services to support through grants a certification program to improve and evaluate the effectiveness and responsiveness of suicide hotlines and crisis centers in the United States and to help support and evaluate a national hotline and crisis center network.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

HEALTHCARE RESEARCH AND QUALITY

For carrying out titles III and IX of the Public Health Service Act, amounts received from Freedom of Information Act fees, reimbursable and interagency agreements, and the sale of data shall be credited to this appropriation and shall remain available until expended: Provided, That the amount made available pursuant to section 926(b) of the Public Health Service Act shall not exceed $269,943,000.

HEALTH CARE FINANCING ADMINISTRATION

GRANTS TO STATES FOR MEDICAID

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, $93,586,251,000, to remain available until expended.

For making, after May 31, 2001, payments to States under title XIX of the Social Security Act for the last quarter of fiscal year 2001 for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

For making payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act for the first quarter of fiscal year 2002, $36,207,551,000, to remain available until expended.

Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.

PAYMENTS TO HEALTH CARE TRUST FUNDS

For payment to the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as provided under sections 217(g) and 1844 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d) of Public Law 97–248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, $70,381,600,000.

PROGRAM MANAGEMENT

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the Public Health Service Act, and the Clinical Laboratory Improvement Amendments of 1988, not to exceed $2,018,500,000, to be transferred from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the Public Health Service Act and such sums as may be collected from authorized user fees and the sale of data, which shall remain available until expended, and together with administrative fees collected relative to Medicare overpayment recovery activities, which shall remain available until expended: Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the Public Health Service Act shall be credited to and available for carrying out the purposes of this appropriation: Provided further, That $18,000,000 appropriated under this heading for the managed care system redesign shall remain available until expended: Provided further, That $3,000,000 of the amount available for research, demonstration, and evaluation activities shall be available to continue carrying out demonstration projects on Medicaid coverage of community-based attendant care services for people with disabilities which ensures maximum control by the consumer to select and manage their attendant care services: Provided further, That the Secretary of Health and Human Services is directed to collect fees in fiscal year 2001 from Medicare+Choice organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of

that Act pursuant to section 1876(k)(4)(D) of that Act: Provided further, That administrative fees collected relative to Medicare overpayment recovery activities shall be transferred to the Health Care Fraud and Abuse Control (HCFAC) account, to be used for Medicare Integrity Program (MIP) activities in addition to the amounts already specified, and shall remain available until expended.

ADMINISTRATION FOR CHILDREN AND FAMILIES

LOW INCOME HOME ENERGY ASSISTANCE

For making payments under title XXVI of the Omnibus Reconciliation Act of 1981, $300,000,000: Provided, That these funds are hereby designated by the Congress to be emergency requirements pursuant to section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985: Provided further, That these funds shall be made available only after submission to the Congress of a formal budget request by the President that includes designation of the entire amount of the request as an emergency requirement as defined in such Act.

REFUGEE AND ENTRANT ASSISTANCE

For making payments for refugee and entrant assistance activities authorized by title IV of the Immigration and Nationality Act and section 501 of the Refugee Education Assistance Act of 1980 (Public Law 96–422), $418,321,000, to remain available through September 30, 2003.

For carrying out section 5 of the Torture Victims Relief Act of 1998 (Public Law 105–320), $7,265,000.

PAYMENTS TO STATES FOR CHILD SUPPORT ENFORCEMENT AND FAMILY SUPPORT PROGRAMS

For making payments to States or other non-Federal entities under titles I, IV–D, X, XI, XIV, and XVI of the Social Security Act and the Act of July 5, 1960 (24 U.S.C. ch. 9), $2,473,880,000, to remain available until expended; and for such purposes for the first quarter of fiscal year 2002, $1,000,000,000, to remain available until expended.

For making payments to each State for carrying out the program of Aid to Families with Dependent Children under title IV–A of the Social Security Act before the effective date of the program of Temporary Assistance to Needy Families (TANF) with respect to such State, such sums as may be necessary: Provided, That the sum of the amounts available to a State with respect to expenditures under such title IV–A in fiscal year 1997 under this appropriation and under such title IV–A as amended by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 shall not exceed the limitations under section 116(b) of such Act.

For making, after May 31 of the current fiscal year, payments to States or other non-Federal entities under titles I, IV–D, X, XI, XIV, and XVI of the Social Security Act and the Act of July 5, 1960 (24 U.S.C. ch. 9), for the last 3 months of the current year for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

PAYMENTS TO STATES FOR THE CHILD CARE AND DEVELOPMENT BLOCK GRANT

For carrying out sections 658A through 658R of the Omnibus Budget Reconciliation Act of 1981 (The Child Care and Development Block Grant Act of 1990), in addition to amounts already appropriated for fiscal year 2001, $817,328,000: Provided, That of the funds appropriated for fiscal year 2001, $19,120,000 shall be available for child care resource and referral and school-aged child care activities: Provided further, That of the funds appropriated for fiscal year 2001, in addition to the amounts required to be reserved by the States under section 658G, $222,672,000 shall be reserved by the States for activities authorized under section 658G, of which $100,000,000 shall be for activities that improve the quality of infant and toddler child care.

SOCIAL SERVICES BLOCK GRANT

For making grants to States pursuant to section 2002 of the Social Security Act, $600,000,000: Provided, That notwithstanding section 2003(c) of such Act, as amended, the amount specified for allocation under such section for fiscal year 2001 shall be $600,000,000.

CHILDREN AND FAMILIES SERVICES PROGRAMS

(INCLUDING RESCISSIONS)

For carrying out, except as otherwise provided, the Runaway and Homeless Youth Act, the Developmental Disabilities Assistance and Bill of Rights Act, the Head Start Act, the Child Abuse Prevention and Treatment Act, the Native American Programs Act of 1974, title II of Public Law 95–266 (adoption opportunities), the Adoption and Safe Families Act of 1997 (Public Law 105–89), the Abandoned Infants Assistance Act of 1988, part B(1) of title IV and sections 413, 429A, 1110, and 1115 of the Social Security Act; for making payments under the Community Services Block Grant Act, section 473A of the Social Security Act, and title IV of Public Law 105–285; and for necessary administrative expenses to carry out said Acts and titles I, IV, X, XI, XIV, XVI, and XX of the Social Security Act, the Act of July 5, 1960 (24 U.S.C. ch. 9), the Omnibus Budget Reconciliation Act of 1981, title IV of the Immigration and Nationality Act, section 501 of the Refugee Education Assistance Act of 1980, section 5 of the Torture Victims Relief Act of 1998 (Public Law 105–320), sections 40155, 40211, and 40241 of Public Law 103–322 and section 126 and titles IV and V of Public Law 100–485, $7,895,723,000, of which $5,000,000 shall be made available to provide grants for early childhood learning for young children, of which $55,928,000, to remain available until September 30, 2002, shall be for grants to States for adoption incentive payments, as authorized by section 473A of title IV of the Social Security Act (42 U.S.C. 670–679); of which $134,074,000, to remain available until expended, shall be for activities authorized by sections 40155, 40211, and 40241 of Public Law 103–322; of which $606,676,000 shall be for making payments under the Community Services Block Grant Act; and of which $6,267,000,000 shall be for making payments under the Head Start Act, of which $1,400,000,000 shall become available October 1, 2001 and remain available through September 30, 2002: Provided, That to the extent Community Services Block Grant funds are distributed as grant funds by a State to an eligible entity as provided under the Act, and have not been expended by such entity, they shall remain with such entity for carryover into the next fiscal year for expenditure by such entity consistent with program purposes: Provided further, That the Secretary shall establish procedures regarding the disposition of intangible property which permits grant funds, or intangible assets acquired with funds authorized under section 680 of the Community Services Block Grant Act, as amended, to become the sole property of such grantees after a period of not more than 12 years after the end of the grant for purposes and uses consistent with the original grant: Provided further, That amounts made available under this Act for the administrative and related expenses of the Department of Health and Human Services, the Department of Labor, and the Department of Education shall be further reduced on a pro rata basis by $14,137,000.

Funds appropriated for fiscal year 2000 under section 429A(e), part B of title IV of the Social Security Act shall be reduced by $6,000,000.

Funds appropriated for fiscal year 2000 under section 413(h)(1) of the Social Security Act shall be reduced by $15,000,000.

PROMOTING SAFE AND STABLE FAMILIES

For carrying out section 430 of the Social Security Act, $305,000,000.

PAYMENTS TO STATES FOR FOSTER CARE AND ADOPTION ASSISTANCE

For making payments to States or other non-Federal entities under title IV–E of the Social Security Act, $4,868,100,000.

For making payments to States or other non-Federal entities under title IV–E of the Social Security Act, for the first quarter of fiscal year 2002, $1,735,900,000.

ADMINISTRATION ON AGING

AGING SERVICES PROGRAMS

For carrying out, to the extent not otherwise provided, the Older Americans Act of 1965, as amended, and section 398 of the Public Health Service Act, $954,619,000, of which $5,000,000 shall be available for activities regarding medication management, screening, and education to prevent incorrect medication and adverse drug reactions: Provided, That notwithstanding section 308(b)(1) of the Older Americans Act of 1965, as amended, the amounts available to each State for administration of the State plan under title III of such Act shall be reduced not more than 5 percent below the amount that was available to such State for such purpose for fiscal year 1995: Provided further, That in considering grant applications for nutrition services for elder Indian recipients, the Assistant Secretary shall provide maximum flexibility to applicants who seek to take into account subsistence, local customs, and other characteristics that are appropriate to the unique cultural, regional, and geographic needs of the American Indian, Alaska and Hawaiian Native communities to be served.

OFFICE OF THE SECRETARY

GENERAL DEPARTMENTAL MANAGEMENT

For necessary expenses, not otherwise provided, for general departmental management, including hire of six sedans, and for carrying out titles III, XVII, and XX of the Public Health Service Act, and the United States-Mexico Border Health Commission Act, $206,766,000, together with $5,851,000, to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Hospital Insurance Trust Fund and the Supplemental Medical Insurance Trust Fund: Provided further, That of the funds made available under this heading for carrying out title XX of the Public Health Service Act, $10,569,000 shall be for activities specified under section 2003(b)(2), of which $9,131,000 shall be for prevention service demonstration grants under section 510(b)(2) of title V of the Social Security Act, as amended, without application of the limitation of section 2010(c) of said title XX.

OFFICE OF INSPECTOR GENERAL

For expenses necessary for the Office of Inspector General in carrying out the provisions of the Inspector General Act of 1978, as amended, $33,849,000.

OFFICE FOR CIVIL RIGHTS

For expenses necessary for the Office for Civil Rights, $20,742,000, together with not to exceed $3,314,000, to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Hospital Insurance Trust Fund and the Supplemental Medical Insurance Trust Fund: Provided, That an additional $2,500,000 shall be made available for the Office for Civil Rights: Provided further, That amounts made available under this title for the administrative and related expenses of the Department of Health and Human Services shall be reduced by $2,500,000''.

POLICY RESEARCH

For carrying out, to the extent not otherwise provided, research studies under section 1110 of the Social Security Act, $16,738,000.

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

For retirement pay and medical benefits of Public Health Service Commissioned Officers as authorized by law, for payments under the Retired Serviceman's Family Protection Plan and Survivor Benefit Plan, for medical care of dependents and retired personnel under the Dependents' Medical Care Act (10 U.S.C. ch. 55), and for payments pursuant to section 229(b) of

the Social Security Act (42 U.S.C. 429(b)), such amounts as may be required during the current fiscal year.

PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

For public health and social services, $264,600,000.

GENERAL PROVISIONS

SEC. 201. Funds appropriated in this title shall be available for not to exceed $37,000 for official reception and representation expenses when specifically approved by the Secretary.

SEC. 202. The Secretary shall make available through assignment not more than 60 employees of the Public Health Service to assist in child survival activities and to work in AIDS programs through and with funds provided by the Agency for International Development, the United Nations International Children's Emergency Fund or the World Health Organization.

SEC. 203. None of the funds appropriated under this Act may be used to implement section 399L(b) of the Public Health Service Act or section 1503 of the National Institutes of Health Revitalization Act of 1993, Public Law 103–43.

SEC. 204. None of the funds appropriated in this Act for the National Institutes of Health and the Substance Abuse and Mental Health Services Administration shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.

SEC. 205. Notwithstanding section 241(a) of the Public Health Service Act, such portion as the Secretary shall determine, but not more than 1.6 percent, of any amounts appropriated for programs authorized under the PHS Act shall be made available for the evaluation (directly or by grants or contracts) of the implementation and effectiveness of such programs.

(TRANSFER OF FUNDS)

SEC. 206. Not to exceed 1 percent of any discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended) which are appropriated for the current fiscal year for the Department of Health and Human Services in this Act may be transferred between appropriations, but no such appropriation shall be increased by more than 3 percent by any such transfer: Provided, That the Appropriations Committees of both Houses of Congress are notified at least 15 days in advance of any transfer.

SEC. 207. The Director of the National Institutes of Health, jointly with the Director of the Office of AIDS Research, may transfer up to 3 percent among institutes, centers, and divisions from the total amounts identified by these two Directors as funding for research pertaining to the human immunodeficiency virus: Provided, That the Congress is promptly notified of the transfer.

SEC. 208. Of the amounts made available in this Act for the National Institutes of Health, the amount for research related to the human immunodeficiency virus, as jointly determined by the Director of the National Institutes of Health and the Director of the Office of AIDS Research, shall be made available to the ''Office of AIDS Research'' account. The Director of the Office of AIDS Research shall transfer from such account amounts necessary to carry out section 2353(d)(3) of the Public Health Service Act.

SEC. 209. None of the funds appropriated in this Act may be made available to any entity under title X of the Public Health Service Act unless the applicant for the award certifies to the Secretary that it encourages family participation in the decision of minors to seek family planning services and that it provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.

SEC. 210. None of the funds appropriated by this Act (including funds appropriated to any trust fund) may be used to carry out the Medicare+Choice program if the Secretary denies participation in such program to an otherwise eligible entity (including a Provider Sponsored Organization) because the entity informs the Secretary that it will not provide, pay for, provide coverage of, or provide referrals for abortions: Provided, That the Secretary shall make appropriate prospective adjustments to the capitation payment to such an entity (based on an actuarially sound estimate of the expected costs of providing the service to such entity's enrollees): Provided further, That nothing in this section shall be construed to change the Medicare program's coverage for such services and a Medicare+Choice organization described in this section shall be responsible for informing enrollees where to obtain information about all Medicare covered services.

SEC. 211. (a) MENTAL HEALTH.—Section 1918(b) of the Public Health Service Act (42 U.S.C. 300x–7(b)) is amended to read as follows:

''(b) MINIMUM ALLOTMENTS FOR STATES.—Each State's allotment for fiscal year 2001 for programs under this subpart shall not be less than such State's allotment for such programs for fiscal year 2000.''.

(b) SUBSTANCE ABUSE.—Section 1933(b) of the Public Health Service Act (42 U.S.C. 300x–33(b)) is amended to read as follows:

''(b) MINIMUM ALLOTMENTS FOR STATES.—Each State's allotment for fiscal year 2001 for programs under this subpart shall not be less than such State's allotment for such programs for fiscal year 2000.''.

SEC. 212. Notwithstanding any other provision of law, no provider of services under title X of the Public Health Service Act shall be exempt from any State law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.

SEC. 213. EXTENSION OF CERTAIN ADJUDICATION PROVISIONS.—The Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1990 (Public Law 101–167) is amended—

(1) in section 599D (8 U.S.C. 1157 note)—

(A) in subsection (b)(3), by striking ''1997, 1998, 1999, and 2000'' and inserting ''1997, 1998, 1999, 2000 and 2001''; and

(B) in subsection (e), by striking ''October 1, 2000'' each place it appears and inserting ''October 1, 2001''; and

(2) in section 599E (8 U.S.C. 1255 note) in subsection (b)(2), by striking ''September 30, 2000'' and inserting ''September 30, 2001''.

SEC. 214. None of the funds provided in this Act or in any other Act making appropriations for fiscal year 2001 may be used to administer or implement in Arizona or in the Kansas City, Missouri or in the Kansas City, Kansas area the Medicare Competitive Pricing Demonstration Project (operated by the Secretary of Health and Human Services).

SEC. 215. WITHHOLDING OF SUBSTANCE ABUSE FUNDS. (a) IN GENERAL.—Except as provided by subsection (e) none of the funds appropriated by this Act may be used to withhold substance abuse funding from a State pursuant to section 1926 of the Public Health Service Act (42 U.S.C. 300x–26) if such State certifies to the Secretary of Health and Human Services by March 1, 2001 that the State will commit additional State funds, in accordance with subsection (b), to ensure compliance with State laws prohibiting the sale of tobacco products to individuals under 18 years of age.

(b) AMOUNT OF STATE FUNDS.—The amount of funds to be committed by a State under subsection (a) shall be equal to 1 percent of such State's substance abuse block grant allocation for each percentage point by which the State misses the retailer compliance rate goal established by the Secretary of Health and Human Services under section 1926 of such Act.

(c) ADDITIONAL STATE FUNDS.—The State is to maintain State expenditures in fiscal year 2001 for tobacco prevention programs and for compliance activities at a level that is not less than the level of such expenditures maintained by the State for fiscal year 2000, and adding to that level the additional funds for tobacco compliance activities required under subsection (a). The State is to submit a report to the Secretary on all fiscal year 2000 State expenditures and all fiscal year 2001 obligations for tobacco prevention and compliance activities by program activity by July 31, 2001.

(d) ENFORCEMENT OF STATE OBLIGATIONS.—The Secretary shall exercise discretion in enforcing the timing of the State obligation of the additional funds required by the certification described in subsection (a) as late as July 31, 2001.

(e) TERRITORIES.—None of the funds appropriated by this Act may be used to withhold substance abuse funding pursuant to section 1926 from a territory that receives less than $1,000,000.

SEC. 216. Section 403(a)(3) of the Social Security Act (42 U.S.C. 603(a)(3)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''and'' at the end;

(B) in clause (ii)—

(i) by striking ''1999, 2000, and 2001'' and inserting ''1999 and 2000''; and

(ii) by striking the period at the end and inserting ''; and''; and

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

''(iii) for fiscal year 2001, a grant in an amount equal to the amount of the grant to the State under clause (i) for fiscal year 1998.'' and

(2) in subparagraph (G), by inserting at the end, ''Upon enactment, the provisions of this Act that would have been estimated by the Director of the Office of Management and Budget as changing direct spending and receipts for fiscal year 2001 under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99–177), to the extent such changes would have been estimated to result in savings in fiscal year 2001 of $240,000,000 in budget authority and $122,000,000 in outlays, shall be treated as if enacted in an appropriations act pursuant to Rule 3 of the Budget Scorekeeping Guidelines set forth in the Joint Explanatory Statement of the Committee of Conference accompanying Conference Report No. 105–217, thereby changing discretionary spending under section 251 of that Act.''.

SEC. 217. (a) Notwithstanding Section 2104(f) of the Social Security Act (the Act), the Secretary of Health and Human Services shall reduce the amounts allotted to a State under subsection (b) of the Act for fiscal year 1998 by the applicable amount with respect to the State; and

(b) Notwithstanding Section 2104(a) of the Act, the Secretary shall increase the amount otherwise payable to each State under such subsection for fiscal year 2003 by the amount of the reduction made under paragraph (a) of this section. Funds made available under this subsection shall remain available through September 30, 2004.

(c) APPLICABLE AMOUNT DEFINED.—In subsection (a), with respect to a State, the term ''applicable amount'' means, with respect to a State, an amount bearing the same proportion to $1,900,000,000 as the unexpended balance of its fiscal year 1998 allotment as of September 30, 2000, which would otherwise be redistributed to States in fiscal year 2001 under Section 2104(f) of the Act, bears to the sum of the unexpended balances of fiscal year 1998 allotments for all States as of September 30, 2000: Provided, That, the applicable amount for a State shall not exceed the unexpended balance of its fiscal year 1998 allotment as of September 30, 2000.

SEC. 218. SENSE OF THE SENATE ON PREVENTION OF NEEDLESTICK INJURIES. (a) FINDINGS.—The Senate finds that—

(1) the Centers for Disease Control and Prevention reports that American health care workers report 600,000 to 800,000 needlestick and sharps injuries each year;

(2) the occurrence of needlestick injuries is believed to be widely under-reported;

(3) needlestick and sharps injuries result in at least 1,000 new cases of health care workers with HIV, hepatitis C or hepatitis B every year;

(4) more than 80 percent of needlestick injuries can be prevented through the use of safer devices; and

(5) the Occupational Safety and Health Administration's November 1999 Compliance Directive has helped clarify the duty of employers to use safer needle devices to protect their workers. However, millions of State and local government employees are not covered by OSHA's bloodborne pathogen standards and are not protected against the hazards of needlesticks.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the Senate should pass legislation that would eliminate or minimize the significant risk of needlestick injury to health care workers.

SEC. 219. (a) IN GENERAL.—There is appropriated $10,000,000 that may be used by the Director of the National Institute for Occupational Safety and Health to—

(1) establish and maintain a national database on existing needleless systems and sharps with engineered sharps injury protections;

(2) develop a set of evaluation criteria for use by employers, employees, and other persons when they are evaluating and selecting needleless systems and sharps with engineered sharps injury protections;

(3) develop a model training curriculum to train employers, employees, and other persons on the process of evaluating needleless systems and sharps with engineered sharps injury protections and to the extent feasible to provide technical assistance to persons who request such assistance; and

(4) establish a national system to collect comprehensive data on needlestick injuries to health care workers, including data on mechanisms to analyze and evaluate prevention interventions in relation to needlestick injury occurrence.

(b) DEFINITIONS.—In this section:

(1) EMPLOYER.—The term ''employer'' means each employer having an employee with occupational exposure to human blood or other material potentially containing bloodborne pathogens.

(2) ENGINEERED SHARPS INJURY PROTECTIONS.—The term ''engineered sharps injury protections'' means—

(A) a physical attribute built into a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, that effectively reduces the risk of an exposure incident by a mechanism such as barrier creation, blunting, encapsulation, withdrawal, retraction, destruction, or other effective mechanisms; or

(B) a physical attribute built into any other type of needle device, or into a nonneedle sharp, which effectively reduces the risk of an exposure incident.

(3) NEEDLELESS SYSTEM.—The term ''needleless system'' means a device that does not use needles for—

(A) the withdrawal of body fluids after initial venous or arterial access is established;

(B) the administration of medication or fluids; and

(C) any other procedure involving the potential for an exposure incident.

(4) SHARP.—The term ''sharp'' means any object used or encountered in a health care setting that can be reasonably anticipated to penetrate the skin or any other part of the body, and to result in an exposure incident, including, but not limited to, needle devices, scalpels, lancets, broken glass, broken capillary tubes, exposed ends of dental wires and dental knives, drills, and burs.

(5) SHARPS INJURY.—The term ''sharps injury'' means any injury caused by a sharp, including cuts, abrasions, or needlesticks.

(c) OFFSET.—Amounts made available under this Act for the travel, consulting, and printing services for the Department of Labor, the Department of Health and Human Services, and the Department of Education shall be reduced on a pro rata basis by $10,000,000.

SEC. 220. None of the funds made available under this Act may be made available to any entity under the Public Health Service Act after September 1, 2001, unless the Director of the National Institutes of Health has provided to the Chairman and Ranking Member of the Senate Committees on Appropriations, and Health, Education, Labor, and Pensions a proposal to require a reasonable rate of return on both intramural and extramural research by March 31, 2001.

SEC. 221. (a) STUDY.—The Secretary of Health and Human Services shall conduct a study to examine—

(1) the experiences of hospitals in the United States in obtaining reimbursement from foreign health insurance companies whose enrollees receive medical treatment in the United States;

(2) the identity of the foreign health insurance companies that do not cooperate with or reimburse (in whole or in part) United States health care providers for medical services rendered in the United States to enrollees who are foreign nationals;

(3) the amount of unreimbursed services that hospitals in the United States provide to foreign nationals described in paragraph (2); and

(4) solutions to the problems identified in the study.

(b) REPORT.—Not later than March 31, 2001, the Secretary of Health and Human Services shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Appropriations, a report concerning the results of the study conducted under subsection (a), including the recommendations described in paragraph (4) of such subsection.

SEC. 222. NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT. Section 448 of the Public Health Service Act (42 U.S.C. 285g) is amended by inserting ''gynecologic health,'' after ''with respect to''.

SEC. 223. In addition to amounts otherwise appropriated under this title for the Centers for Disease Control and Prevention, $37,500,000, to be utilized to provide grants to States and political subdivisions of States under section 317 of the Public Health Service Act to enable such States and political subdivisions to carry out immunization infrastructure and operations activities: Provided, That of the total amount made available in this Act for infrastructure funding for the Centers for Disease Control and Prevention, not less than 10 percent shall be used for immunization projects in areas with low or declining immunization rates or areas that are particularly susceptible to disease outbreaks, and not more than 14 percent shall be used to carry out the incentive bonus program: Provided further, That amounts made available under this Act for the administrative and related expenses of the Department of Health and Human Services, the Department of Labor, and the Department of Education shall be further reduced on a pro rata basis by $37,500,000.

SEC. 224. None of the funds appropriated under this Act shall be expended by the National Institutes of Health on a contract for the care of the 288 chimpanzees acquired by the National Institutes of Health from the Coulston Foundation, unless the contractor is accredited by the Association for the Assessment and Accreditation of Laboratory Animal Care International or has a Public Health Services assurance, and has not been charged multiple times with egregious violations of the Animal Welfare Act.

SEC. 225. (a) In addition to amounts made available under the heading ''Health Resources and Services Administration-Health Resources and Services'' for poison prevention and poison control center activities, there shall be available an additional $20,000,000 to provide assistance for such activities and to stabilize the funding of regional poison control centers as provided for pursuant to the Poison Control Center Enhancement and Awareness Act (Public Law 106–174).

(b) Amounts made available under this Act for the administrative and related expenses of the Department of Health and Human Services, the Department of Labor, and the Department of Education shall be further reduced on a pro rata basis by $20,000,000.

SEC. 226. SENSE OF THE SENATE REGARDING THE DELIVERY OF EMERGENCY MEDICAL SERVICES. (a) FINDINGS.—The Senate finds the following:

(1) Several States have developed and implemented a unique 2-tiered emergency medical services system that effectively provides services to the residents of those States.

(2) These 2-tiered systems include volunteer and for-profit emergency medical technicians who provide basic life support and hospital-based paramedics who provide advanced life support.

(3) These 2-tiered systems have provided universal access for residents of those States to affordable emergency services, while simultaneously ensuring that those persons in need of the most advanced care receive such care from the proper authorities.

(4) One State's 2-tiered system currently has an estimated 20,000 emergency medical technicians providing ambulance transportation for basic life support and advanced life support emergencies, over 80 percent of which are handled by volunteers who are not reimbursed under the medicare program under title XVIII of the Social Security Act.

(5) The hospital-based paramedics, also known as mobile intensive care units, are reimbursed under the medicare program when they respond to advanced life support emergencies.

(6) These 2-tiered State health systems save the lives of thousands of residents of those States each year, while saving the medicare program, in some instances, as much as $39,000,000 in reimbursement fees.

(7) When Congress requested that the Health Care Financing Administration enact changes to the emergency medical services fee schedule as a result of the Balanced Budget Act of 1997, including a general overhaul of reimbursement rates and administrative costs, it was in the spirit of streamlining the agency, controlling skyrocketing health care costs, and lengthening the solvency of the medicare program.

(8) The Health Care Financing Administration is considering implementing new emergency medical services reimbursement guidelines that may destabilize the 2-tier system that has developed in these States.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the Health Care Financing Administration should—

(1) consider the unique nature of 2-tiered emergency medical services delivery systems when implementing new reimbursement guidelines for paramedics and hospitals under the medicare program under title XVIII of the Social Security Act; and

(2) promote innovative emergency medical service systems enacted by States that reduce reimbursement costs to the medicare program while ensuring that all residents receive quick and appropriate emergency care when needed.

SEC. 227. SENSE OF THE SENATE REGARDING IMPACTS OF THE BALANCED BUDGET ACT OF 1997. (a) FINDINGS.—The Senate makes the following findings:

(1) Since its passage in 1997, the Balanced Budget Act of 1997 has drastically cut payments under the medicare program under title XVIII of the Social Security Act in the areas of hospital, home health, and skilled nursing care, among others. While Congress intended to cut approximately $100,000,000,000 from the medicare program over 5 years, recent estimates put the actual cut at over $200,000,000,000.

(2) A recent study on home health care found that nearly 70 percent of hospital discharge

planners surveyed reported a greater difficulty obtaining home health services for medicare beneficiaries as a result of the Balanced Budget Act of 1997.

(3) According to the Medicare Payment Advisory Commission, rural hospitals were disproportionately affected by the Balanced Budget Act of 1997, dropping the inpatient margins of such hospitals over 4 percentage points in 1998.

(b) SENSE OF SENATE.—It is the sense of the Senate that Congress and the President should act expeditiously to alleviate the adverse impacts of the Balanced Budget Act of 1997 on beneficiaries under the medicare program under title XVIII of the Social Security Act and health care providers participating in such program.

TITLE III—DEPARTMENT OF EDUCATION

OFFICE OF ELEMENTARY AND SECONDARY EDUCATION

EDUCATION REFORM

For carrying out activities authorized by title IV of the Goals 2000: Educate America Act as in effect prior to September 30, 2000, and sections 3122, 3132, 3136, and 3141, parts B, C, and D of title III, and part I of title X of the Elementary and Secondary Education Act of 1965, $1,434,500,000, of which $40,000,000 shall be for the Goals 2000: Educate America Act, and of which $192,000,000 shall be for section 3122: Provided, That up to one-half of 1 percent of the amount available under section 3132 shall be set aside for the outlying areas, to be distributed on the basis of their relative need as determined by the Secretary in accordance with the purposes of the program: Provided further, That if any State educational agency does not apply for a grant under section 3132, that State's allotment under section 3131 shall be reserved by the Secretary for grants to local educational agencies in that State that apply directly to the Secretary according to the terms and conditions published by the Secretary in the Federal Register: Provided further, That, notwithstanding part I of title X of the Elementary and Secondary Education Act of 1965 or any other provision of law, a community-based organization that has experience in providing before- and after-school services shall be eligible to receive a grant under that part, on the same basis as a school or consortium described in section 10904 of that Act, and the Secretary shall give priority to any application for such a grant that is submitted jointly by such a community-based organization and such a school or consortium.

EDUCATION FOR THE DISADVANTAGED

For carrying out title I of the Elementary and Secondary Education Act of 1965, and section 418A of the Higher Education Act of 1965, $8,986,800,000, of which $2,729,958,000 shall become available on July 1, 2001, and shall remain available through September 30, 2002, and of which $6,223,342,000 shall become available on October 1, 2001 and shall remain available through September 30, 2002, for academic year 2000–2001: Provided, That $7,113,403,000 shall be available for basic grants under section 1124: Provided further, That up to $3,500,000 of these funds shall be available to the Secretary on October 1, 2000, to obtain updated local educational agency level census poverty data from the Bureau of the Census: Provided further, That $1,222,397,000 shall be available for concentration grants under section 1124A: Provided further, That grant awards under sections 1124 and 1124A of title I of the Elementary and Secondary Education Act of 1965 shall be made to each State and local educational agency at no less than 100 percent of the amount such State or local educational agency received under this authority for fiscal year 2000: Provided further, That notwithstanding any other provision of law, grant awards under section 1124A of title I of the Elementary and Secondary Education Act of 1965 shall be made to those local educational agencies that received a Concentration Grant under the Department of Education Appropriations Act, 2000, but are not eligible to receive such a grant for fiscal year 2001: Provided further, That each such local educational agency shall receive an amount equal to the Concentration Grant the agency received in fiscal year 2000, ratably reduced, if necessary, to ensure that these local educational agencies receive no greater share of their hold-harmless amounts than other local educational agencies: Provided further, That notwithstanding any other provision of law, in calculating the amount of Federal assistance awarded to a State or local educational agency under any program under title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.) on the basis of a formula described in section 1124 or 1124A of such Act (20 U.S.C. 6333, 6334), any funds appropriated for the program in excess of the amount appropriated for the program for fiscal year 2000 shall be awarded according to the formula, except that, for such purposes, the formula shall be applied only to States or local educational agencies that experience a reduction under the program for fiscal year 2001 as a result of the application of the 100 percent hold harmless provisions under the heading ''Education for the Disadvantaged'': Provided further, That the Secretary shall not take into account the hold harmless provisions in this section in determining State allocations under any other program administered by the Secretary in any fiscal year.

IMPACT AID

For carrying out programs of financial assistance to federally affected schools authorized by title VIII of the Elementary and Secondary Education Act of 1965, $1,030,000,000, of which $818,000,000 shall be for basic support payments under section 8003(b), $50,000,000 shall be for payments for children with disabilities under section 8003(d), $82,000,000, to remain available until expended, shall be for payments under section 8003(f), $35,000,000 shall be for construction under section 8007, $47,000,000 shall be for Federal property payments under section 8002 and $8,000,000 to remain available until expended shall be for facilities maintenance under section 8008: Provided, That amounts made available under this Act for the administrative and related expenses of the Department of Health and Human Services, the Department of Labor, and the Department of Education shall be further reduced on a pro rata basis by $10,000,000.

SCHOOL IMPROVEMENT PROGRAMS

For carrying out school improvement activities authorized by titles II, IV, V–A and B, VI, IX, X, and XIII of the Elementary and Secondary Education Act of 1965 (''ESEA''); the Stewart B. McKinney Homeless Assistance Act; and the Civil Rights Act of 1964 and part B of title VIII of the Higher Education Act of 1965; $4,672,534,000, of which $1,100,200,000 shall become available on July 1, 2001, and remain available through September 30, 2002, and of which $2,915,000,000 shall become available on October 1, 2001 and shall remain available through September 30, 2002 for academic year 2001–2002: Provided, That of the amount appropriated, $435,000,000 shall be for Eisenhower professional development State grants under title II–B and $3,100,000,000 shall be for title VI and up to $750,000 shall be for an evaluation of comprehensive regional assistance centers under title XIII of ESEA: Provided further, That of the amount made available for Title VI, $2,700,000,000 shall be available, notwithstanding any other provision of law, for purposes consistent with title VI to be determined by the local education agency as part of a local strategy for improving academic achievement: Provided further, That these funds may also be used to address the shortage of highly qualified teachers to reduce class size, particularly in early grades, using highly qualified teachers to improve educational achievement for regular and special needs children; to support efforts to recruit, train and retrain highly qualified teachers; to carry out part B of the Individuals with Disabilities Education Act (20 U.S.C. 1411 et seq.); or for school construction and renovation of facilities, at the sole discretion of the local educational agency: Provided further, That funds made available under this heading to carry out section 6301(b) of the Elementary and Secondary Education Act of 1965 shall be available for education reform projects that provide same gender schools and classrooms, consistent with applicable law: Provided further, That of the amount made available under this heading for activities carried out through the Fund for the Improvement of Education under part A of title X, $10,000,000 shall be made available to enable the Secretary of Education to award grants to develop and implement school dropout prevention programs.

READING EXCELLENCE

For necessary expenses to carry out the Reading Excellence Act, $91,000,000, which shall become available on July 1, 2001 and shall remain available through September 30, 2002 and $195,000,000 which shall become available on October 1, 2001 and remain available through September 30, 2002.

INDIAN EDUCATION

For expenses necessary to carry out, to the extent not otherwise provided, title IX, part A of the Elementary and Secondary Education Act of 1965, as amended, $115,500,000.

OFFICE OF BILINGUAL EDUCATION AND MINORITY LANGUAGES AFFAIRS

BILINGUAL AND IMMIGRANT EDUCATION

For carrying out, to the extent not otherwise provided, bilingual, foreign language and immigrant education activities authorized by parts A and C and section 7203 of title VII of the Elementary and Secondary Education Act of 1965, without regard to section 7103(b), $443,000,000: Provided, That State educational agencies may use all, or any part of, their part C allocation for competitive grants to local educational agencies.

OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES

SPECIAL EDUCATION

For carrying out the Individuals with Disabilities Education Act, $7,352,341,000, of which $2,464,452,000 shall become available for obligation on July 1, 2001, and shall remain available through September 30, 2002, and of which $4,624,000,000 shall become available on October 1, 2001 and shall remain available through September 30, 2002, for academic year 2001–2002: Provided, That $1,500,000 shall be for the recipient of funds provided by Public Law 105–78 under section 687(b)(2)(G) of the Act to provide information on diagnosis, intervention, and teaching strategies for children with disabilities: Provided further, That the amount for section 611(c) of the Act shall be equal to the amount available for that section under Public Law 106–113, increased by the rate of inflation as specified in section 611(f)(1)(B)(ii) of the Act.

REHABILITATION SERVICES AND DISABILITY RESEARCH

For carrying out, to the extent not otherwise provided, the Rehabilitation Act of 1973, the Assistive Technology Act of 1998, and the Helen Keller National Center Act, $2,799,519,000: Provided, That notwithstanding section 105(b)(1) of the Assistive Technology Act of 1998 (''the AT Act''), each State shall be provided $50,000 for activities under section 102 of the AT Act: Provided further, That notwithstanding section 105(b)(1) and section 101(f)(2) and (3) of the Assistive Technology Act of 1998, each State shall be provided a minimum of $500,000 for activities under section 101: Provided further, That $7,000,000 shall be used to support grants for up to three years to states under title III of the AT Act, of which the Federal share shall not exceed 75 percent in the first year, 50 percent in the second year, and 25 percent in the third year, and that the requirements in section 301(c)(2) and section 302 of that Act shall not apply to such grants.

SPECIAL INSTITUTIONS FOR PERSONS WITH DISABILITIES

AMERICAN PRINTING HOUSE FOR THE BLIND

For carrying out the Act of March 3, 1879, as amended (20 U.S.C. 101 et seq.), $12,500,000.

NATIONAL TECHNICAL INSTITUTE FOR THE DEAF

For the National Technical Institute for the Deaf under titles I and II of the Education of the Deaf Act of 1986 (20 U.S.C. 4301 et seq.), $54,366,000, of which $7,176,000 shall be for construction and shall remain available until expended: Provided, That from the total amount available, the Institute may at its discretion use funds for the endowment program as authorized under section 207.

GALLAUDET UNIVERSITY

For the Kendall Demonstration Elementary School, the Model Secondary School for the Deaf, and the partial support of Gallaudet University under titles I and II of the Education of the Deaf Act of 1986 (20 U.S.C. 4301 et seq.), $87,650,000: Provided, That from the total amount available, the University may at its discretion use funds for the endowment program as authorized under section 207.

OFFICE OF VOCATIONAL AND ADULT EDUCATION

VOCATIONAL AND ADULT EDUCATION

For carrying out, to the extent not otherwise provided, the Carl D. Perkins Vocational and Technical Education Act, the Adult Education and Family Literacy Act, and title VIII–D of the Higher Education Act of 1965, as amended, and Public Law 102–73, $1,726,600,000, of which $1,000,000 shall remain available until expended, and of which $929,000,000 shall become available on July 1, 2001 and shall remain available through September 30, 2002 and of which $791,000,000 shall become available on October 1, 2001 and shall remain available through September 30, 2002: Provided, That of the amounts made available for the Carl D. Perkins Vocational and Technical Education Act, $5,600,000 shall be for tribally controlled postsecondary vocational and technical institutions under section 117: Provided further, That $9,000,000 shall be for carrying out section 118 of such Act: Provided further, That up to 15 percent of the funds provided may be used by the national entity designated under section 118(a) to cover the cost of authorized activities and operations, including Federal salaries and expenses: Provided further, That the national entity is authorized, effective upon enactment, to charge fees for publications, training, and technical assistance developed by that national entity: Provided further, That revenues received from publications and delivery of technical assistance and training, notwithstanding 31 U.S.C. 3302, may be credited to the national entity's account and shall be available to the national entity, without fiscal year limitation, so long as such revenues are used for authorized activities and operations of the national entity: Provided further, That of the funds made available to carry out section 204 of the Perkins Act, all funds that a State receives in excess of its prior-year allocation shall be competitively awarded: Provided further, That in making these awards, each State shall give priority to consortia whose applications most effectively integrate all components under section 204(c): Provided further, That of the amounts made available for the Carl D. Perkins Vocational and Technical Education Act, $5,000,000 shall be for demonstration activities authorized by section 207: Provided further, That of the amounts made available for the Adult Education and Family Literacy Act, $14,000,000 shall be for national leadership activities under section 243 and $6,500,000 shall be for the National Institute for Literacy under section 242: Provided further, That $22,000,000 shall be for Youth Offender Grants, of which $5,000,000 shall be used in accordance with section 601 of Public Law 102–73 as that section was in effect prior to the enactment of Public Law 105–220: Provided further, That of the amounts made available for title I of the Perkins Act, the Secretary may reserve up to 0.54 percent for incentive grants under section 503 of the Workforce Investment Act, without regard to section 111(a)(1)(C) of the Perkins Act: Provided further, That of the amounts made available for the Adult Education and Family Literacy Act, the Secretary may reserve up to 0.54 percent for incentive grants under section 503 of the Workforce Investment Act, without regard to section 211(a)(3) of the Adult Education and Family Literacy Act.

OFFICE OF STUDENT FINANCIAL ASSISTANCE

STUDENT FINANCIAL ASSISTANCE

For carrying out subparts 1, 3 and 4 of part A, part C and part E of title IV of the Higher Education Act of 1965, as amended, $10,624,000,000, which shall remain available through September 30, 2002.

The maximum Pell Grant for which a student shall be eligible during award year 2001–2002 shall be $3,650: Provided, That notwithstanding section 401(g) of the Act, if the Secretary determines, prior to publication of the payment schedule for such award year, that the amount included within this appropriation for Pell Grant awards in such award year, and any funds available from the fiscal year 2000 appropriation for Pell Grant awards, are insufficient to satisfy fully all such awards for which students are eligible, as calculated under section 401(b) of the Act, the amount paid for each such award shall be reduced by either a fixed or variable percentage, or by a fixed dollar amount, as determined in accordance with a schedule of reductions established by the Secretary for this purpose.

FEDERAL FAMILY EDUCATION LOAN PROGRAM ACCOUNT

For Federal administrative expenses to carry out guaranteed student loans authorized by title IV, part B, of the Higher Education Act of 1965, as amended, $48,000,000.

OFFICE OF POSTSECONDARY EDUCATION

HIGHER EDUCATION

For carrying out, to the extent not otherwise provided, section 121 and titles II, III, IV, V, VI, VII, and VIII of the Higher Education Act of 1965, as amended, and the Mutual Educational and Cultural Exchange Act of 1961; $1,694,520,000, of which $10,000,000 for interest subsidies authorized by section 121 of the Higher Education Act of 1965, shall remain available until expended: Provided, That $11,000,000, to remain available through September 30, 2002, shall be available to fund fellowships under part A, subpart 1 of title VII of said Act, of which up to $1,000,000 shall be available to fund fellowships for academic year 2001–2002, and the remainder shall be available to fund fellowships for academic year 2002–2003: Provided further, That $3,000,000 is for data collection and evaluation activities for programs under the Higher Education Act of 1965, including such activities needed to comply with the Government Performance and Results Act of 1993: Provided further, That section 404F(a) of the Higher Education Amendments of 1998 is amended by striking out ''using funds appropriated under section 404H that do not exceed $200,000'' and inserting in lieu thereof ''using not more than 0.2 percent of the funds appropriated under section 404H''.

HOWARD UNIVERSITY

For partial support of Howard University (20 U.S.C. 121 et seq.), $224,000,000, of which not less than $3,530,000 shall be for a matching endowment grant pursuant to the Howard University Endowment Act (Public Law 98–480) and shall remain available until expended.

COLLEGE HOUSING AND ACADEMIC FACILITIES LOANS PROGRAM

For Federal administrative expenses authorized under section 121 of the Higher Education Act of 1965, $737,000 to carry out activities related to existing facility loans entered into under the Higher Education Act of 1965.

HISTORICALLY BLACK COLLEGE AND UNIVERSITY CAPITAL FINANCING PROGRAM ACCOUNT

The total amount of bonds insured pursuant to section 344 of title III, part D of the Higher Education Act of 1965 shall not exceed $357,000,000, and the cost, as defined in section 502 of the Congressional Budget Act of 1974, of such bonds shall not exceed zero.

For administrative expenses to carry out the Historically Black College and University Capital Financing Program entered into pursuant to title III, part D of the Higher Education Act of 1965, as amended, $208,000.

OFFICE OF EDUCATIONAL RESEARCH AND IMPROVEMENT

EDUCATION RESEARCH, STATISTICS, AND IMPROVEMENT

For carrying out activities authorized by the Educational Research, Development, Dissemination, and Improvement Act of 1994, including part E; the National Education Statistics Act of 1994, including sections 411 and 412; section 2102 of title II, and parts A, B, and K and section 10102, section 10105, and 10601 of title X, and part C of title XIII of the Elementary and Secondary Education Act of 1965, as amended, and title VI of Public Law 103–227, $506,519,000, of which $250,000 shall be for the Web-Based Education Commission: Provided, That of the funds appropriated under section 10601 of title X of the Elementary and Secondary Education Act of 1965, as amended, $1,500,000 shall be used to conduct a violence prevention demonstration program: Provided further, That of the funds appropriated $5,000,000 shall be made available for a high school State grant program to improve academic performance and provide technical skills training, $5,000,000 shall be made available to provide grants to enable elementary and secondary schools to provide physical education and improve physical fitness: Provided further, That $50,000,000 of the funds provided for the national education research institutes shall be allocated notwithstanding section 912(m)(1)(B–F) and subparagraphs (B) and (C) of section 931(c)(2) of Public Law 103–227 and $20,000,000 of that $50,000,000 shall be made available for the Interagency Education Research Initiative: Provided further, That the amounts made available under this Act for the administrative and related expenses of the Department of Health and Human Services, the Department of Labor, and the Department of Education shall be further reduced on a pro rata basis by $10,000,000: Provided further, That of the funds available for section 10601 of title X of the Elementary and Secondary Education Act of 1965, as amended, $150,000 shall be awarded to the Center for Educational Technologies to complete production and distribution of an effective CD–ROM product that would complement the ''We the People: The Citizen and the Constitution'' curriculum: Provided further, That, in addition to the funds for title VI of Public Law 103–227 and notwithstanding the provisions of section 601(c)(1)(C) of that Act, $1,000,000 shall be available to the Center for Civic Education to conduct a civic education program with Northern Ireland and the Republic of Ireland and, consistent with the civics and Government activities authorized in section 601(c)(3) of Public Law 103–227, to provide civic education assistance to democracies in developing countries. The term ''developing countries'' shall have the same meaning as the term ''developing country'' in the Education for the Deaf Act: Provided further, That of the amount made available under this heading for activities carried out through the Fund for the Improvement of Education under part A of title X, $50,000,000 shall be made available to enable the Secretary of Education to award grants to develop, implement, and strengthen programs to teach American history (not social studies) as a separate subject within school curricula.

DEPARTMENTAL MANAGEMENT

PROGRAM ADMINISTRATION

For carrying out, to the extent not otherwise provided, the Department of Education Organization Act, including rental of conference rooms in the District of Columbia and hire of two passenger motor vehicles, $396,671,000.

OFFICE FOR CIVIL RIGHTS

For expenses necessary for the Office for Civil Rights, as authorized by section 203 of the Department of Education Organization Act, $73,224,000.

OFFICE OF THE INSPECTOR GENERAL

For expenses necessary for the Office of Inspector General, as authorized by section 212 of the Department of Education Organization Act, $35,456,000.

GENERAL PROVISIONS

SEC. 301. No funds appropriated in this Act may be used for the transportation of students or teachers (or for the purchase of equipment for such transportation) in order to overcome racial imbalance in any school or school system, or for the transportation of students or teachers (or for the purchase of equipment for such transportation) in order to carry out a plan of racial desegregation of any school or school system.

SEC. 302. None of the funds contained in this Act shall be used to require, directly or indirectly, the transportation of any student to a school other than the school which is nearest the student's home, except for a student requiring special education, to the school offering such special education, in order to comply with title VI of the Civil Rights Act of 1964. For the purpose of this section an indirect requirement of transportation of students includes the transportation of students to carry out a plan involving the reorganization of the grade structure of schools, the pairing of schools, or the clustering of schools, or any combination of grade restructuring, pairing or clustering. The prohibition described in this section does not include the establishment of magnet schools.

SEC. 303. No funds appropriated under this Act may be used to prevent the implementation of programs of voluntary prayer and meditation in the public schools.

(TRANSFER OF FUNDS)

SEC. 304. Not to exceed 1 percent of any discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended) which are appropriated for the Department of Education in this Act may be transferred between appropriations, but no such appropriation shall be increased by more than 3 percent by any such transfer: Provided, That the Appropriations Committees of both Houses of Congress are notified at least 15 days in advance of any transfer.

SEC. 305. IMPACT AID. Notwithstanding any other provision of this Act—

(1) the total amount appropriated under this title to carry out title VIII of the Elementary and Secondary Education Act of 1965 shall be $1,075,000,000;

(2) the total amount appropriated under this title for basic support payments under section 8003(b) of the Elementary and Secondary Education Act of 1965 shall be $853,000,000; and

(3) amounts made available for the administrative and related expenses of the Department of Labor, Health and Human Services, and Education, shall be further reduced on a pro rata basis by $35,000,000.

SEC. 306. (a) In addition to any amounts appropriated under this title for the loan forgiveness for child care providers program under section 428K of the Higher Education Act of 1965 (20 U.S.C. 1078–11), an additional $10,000,000 is appropriated to carry out such program.

(b) Notwithstanding any other provision of this Act, amounts made available under titles I and II, and this title, for salaries and expenses at the Departments of Labor, Health and Human Services, and Education, respectively, shall be reduced on a pro rata basis by $10,000,000.

SEC. 307. TECHNOLOGY AND MEDIA SERVICES. Notwithstanding any other provision of this Act—

(1) the total amount appropriated under this title under the heading ''OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES'' under the heading ''SPECIAL EDUCATION'' to carry out the Individuals with Disabilities Education Act shall be $7,353,141,000, of which $35,323,000 shall be available for technology and media services; and

(2) the total amount appropriated under this title under the heading ''DEPARTMENTAL MANAGEMENT'' under the heading ''PROGRAM ADMINISTRATION'' shall be further reduced by $800,000.

SEC. 308. (a) In addition to any amounts appropriated under this title for the Perkin's loan cancellation program under section 465 of the Higher Education Act of 1965 (20 U.S.C. 1087ee), an additional $15,000,000 is appropriated to carry out such program.

(b) Notwithstanding any other provision of this Act, amounts made available under titles I and II, and this title, for salaries and expenses at the Departments of Labor, Health and Human Services, and Education, respectively, shall be further reduced on a pro rata basis by $15,000,000.

SEC. 309. The Comptroller General of the United States shall evaluate the extent to which funds made available under part A of title I of the Elementary and Secondary Education Act of 1965 are allocated to schools and local educational agencies with the greatest concentrations of school-age children from low-income families, the extent to which allocations of such funds adjust to shifts in concentrations of pupils from low-income families in different regions, States, and substate areas, the extent to which the allocation of such funds encourages the targeting of State funds to areas with higher concentrations of children from low-income families, the implications of current distribution methods for such funds, and formula and other policy recommendations to improve the targeting of such funds to more effectively serve low-income children in both rural and urban areas, and for preparing interim and final reports based on the results of the study, to be submitted to Congress not later than February 1, 2001, and April 1, 2001.

SEC. 310. The amount made available under this title under the heading ''OFFICE OF POSTSECONDARY EDUCATION'' under the heading ''HIGHER EDUCATION'' to carry out section 316 of the Higher Education Act of 1965 is increased by $5,000,000, which increase shall be used for construction and renovation projects under such section; and the amount made available under this title under the heading ''OFFICE OF POSTSECONDARY EDUCATION'' under the heading ''HIGHER EDUCATION'' to carry out part B of title VII of the Higher Education Act of 1965 is decreased by $5,000,000.

TITLE IV—RELATED AGENCIES

ARMED FORCES RETIREMENT HOME

ARMED FORCES RETIREMENT HOME

For expenses necessary for the Armed Forces Retirement Home to operate and maintain the United States Soldiers' and Airmen's Home and the United States Naval Home, to be paid from funds available in the Armed Forces Retirement Home Trust Fund, $69,832,000, of which $9,832,000 shall remain available until expended for construction and renovation of the physical plants at the United States Soldiers' and Airmen's Home and the United States Naval Home: Provided, That, notwithstanding any other provision of law, a single contract or related contracts for development and construction, to include construction of a long-term care facility at the United States Naval Home, may be employed which collectively include the full scope of the project: Provided further, That the solicitation and contract shall contain the clause ''availability of funds'' found at 48 CFR 52.232–18 and 252.232–7007, Limitation of Government Obligations. In addition, for completion of the long-term care facility at the United States Naval Home, $6,228,000 to become available on October 1, 2001, and remain available until expended.

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

DOMESTIC VOLUNTEER SERVICE PROGRAMS, OPERATING EXPENSES

For expenses necessary for the Corporation for National and Community Service to carry out the provisions of the Domestic Volunteer Service Act of 1973, as amended, $302,504,000: Provided, That none of the funds made available to the Corporation for National and Community Service in this Act for activities authorized by part E of title II of the Domestic Volunteer Service Act of 1973 shall be used to provide stipends or other monetary incentives to volunteers or volunteer leaders whose incomes exceed 125 percent of the national poverty level.

CORPORATION FOR PUBLIC BROADCASTING

For payment to the Corporation for Public Broadcasting, as authorized by the Communications Act of 1934, an amount which shall be available within limitations specified by that Act, for the fiscal year 2003, $365,000,000: Provided, That no funds made available to the Corporation for Public Broadcasting by this Act shall be used to pay for receptions, parties, or similar forms of entertainment for Government officials or employees: Provided further, That none of the funds contained in this paragraph shall be available or used to aid or support any program or activity from which any person is excluded, or is denied benefits, or is discriminated against, on the basis of race, color, national origin, religion, or sex: Provided further, That in addition to the amounts provided above, $20,000,000, to remain available until expended, shall be for digitalization, pending enactment of authorizing legislation.

FEDERAL MEDIATION AND CONCILIATION SERVICE

SALARIES AND EXPENSES

For expenses necessary for the Federal Mediation and Conciliation Service to carry out the functions vested in it by the Labor Management Relations Act, 1947 (29 U.S.C. 171–180, 182–183), including hire of passenger motor vehicles; for expenses necessary for the Labor-Management Cooperation Act of 1978 (29 U.S.C. 175a); and for expenses necessary for the Service to carry out the functions vested in it by the Civil Service Reform Act, Public Law 95–454 (5 U.S.C. ch. 71), $38,200,000, including $1,500,000, to remain available through September 30, 2002, for activities authorized by the Labor-Management Cooperation Act of 1978 (29 U.S.C. 175a): Provided, That notwithstanding 31 U.S.C. 3302, fees charged, up to full-cost recovery, for special training activities and other conflict resolution services and technical assistance, including those provided to foreign governments and international organizations, and for arbitration services shall be credited to and merged with this account, and shall remain available until expended: Provided further, That fees for arbitration services shall be available only for education, training, and professional development of the agency workforce: Provided further, That the Director of the Service is authorized to accept and use on behalf of the United States gifts of services and real, personal, or other property in the aid of any projects or functions within the Director's jurisdiction.

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

SALARIES AND EXPENSES

For expenses necessary for the Federal Mine Safety and Health Review Commission (30 U.S.C. 801 et seq.), $6,320,000.

INSTITUTE OF MUSEUM AND LIBRARY SERVICES

OFFICE OF LIBRARY SERVICES: GRANTS AND ADMINISTRATION

For carrying out subtitle B of the Museum and Library Services Act, $168,000,000, to remain available until expended.

MEDICARE PAYMENT ADVISORY COMMISSION

SALARIES AND EXPENSES

For expenses necessary to carry out section 1805 of the Social Security Act, $8,000,000, to be transferred to this appropriation from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds.

NATIONAL COMMISSION ON LIBRARIES AND INFORMATION SCIENCE

SALARIES AND EXPENSES

For necessary expenses for the National Commission on Libraries and Information Science, established by the Act of July 20, 1970 (Public Law 91–345, as amended), $1,495,000.

NATIONAL COUNCIL ON DISABILITY

SALARIES AND EXPENSES

For expenses necessary for the National Council on Disability as authorized by title IV of the Rehabilitation Act of 1973, as amended, $2,615,000.

NATIONAL EDUCATION GOALS PANEL

For expenses necessary for the National Education Goals Panel, as authorized by title II, part A of the Goals 2000: Educate America Act, $2,350,000.

NATIONAL LABOR RELATIONS BOARD

SALARIES AND EXPENSES

For expenses necessary for the National Labor Relations Board to carry out the functions vested in it by the Labor-Management Relations Act, 1947, as amended (29 U.S.C. 141–167), and other laws, $216,438,000: Provided, That no part of this appropriation shall be available to organize or assist in organizing agricultural laborers or used in connection with investigations, hearings, directives, or orders concerning bargaining units composed of agricultural laborers as referred to in section 2(3) of the Act of July 5, 1935 (29 U.S.C. 152), and as amended by the Labor-Management Relations Act, 1947, as amended, and as defined in section 3(f) of the Act of June 25, 1938 (29 U.S.C. 203), and including in said definition employees engaged in the maintenance and operation of ditches, canals, reservoirs, and waterways when maintained or operated on a mutual, nonprofit basis and at least 95 percent of the water stored or supplied thereby is used for farming purposes.

NATIONAL MEDIATION BOARD

SALARIES AND EXPENSES

For expenses necessary to carry out the provisions of the Railway Labor Act, as amended (45 U.S.C. 151–188), including emergency boards appointed by the President, $10,400,000.

OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

SALARIES AND EXPENSES

For expenses necessary for the Occupational Safety and Health Review Commission (29 U.S.C. 661), $8,720,000.

RAILROAD RETIREMENT BOARD

DUAL BENEFITS PAYMENTS ACCOUNT

For payment to the Dual Benefits Payments Account, authorized under section 15(d) of the Railroad Retirement Act of 1974, $160,000,000, which shall include amounts becoming available in fiscal year 2001 pursuant to section 224(c)(1)(B) of Public Law 98–76; and in addition, an amount, not to exceed 2 percent of the amount provided herein, shall be available proportional to the amount by which the product of recipients and the average benefit received exceeds $160,000,000: Provided, That the total amount provided herein shall be credited in 12 approximately equal amounts on the first day of each month in the fiscal year.

FEDERAL PAYMENTS TO THE RAILROAD RETIREMENT ACCOUNTS

For payment to the accounts established in the Treasury for the payment of benefits under the Railroad Retirement Act for interest earned on unnegotiated checks, $150,000, to remain available through September 30, 2002, which shall be the maximum amount available for payment pursuant to section 417 of Public Law 98–76.

LIMITATION ON ADMINISTRATION

For necessary expenses for the Railroad Retirement Board for administration of the Railroad Retirement Act and the Railroad Unemployment Insurance Act, $92,500,000, to be derived in such amounts as determined by the Board from the railroad retirement accounts and from moneys credited to the railroad unemployment insurance administration fund.

LIMITATION ON THE OFFICE OF INSPECTOR GENERAL

For expenses necessary for the Office of Inspector General for audit, investigatory and review activities, as authorized by the Inspector General Act of 1978, as amended, not more than $5,700,000, to be derived from the railroad retirement accounts and railroad unemployment insurance account: Provided, That none of the funds made available in any other paragraph of this Act may be transferred to the Office; used to carry out any such transfer; used to provide any office space, equipment, office supplies, communications facilities or services, maintenance services, or administrative services for the Office; used to pay any salary, benefit, or award for any personnel of the Office; used to pay any other operating expense of the Office; or used to reimburse the Office for any service provided, or expense incurred, by the Office.

SOCIAL SECURITY ADMINISTRATION

PAYMENTS TO SOCIAL SECURITY TRUST FUNDS

For payment to the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance trust funds, as provided under sections 201(m), 228(g), and 1131(b)(2) of the Social Security Act, $20,400,000.

SPECIAL BENEFITS FOR DISABLED COAL MINERS

For carrying out title IV of the Federal Mine Safety and Health Act of 1977, $365,748,000, to remain available until expended.

For making, after July 31 of the current fiscal year, benefit payments to individuals under title IV of the Federal Mine Safety and Health Act of 1977, for costs incurred in the current fiscal year, such amounts as may be necessary.

For making benefit payments under title IV of the Federal Mine Safety and Health Act of 1977 for the first quarter of fiscal year 2002, $114,000,000, to remain available until expended.

SUPPLEMENTAL SECURITY INCOME PROGRAM

For carrying out titles XI and XVI of the Social Security Act, section 401 of Public Law 92–603, section 212 of Public Law 93–66, as amended, and section 405 of Public Law 95–216, including payment to the Social Security trust funds for administrative expenses incurred pursuant to section 201(g)(1) of the Social Security Act, $23,053,000,000, to remain available until expended: Provided, That any portion of the funds provided to a State in the current fiscal year and not obligated by the State during that year shall be returned to the Treasury.

From funds provided under the previous paragraph, not less than $100,000,000 shall be available for payment to the Social Security trust funds for administrative expenses for conducting continuing disability reviews.

In addition, $210,000,000, to remain available until September 30, 2002, for payment to the Social Security trust funds for administrative expenses for continuing disability reviews as authorized by section 103 of Public Law 104–121 and section 10203 of Public Law 105–33. The term ''continuing disability reviews'' means reviews and redeterminations as defined under section 201(g)(1)(A) of the Social Security Act, as amended.

For making, after June 15 of the current fiscal year, benefit payments to individuals under title XVI of the Social Security Act, for unanticipated costs incurred for the current fiscal year, such sums as may be necessary.

For making benefit payments under title XVI of the Social Security Act for the first quarter of fiscal year 2002, $10,470,000,000, to remain available until expended.

LIMITATION ON ADMINISTRATIVE EXPENSES

For necessary expenses, including the hire of two passenger motor vehicles, and not to exceed $10,000 for official reception and representation expenses, not more than $6,469,800,000 may be expended, as authorized by section 201(g)(1) of the Social Security Act, from any one or all of the trust funds referred to therein: Provided, That not less than $1,800,000 shall be for the Social Security Advisory Board: Provided further, That unobligated balances at the end of fiscal year 2001 not needed for fiscal year 2001 shall remain available until expended to invest in the Social Security Administration information technology and telecommunications hardware and software infrastructure, including related equipment and non-payroll administrative expenses.

From funds provided under the first paragraph, not less than $200,000,000 shall be available for conducting continuing disability reviews.

In addition to funding already available under this heading, and subject to the same terms and conditions, $450,000,000, to remain available until September 30, 2002, for continuing disability reviews as authorized by section 103 of Public Law 104–121 and section 10203 of Public Law 105–33. The term ''continuing disability reviews'' means reviews and redeterminations as defined under section 201(g)(1)(A) of the Social Security Act, as amended.

In addition, $91,000,000 to be derived from administration fees in excess of $5.00 per supplementary payment collected pursuant to section 1616(d) of the Social Security Act or section 212(b)(3) of Public Law 93–66, which shall remain available until expended. To the extent that the amounts collected pursuant to such section 1616(d) or 212(b)(3) in fiscal year 2001 exceed $91,000,000, the amounts shall be available in fiscal year 2002 only to the extent provided in advance in appropriations Acts.

From funds previously appropriated for this purpose, any unobligated balances at the end of fiscal year 2000 shall be available to continue Federal-State partnerships which will evaluate means to promote Medicare buy-in programs targeted to elderly and disabled individuals under titles XVIII and XIX of the Social Security Act.

OFFICE OF INSPECTOR GENERAL

(INCLUDING TRANSFER OF FUNDS)

For expenses necessary for the Office of Inspector General in carrying out the provisions of the Inspector General Act of 1978, as amended, $16,944,000, together with not to exceed $52,500,000, to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund.

In addition, an amount not to exceed 3 percent of the total provided in this appropriation may be transferred from the ''Limitation on Administrative Expenses'', Social Security Administration, to be merged with this account, to be available for the time and purposes for which this account is available: Provided, That notice of such transfers shall be transmitted promptly to the Committees on Appropriations of the House and Senate.

UNITED STATES INSTITUTE OF PEACE

OPERATING EXPENSES

For necessary expenses of the United States Institute of Peace as authorized in the United States Institute of Peace Act, $12,951,000.

TITLE V—GENERAL PROVISIONS

SEC. 501. The Secretaries of Labor, Health and Human Services, and Education are authorized to transfer unexpended balances of prior appropriations to accounts corresponding to current appropriations provided in this Act: Provided, That such transferred balances are used for the same purpose, and for the same periods of time, for which they were originally appropriated.

SEC. 502. No part of any appropriation contained in this Act shall remain available for obligation beyond the current fiscal year unless expressly so provided herein.

SEC. 503. (a) No part of any appropriation contained in this Act shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress or any State legislature, except in presentation to the Congress or any State legislature itself.

(b) No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

SEC. 504. The Secretaries of Labor and Education are authorized to make available not to exceed $20,000 and $15,000, respectively, from funds available for salaries and expenses under titles I and III, respectively, for official reception and representation expenses; the Director of the Federal Mediation and Conciliation Service is authorized to make available for official reception and representation expenses not to exceed $2,500 from the funds available for ''Salaries and expenses, Federal Mediation and Conciliation Service''; and the Chairman of the National Mediation Board is authorized to make available for official reception and representation expenses not to exceed $2,500 from funds available for ''Salaries and expenses, National Mediation Board''.

SEC. 505. Notwithstanding any other provision of this Act, no funds appropriated under this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug unless the Secretary of Health and Human Services determines that such programs are effective in preventing the spread of HIV and do not encourage the use of illegal drugs.

SEC. 506. (a) PURCHASE OF AMERICAN-MADE EQUIPMENT AND PRODUCTS.—It is the sense of the Congress that, to the greatest extent practicable, all equipment and products purchased with funds made available in this Act should be American-made.

(b) NOTICE REQUIREMENT.—In providing financial assistance to, or entering into any contract with, any entity using funds made available in this Act, the head of each Federal agency, to the greatest extent practicable, shall provide to such entity a notice describing the statement made in subsection (a) by the Congress.

(c) PROHIBITION OF CONTRACTS WITH PERSONS FALSELY LABELING PRODUCTS AS MADE IN AMERICA.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a ''Made in America'' inscription, or any inscription with the same meaning, to any product sold in or shipped to the United States that is not made in the United States, the person shall be ineligible to receive any contract or subcontract made with funds made available in this Act, pursuant to the debarment, suspension, and ineligibility procedures described in sections 9.400 through 9.409 of title 48, Code of Federal Regulations.

SEC. 507. When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds included in this Act, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state: (1) the percentage of the total costs of the program or project which will be financed with Federal money; (2) the dollar amount of Federal funds for the project or program; and (3) percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

SEC. 508. (a) None of the funds appropriated under this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, shall be expended for any abortion.

(b) None of the funds appropriated under this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, shall be expended for health benefits coverage that includes coverage of abortion.

(c) The term ''health benefits coverage'' means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement.

SEC. 509. (a) The limitations established in the preceding section shall not apply to an abortion—

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

SEC. 510. (a) None of the funds made available in this Act may be used for—

(1) the creation of a human embryo or embryos for research purposes; or

(2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.208(a)(2) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).

(b) For purposes of this section, the term ''human embryo or embryos'' includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

SEC. 511. (a) LIMITATION ON USE OF FUNDS FOR PROMOTION OF LEGALIZATION OF CONTROLLED SUBSTANCES.—None of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established by section 202 of the Controlled Substances Act (21 U.S.C. 812).

(b) EXCEPTIONS.—The limitation in subsection (a) shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance or that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

SEC. 512. None of the funds made available in this Act may be obligated or expended to enter into or renew a contract with an entity if—

(1) such entity is otherwise a contractor with the United States and is subject to the requirement in section 4212(d) of title 38, United States Code, regarding submission of an annual report to the Secretary of Labor concerning employment of certain veterans; and

(2) such entity has not submitted a report as required by that section for the most recent year for which such requirement was applicable to such entity.

SEC. 513. Except as otherwise specifically provided by law, unobligated balances remaining available at the end of fiscal year 2000 from appropriations made available for salaries and expenses for fiscal year 2000 in this Act, shall remain available through December 31, 2001, for each such account for the purposes authorized: Provided, That the House and Senate Committees on Appropriations shall be notified at least 15 days prior to the obligation of such funds.

SEC. 514. None of the funds made available in this Act may be used to promulgate or adopt any final standard under section 1173(b) of the Social Security Act (42 U.S.C. 1320d–2(b)) providing for, or providing for the assignment of, a unique health identifier for an individual (except in an individual's capacity as an employer or a health care provider), until legislation is enacted specifically approving the standard.

SEC. 515. Section 410(b) of The Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106–170) is amended by striking ''2009'' both places it appears and inserting ''2001''.

SEC. 516. Amounts made available under this Act for the administrative and related expenses for departmental management for the Department of Labor, the Department of Health and Human Services, and the Department of Education shall be reduced on pro rata basis by $50,000,000.

SEC. 517. (a) None of the funds appropriated under this Act to carry out section 330 or title X of the Public Health Service Act (42 U.S.C. 254b, 300 et seq.), title V or XIX of the Social Security Act (42 U.S.C. 701 et seq., 1396 et seq.), or any other provision of law, shall be used for the distribution or provision of postcoital emergency contraception, or the provision of a prescription for postcoital emergency contraception, to an unemancipated minor, on the premises or in the facilities of any elementary school or secondary school.

(b) This section takes effect 1 day after the date of enactment of this Act.

(c) In this section:

(1) The terms ''elementary school'' and ''secondary school'' have the meanings given the terms in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801).

(2) The term ''unemancipated minor'' means an unmarried individual who is 17 years of age or younger and is a dependent, as defined in section 152(a) of the Internal Revenue Code of 1986.

SEC. 518. Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended by adding at the end the following:

''PART G—REQUIREMENT RELATING TO THE RIGHTS OF RESIDENTS OF CERTAIN FACILITIES

''SEC. 581. REQUIREMENT RELATING TO THE RIGHTS OF RESIDENTS OF CERTAIN FACILITIES.

''(a) IN GENERAL.—A public or private general hospital, nursing facility, intermediate care facility, residential treatment center, or other health care facility, that receives support in any form from any program supported in whole or in part with funds appropriated to any Federal department or agency shall protect and promote the rights of each resident of the facility, including the right to be free from physical or mental abuse, corporal punishment, and any restraints or involuntary seclusions imposed for purposes of discipline or convenience.

''(b) REQUIREMENTS.—Restraints and seclusion may only be imposed on a resident of a facility described in subsection (a) if—

''(1) the restraints or seclusion are imposed to ensure the physical safety of the resident, a staff member, or others; and

''(2) the restraints or seclusion are imposed only upon the written order of a physician, or other licensed independent practitioner permitted by the State and the facility to order such restraint or seclusion, that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

''(c) DEFINITIONS.—In this section:

''(1) RESTRAINTS.—The term 'restraints' means—

''(A) any physical restraint that is a mechanical or personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or any other methods that involves the physical holding of a resident for the purpose of conducting routine physical examinations or tests or to protect the resident from falling out of bed or to permit the resident to participate in activities without the risk of physical harm to the resident; and

''(B) a drug or medication that is used as a restraint to control behavior or restrict the resident's freedom of movement that is not a standard treatment for the resident's medical or psychiatric condition.

''(2) SECLUSION.—The term 'seclusion' means any separation of the resident from the general population of the facility that prevents the resident from returning to such population if he or she desires.

''SEC. 582. REPORTING REQUIREMENT.

''(a) IN GENERAL.— Each facility to which the Protection and Advocacy for Mentally Ill Individuals Act of 1986 applies shall notify the appropriate agency, as determined by the Secretary, of each death that occurs at each such facility while a patient is restrained or in seclusion, of each death occurring within 24 hours after the patient has been removed from restraints and seclusion, or where it is reasonable to assume that a patient's death is a result of such seclusion or restraint. A notification under this section shall include the name of the resident and shall be provided not later than 7 days after the date of the death of the individual involved.

''(b) FACILITY.—In this section, the term 'facility' has the meaning given the term 'facilities' in section 102(3) of the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10802(3)).''.

''SEC. 583. REGULATIONS AND ENFORCEMENT.

''(a) TRAINING.—Not later than 1 year after the date of enactment of this part, the Secretary, after consultation with appropriate State and local protection and advocacy organizations, physicians, facilities, and other health care professionals and patients, shall promulgate regulations that require facilities to which the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 et seq.) applies, to meet the requirements of subsection (b).

''(b) REQUIREMENTS.—The regulations promulgated under subsection (a) shall require that—

''(1) facilities described in subsection (a) ensure that there is an adequate number of qualified professional and supportive staff to evaluate patients, formulate written individualized, comprehensive treatment plans, and to provide active treatment measures;

''(2) appropriate training be provided for the staff of such facilities in the use of restraints and any alternatives to the use of restraints; and

''(3) such facilities provide complete and accurate notification of deaths, as required under section 582(a).

''(c) ENFORCEMENT.—A facility to which this part applies that fails to comply with any requirement of this part, including a failure to provide appropriate training, shall not be eligible for participation in any program supported in whole or in part by funds appropriated to any Federal department or agency.''.

SEC. 519. It is the sense of the Senate that each entity carrying out an Early Head Start program under the Head Start Act should—

(1) determine whether a child eligible to participate in the Early Head Start program has received a blood lead screening test, using a test that is appropriate for age and risk factors, upon the enrollment of the child in the program; and

(2) in the case of an child who has not received such a blood lead screening test, ensure that each enrolled child receives such a test either by referral or by performing the test (under contract or otherwise).

SEC. 520. (a) Whereas sexual abuse in schools between a student and a member of the school staff or a student and another student is a cause for concern in America;

(b) Whereas relatively few studies have been conducted on sexual abuse in schools and the extent of this problem is unknown;

(c) Whereas according to the Child Abuse and Neglect Reporting Act, a school administrator is required to report any allegation of sexual abuse to the appropriate authorities;

(d) Whereas an individual who is falsely accused of sexual misconduct with a student deserves appropriate legal and professional protections;

(e) Whereas it is estimated that many cases of sexual abuse in schools are not reported;

(f) Whereas many of the accused staff quietly resign at their present school district and are then rehired at a new district which has no knowledge of their alleged abuse;

(g) Therefore, it is the Sense of the Senate that the Secretary of Education should initiate a study and make recommendations to Congress and State and local governments on the issue of sexual abuse in schools.

TITLE VI—CHILDREN'S INTERNET PROTECTION

SEC. 601. SHORT TITLE. This title may be cited as the ''Childrens' Internet Protection Act''.

SEC. 602. REQUIREMENT FOR SCHOOLS AND LIBRARIES TO IMPLEMENT FILTERING OR BLOCKING TECHNOLOGY FOR COMPUTERS WITH INTERNET ACCESS AS CONDITION OF UNIVERSAL SERVICE DISCOUNTS. (a) SCHOOLS.—Section 254(h) of the Communications Act of 1934 (47 U.S.C. 254(h)) is amended—

(1) by redesignating paragraph (5) as paragraph (7); and

(2) by inserting after paragraph (4) the following new paragraph (5):

''(5) REQUIREMENTS FOR CERTAIN SCHOOLS WITH COMPUTERS HAVING INTERNET ACCESS.—

''(A) INTERNET FILTERING.—

''(i) IN GENERAL.—Except as provided in clause (ii), an elementary or secondary school having computers with Internet access may not receive services at discount rates under paragraph (1)(B) unless the school, school board, or other authority with responsibility for administration of the school—

''(I) submits to the Commission a certification described in subparagraph (B); and

''(II) ensures the use of such computers in accordance with the certification.

''(ii) APPLICABILITY.—The prohibition in paragraph (1) shall not apply with respect to a school that receives services at discount rates under paragraph (1)(B) only for purposes other than the provision of Internet access, Internet service, or internal connections.

''(B) CERTIFICATION.—A certification under this subparagraph is a certification that the school, school board, or other authority with responsibility for administration of the school—

''(i) has selected a technology for its computers with Internet access in order to filter or block Internet access through such computers to—

''(I) material that is obscene; and

''(II) child pornography; and

''(ii) is enforcing a policy to ensure the operation of the technology during any use of such computers by minors.

''(C) ADDITIONAL USE OF TECHNOLOGY.—A school, school board, or other authority may also use a technology covered by a certification under subparagraph (B) to filter or block Internet access through the computers concerned to any material in addition to the material specified in that subparagraph that the school, school board, or other authority determines to be inappropriate for minors.

''(D) TIMING OF CERTIFICATIONS.—

''(i) SCHOOLS WITH COMPUTERS ON EFFECTIVE DATE.—

''(I) IN GENERAL.—Subject to subclause (II), in the case of any school covered by this paragraph as of the effective date of this paragraph under section 602(h) of the Childrens' Internet Protection Act, the certification under subparagraph (B) shall be made not later than 30 days after such effective date.

''(II) DELAY.—A certification for a school covered by subclause (I) may be made at a date that is later than is otherwise required by that subclause if State or local procurement rules or regulations or competitive bidding requirements prevent the making of the certification on the date otherwise required by that subclause. A school, school board, or other authority with responsibility for administration of the school shall notify the Commission of the applicability of this subclause to the school. Such notice shall specify the date on which the certification with respect to the school shall be effective for purposes of this clause.

''(ii) SCHOOLS ACQUIRING COMPUTERS AFTER EFFECTIVE DATE.—In the case of any school that first becomes covered by this paragraph after such effective date, the certification under subparagraph (B) shall be made not later than 10 days after the date on which the school first becomes so covered.

''(iii) NO REQUIREMENT FOR ADDITIONAL CERTIFICATIONS.—A school that has submitted a certification under subparagraph (B) shall not be required for purposes of this paragraph to submit an additional certification under that subparagraph with respect to any computers having Internet access that are acquired by the school after the submittal of the certification.

''(E) NONCOMPLIANCE.—

''(i) FAILURE TO SUBMIT CERTIFICATION.—Any school that knowingly fails to submit a certification required by this paragraph shall reimburse each telecommunications carrier that provided such school services at discount rates under paragraph (1)(B) after the effective date of this paragraph under section 602(h) of the Childrens' Internet Protection Act in an amount equal to the amount of the discount provided such school by such carrier for such services during the period beginning on such effective date and ending on the date on which the provision of such services at discount rates under paragraph (1)(B) is determined to cease under subparagraph (F).

''(ii) FAILURE TO COMPLY WITH CERTIFICATION.—Any school that knowingly fails to ensure the use of its computers in accordance with a certification under subparagraph (B) shall reimburse each telecommunications carrier that provided such school services at discount rates under paragraph (1)(B) after the date of such certification in an amount equal to the amount of the discount provided such school by such carrier for such services during the period beginning on the date of such certification and ending on the date on which the provision of such services at discount rates under paragraph (1)(B) is determined to cease under subparagraph (F).

''(iii) TREATMENT OF REIMBURSEMENT.—The receipt by a telecommunications carrier of any

reimbursement under this subparagraph shall not affect the carrier's treatment of the discount on which such reimbursement was based in accordance with the third sentence of paragraph (1)(B).

''(F) CESSATION DATE.—

''(i) DETERMINATION.—The Commission shall determine the date on which the provision of services at discount rates under paragraph (1)(B) shall cease under this paragraph by reason of the failure of a school to comply with the requirements of this paragraph.

''(ii) NOTIFICATION.—The Commission shall notify telecommunications carriers of each school determined to have failed to comply with the requirements of this paragraph and of the period for which such school shall be liable to make reimbursement under subparagraph (E).

''(G) RECOMMENCEMENT OF DISCOUNTS.—

''(i) RECOMMENCEMENT.—Upon submittal to the Commission of a certification under subparagraph (B) with respect to a school to which clause (i) or (ii) of subparagraph (E) applies, the school shall be entitled to services at discount rates under paragraph (1)(B).

''(ii) NOTIFICATION.—The Commission shall notify the school and telecommunications carriers of the recommencement of the school's entitlement to services at discount rates under this subparagraph and of the date on which such recommencement begins.

''(iii) ADDITIONAL NONCOMPLIANCE.—The provisions of subparagraphs (E) and (F) shall apply to any certification submitted under clause (i).

''(H) PUBLIC AVAILABILITY OF POLICY.—A school, school board, or other authority that enforces a policy under subparagraph (B)(ii) shall take appropriate actions to ensure the ready availability to the public of information on such policy and on its policy, if any, relating to the use of technology under subparagraph (C).

''(I) LIMITATION ON FEDERAL ACTION.—

''(i) IN GENERAL.—No agency or instrumentality of the United States Government may—

''(I) establish any criteria for making a determination under subparagraph (C);

''(II) review a determination made by a school, school board, or other authority for purposes of a certification under subparagraph (B); or

''(III) consider the criteria employed by a school, school board, or other authority for purposes of determining the eligibility of a school for services at discount rates under paragraph (1)(B).

''(ii) ACTION BY COMMISSION.—The Commission may not take any action against a school, school board, or other authority for a violation of a provision of this paragraph if the school, school board, or other authority, as the case may be, has made a good faith effort to comply with such provision.''.

(b) LIBRARIES.—Such section 254(h) is further amended by inserting after paragraph (5), as amended by subsection (a) of this section, the following new paragraph:

''(6) REQUIREMENTS FOR CERTAIN LIBRARIES WITH COMPUTERS HAVING INTERNET ACCESS.—

''(A) INTERNET FILTERING.—

''(i) IN GENERAL.—A library having one or more computers with Internet access may not receive services at discount rates under paragraph (1)(B) unless the library—

''(I) submits to the Commission a certification described in subparagraph (B); and

''(II) ensures the use of such computers in accordance with the certification.

''(ii) APPLICABILITY.—The prohibition in paragraph (1) shall not apply with respect to a library that receives services at discount rates under paragraph (1)(B) only for purposes other than the provision of Internet access, Internet service, or internal connections.

''(B) CERTIFICATION.—

''(i) ACCESS OF MINORS TO CERTAIN MATERIAL.—A certification under this subparagraph is a certification that the library—

''(I) has selected a technology for its computer or computers with Internet access in order to filter or block Internet access through such computer or computers to—

''(aa) material that is obscene;

''(bb) child pornography; and

''(cc) any other material that the library determines to be inappropriate for minors; and

''(II) is enforcing a policy to ensure the operation of the technology during any use of such computer or computers by minors.

''(ii) ACCESS TO CHILD PORNOGRAPHY GENERALLY.—

''(I) IN GENERAL.—A certification under this subparagraph with respect to a library is also a certification that the library—

''(aa) has selected a technology for its computer or computers with Internet access in order to filter or block Internet access through such computer or computers to child pornography; and

''(bb) is enforcing a policy to ensure the operation of the technology during any use of such computer or computers.

''(II) SCOPE.—For purposes of identifying child pornography under subclause (I), a library may utilize the definition of that term in section 2256(8) of title 18, United States Code.

''(III) RELATIONSHIP TO OTHER CERTIFICATIONS.—The certification under this clause is in addition to any other certification applicable with respect to a library under this subparagraph.

''(C) ADDITIONAL USE OF TECHNOLOGY.—A library may also use a technology covered by a certification under subparagraph (B) to filter or block Internet access through the computers concerned to any material in addition to the material specified in that subparagraph that the library determines to be inappropriate for minors.

''(D) TIMING OF CERTIFICATIONS.—

''(i) LIBRARIES WITH COMPUTERS ON EFFECTIVE DATE.—

''(I) IN GENERAL.—In the case of any library covered by this paragraph as of the effective date of this paragraph under section 602(h) of the Childrens' Internet Protection Act, the certifications under subparagraph (B) shall be made not later than 30 days after such effective date.

''(II) DELAY.—The certifications for a library covered by subclause (I) may be made at a date than is later than is otherwise required by that subclause if State or local procurement rules or regulations or competitive bidding requirements prevent the making of the certifications on the date otherwise required by that subclause. A library shall notify the Commission of the applicability of this subclause to the library. Such notice shall specify the date on which the certifications with respect to the library shall be effective for purposes of this clause.

''(ii) LIBRARIES ACQUIRING COMPUTERS AFTER EFFECTIVE DATE.—In the case of any library that first becomes subject to the certifications under subparagraph (B) after such effective date, the certifications under that subparagraph shall be made not later than 10 days after the date on which the library first becomes so subject.

''(iii) NO REQUIREMENT FOR ADDITIONAL CERTIFICATIONS.—A library that has submitted the certifications under subparagraph (B) shall not be required for purposes of this paragraph to submit an additional certifications under that subparagraph with respect to any computers having Internet access that are acquired by the library after the submittal of such certifications.

''(E) NONCOMPLIANCE.—

''(i) FAILURE TO SUBMIT CERTIFICATION.—Any library that knowingly fails to submit the certifications required by this paragraph shall reimburse each telecommunications carrier that provided such library services at discount rates under paragraph (1)(B) after the effective date of this paragraph under section 602(h) of the Childrens' Internet Protection Act in an amount equal to the amount of the discount provided such library by such carrier for such services during the period beginning on such effective date and ending on the date on which the provision of such services at discount rates under paragraph (1)(B) is determined to cease under subparagraph (F).

''(ii) FAILURE TO COMPLY WITH CERTIFICATION.—Any library that knowingly fails to ensure the use of its computers in accordance with a certification under subparagraph (B) shall reimburse each telecommunications carrier that provided such library services at discount rates under paragraph (1)(B) after the date of such certification in an amount equal to the amount of the discount provided such library by such carrier for such services during the period beginning on the date of such certification and ending on the date on which the provision of such services at discount rates under paragraph (1)(B) is determined to cease under subparagraph (F).

''(iii) TREATMENT OF REIMBURSEMENT.—The receipt by a telecommunications carrier of any reimbursement under this subparagraph shall not affect the carrier's treatment of the discount on which such reimbursement was based in accordance with the third sentence of paragraph (1)(B).

''(F) CESSATION DATE.—

''(i) DETERMINATION.—The Commission shall determine the date on which the provision of services at discount rates under paragraph (1)(B) shall cease under this paragraph by reason of the failure of a library to comply with the requirements of this paragraph.

''(ii) NOTIFICATION.—The Commission shall notify telecommunications carriers of each library determined to have failed to comply with the requirements of this paragraph and of the period for which such library shall be liable to make reimbursement under subparagraph (E).

''(G) RECOMMENCEMENT OF DISCOUNTS.—

''(i) RECOMMENCEMENT.—Upon submittal to the Commission of a certification under subparagraph (B) with respect to a library to which clause (i) or (ii) of subparagraph (E) applies, the library shall be entitled to services at discount rates under paragraph (1)(B).

''(ii) NOTIFICATION.—The Commission shall notify the library and telecommunications carriers of the recommencement of the library's entitlement to services at discount rates under this paragraph and of the date on which such recommencement begins.

''(iii) ADDITIONAL NONCOMPLIANCE.—The provisions of subparagraphs (E) and (F) shall apply to any certification submitted under clause (i).

''(H) PUBLIC AVAILABILITY OF POLICY.—A library that enforces a policy under clause (i)(II) or (ii)(I)(bb) of subparagraph (B) shall take appropriate actions to ensure the ready availability to the public of information on such policy and on its policy, if any, relating to the use of technology under subparagraph (C).

''(I) LIMITATION ON FEDERAL ACTION.—

''(i) IN GENERAL.—No agency or instrumentality of the United States Government may—

''(I) establish any criteria for making a determination under subparagraph (C);

''(II) review a determination made by a library for purposes of a certification under subparagraph (B); or

''(III) consider the criteria employed by a library purposes of determining the eligibility of the library for services at discount rates under paragraph (1)(B).

''(ii) ACTION BY COMMISSION.—The Commission may not take any action against a library for a violation of a provision of this paragraph if the library has made a good faith effort to comply with such provision.''.

(c) MINOR DEFINED.—Paragraph (7) of such section, as redesignated by subsection (a)(1) of this section, is amended by adding at the end the following:

''(D) MINOR.—The term 'minor' means any individual who has not attained the age of 17 years.''.

(d) CONFORMING AMENDMENT.—Paragraph (4) of such section is amended by striking ''paragraph (5)(A)'' and inserting ''paragraph (7)(A)''.

(e) SEPARABILITY.—If any provision of paragraph (5) or (6) of section 254(h) of the Communications Act of 1934, as amended by this section, or the application thereof to any person or circumstance is held invalid, the remainder of such paragraph and the application of such paragraph to other persons or circumstances shall not be affected thereby.

(f) REGULATIONS.—

(1) REQUIREMENT.—The Federal Communications Commission shall prescribe regulations for purposes of administering the provisions of paragraphs (5) and (6) of section 254(h) of the Communications Act of 1934, as amended by this section.

(2) DEADLINE.—Notwithstanding any other provision of law, the requirements prescribed under paragraph (1) shall take effect 120 days after the date of the enactment of this Act.

(g) AVAILABILITY OF RATES.—Discounted rates under section 254(h)(1)(B) of the Communications Act of 1934 (47 U.S.C. 254(h)(1)(B))—

(1) shall be available in amounts up to the annual cap on Federal universal service support for schools and libraries only for services covered by Federal Communications Commission regulations on priorities for funding telecommunications services, Internet access, Internet services, and Internet connections that assign priority for available funds for the poorest schools; and

(2) to the extent made available under paragraph (1), may be used for the purchase or acquisition of filtering or blocking products necessary to meet the requirements of section 254(h)(5) and (6) of that Act, but not for the purchase of software or other technology other than what is required to meet those requirements.

(h) EFFECTIVE DATE.—The amendments made by this section shall take effect 120 days after the date of the enactment of this Act.

SEC. 603. FETAL TISSUE. The General Accounting Office shall conduct a comprehensive study into Federal involvement in the use of fetal tissue for research purposes within the scope of this Act to be completed by September 1, 2000. The study shall include but not be limited to—

(1) the annual number of orders for fetal tissue filled in conjunction with federally funded fetal tissue research or programs over the last 3 years;

(2) the costs associated with the procurement, dissemination, and other use of fetal tissue, including but not limited to the costs associated with the processing, transportation, preservation, quality control, and storage of such tissue;

(3) the manner in which Federal agencies ensure that intramural and extramural research facilities and their employees comply with Federal fetal tissue law;

(4) the number of fetal tissue procurement contractors and tissue resource sources, or other entities or individuals that are used to obtain, transport, process, preserve, or store fetal tissue, which receive Federal funds and the quantity, form, and nature of the services provided and the amount of Federal funds received by such entities;

(5) the number and identity of all Federal agencies within the scope of this Act expending or exchanging Federal funds in connection with obtaining or processing fetal tissue or the conduct of research using such tissue;

(6) the extent to which Federal fetal tissue procurement policies and guidelines adhere to Federal law;

(7) the criteria that Federal fetal tissue research facilities use for selecting their fetal tissue sources, and the manner in which the facilities ensure that such sources comply with Federal law.

SEC. 604. PROVISION OF INTERNET FILTERING OR SCREENING SOFTWARE BY CERTAIN INTERNET SERVICE PROVIDERS. (a) REQUIREMENT TO PROVIDE.—Each Internet service provider shall at the time of entering an agreement with a residential customer for the provision of Internet access services, provide to such customer, either at no fee or at a fee not in excess of the amount specified in subsection (c), computer software or other filtering or blocking system that allows the customer to prevent the access of minors to material on the Internet.

(b) SURVEYS OF PROVISION OF SOFTWARE OR SYSTEMS.—

(1) SURVEYS.—The Office of Juvenile Justice and Delinquency Prevention of the Department of Justice and the Federal Trade Commission shall jointly conduct surveys of the extent to which Internet service providers are providing computer software or systems described in subsection (a) to their subscribers. In performing such surveys, neither the Department nor the Commission shall collect personally identifiable information of subscribers of the Internet service providers.

(2) FREQUENCY.—The surveys required by paragraph (1) shall be completed as follows:

(A) One shall be completed not later than one year after the date of the enactment of this Act.

(B) One shall be completed not later than two years after that date.

(C) One shall be completed not later than three years after that date.

(c) FEES.—The fee, if any, charged and collected by an Internet service provider for providing computer software or a system described in subsection (a) to a residential customer shall not exceed the amount equal to the cost of the provider in providing the software or system to the subscriber, including the cost of the software or system and of any license required with respect to the software or system.

(d) APPLICABILITY.—The requirement described in subsection (a) shall become effective only if—

(1) 1 year after the date of the enactment of this Act, the Office and the Commission determine as a result of the survey completed by the deadline in subsection (b)(2)(A) that less than 75 percent of the total number of residential subscribers of Internet service providers as of such deadline are provided computer software or systems described in subsection (a) by such providers;

(2) 2 years after the date of enactment of this Act, the Office and the Commission determine as a result of the survey completed by the deadline in subsection (b)(2)(B) that less than 85 percent of the total number of residential subscribers of Internet service providers as of such deadline are provided such software or systems by such providers; or

(3) 3 years after the date of the enactment of this Act, if the Office and the Commission determine as a result of the survey completed by the deadline in subsection (b)(2)(C) that less than 100 percent of the total number of residential subscribers of Internet service providers as of such deadline are provided such software or systems by such providers.

(e) INTERNET SERVICE PROVIDER DEFINED.—In this section, the term ''Internet service provider'' means a service provider as defined in section 512(k)(1)(A) of title 17, United States Code, which has more than 50,000 subscribers.

TITLE VII—UNIVERSAL SERVICE FOR SCHOOLS AND LIBRARIES

SEC. 701. SHORT TITLE. This title may be cited as the ''Neighborhood Children's Internet Protection Act''.

SEC. 702. NO UNIVERSAL SERVICE FOR SCHOOLS OR LIBRARIES THAT FAIL TO IMPLEMENT A FILTERING OR BLOCKING SYSTEM FOR COMPUTERS WITH INTERNET ACCESS OR ADOPT INTERNET USE POLICIES. (a) NO UNIVERSAL SERVICE.—

(1) IN GENERAL.—Section 254 of the Communications Act of 1934 (47 U.S.C. 254) is amended by adding at the end the following:

''(l) IMPLEMENTATION OF INTERNET FILTERING OR BLOCKING SYSTEM OR USE POLICIES.—

''(1) IN GENERAL.—No services may be provided under subsection (h)(1)(B) to any elementary or secondary school, or any library, unless it provides the certification required by paragraph (2) to the Commission or its designee.

''(2) CERTIFICATION.—A certification under this paragraph with respect to a school or library is a certification by the school, school board, or other authority with responsibility for administration of the school, or the library, or any other entity representing the school or library in applying for universal service assistance, that the school or library—

''(A) has—

''(i) selected a system for its computers with Internet access that are dedicated to student use in order to filter or block Internet access to matter considered to be inappropriate for minors; and

''(ii) installed on such computers, or upon obtaining such computers will install on such computers, a system to filter or block Internet access to such matter; or

''(B)(i) has adopted and implemented an Internet use policy that addresses—

''(I) access by minors to inappropriate matter on the Internet and World Wide Web;

''(II) the safety and security of minors when using electronic mail, chat rooms, and other forms of direct electronic communications;

''(III) unauthorized access, including so-called 'hacking', and other unlawful activities by minors online;

''(IV) unauthorized disclosure, use, and dissemination of personal identification information regarding minors; and

''(V) whether the school or library, as the case may be, is employing hardware, software, or other technological means to limit, monitor, or otherwise control or guide Internet access by minors; and

''(ii) provided reasonable public notice and held at least one public hearing or meeting which addressed the proposed Internet use policy.

''(3) LOCAL DETERMINATION OF CONTENT.—For purposes of a certification under paragraph (2), the determination regarding what matter is inappropriate for minors shall be made by the school board, library, or other authority responsible for making the determination. No agency or instrumentality of the United States Government may—

''(A) establish criteria for making such determination;

''(B) review the determination made by the certifying school, school board, library, or other authority; or

''(C) consider the criteria employed by the certifying school, school board, library, or other authority in the administration of subsection (h)(1)(B).

''(4) EFFECTIVE DATE.—This subsection shall apply with respect to schools and libraries seeking universal service assistance under subsection (h)(1)(B) on or after July 1, 2001.''.

(2) CONFORMING AMENDMENT.—Subsection (h)(1)(B) of that section is amended by striking ''All telecommunications'' and inserting ''Except as provided by subsection (l), all telecommunications''.

(b) STUDY.—Not later than 150 days after the date of the enactment of this Act, the National Telecommunications and Information Administration shall initiate a notice and comment proceeding for purposes of—

(1) evaluating whether or not currently available commercial Internet blocking, filtering, and monitoring software adequately addresses the needs of educational institutions;

(2) making recommendations on how to foster the development of products which meet such needs; and

(3) evaluating the development and effectiveness of local Internet use policies that are currently in operation after community input.

SEC. 703. IMPLEMENTING REGULATIONS. Not later than 100 days after the date of the enactment of this Act, the Federal Communications Commission shall adopt rules implementing this title and the amendments made by this title.

TITLE VIII—SOCIAL SECURITY AND MEDICARE OFF-BUDGET LOCKBOX ACT OF 2000

SEC. 801. SHORT TITLE. This title may be cited as the ''Social Security and Medicare Off-Budget Lockbox Act of 2000''.

SEC. 802. STRENGTHENING SOCIAL SECURITY POINTS OF ORDER. (a) IN GENERAL.—Section 312 of the Congressional Budget Act of 1974 (2 U.S.C. 643) is amended by inserting at the end the following:

''(g) STRENGTHENING SOCIAL SECURITY POINT OF ORDER.—It shall not be in order in the House of Representatives or the Senate to consider a concurrent resolution on the budget (or any amendment thereto or conference report thereon) or any bill, joint resolution, amendment, motion, or conference report that would violate or amend section 13301 of the Budget Enforcement Act of 1990.''.

(b) SUPER MAJORITY REQUIREMENT.—

(1) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting ''312(g),'' after ''310(d)(2),''.

(2) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting ''312(g),'' after ''310(d)(2),''.

(c) ENFORCEMENT IN EACH FISCAL YEAR.—The Congressional Budget Act of 1974 is amended in—

(1) section 301(a)(7) (2 U.S.C. 632(a)(7)), by striking ''for the fiscal year'' through the period and inserting ''for each fiscal year covered by the resolution''; and

(2) section 311(a)(3) (2 U.S.C. 642(a)(3)), by striking beginning with ''for the first fiscal year'' through the period and insert the following: ''for any of the fiscal years covered by the concurrent resolution.''.

Sec. 803. MEDICARE TRUST FUND OFF-BUDGET. (a) IN GENERAL.—

(1) GENERAL EXCLUSION FROM ALL BUDGETS.—Title III of the Congressional Budget Act of 1974 is amended by adding at the end the following:

''EXCLUSION OF MEDICARE TRUST FUND FROM ALL BUDGETS

''SEC. 316. (a) EXCLUSION OF MEDICARE TRUST FUND FROM ALL BUDGETS.—Notwithstanding any other provision of law, the receipts and disbursements of the Federal Hospital Insurance Trust Fund shall not be counted as new budget authority, outlays, receipts, or deficit or surplus for purposes of—

''(1) the budget of the United States Government as submitted by the President;

''(2) the congressional budget; or

''(3) the Balanced Budget and Emergency Deficit Control Act of 1985.

''(b) STRENGTHENING MEDICARE POINT OF ORDER.—It shall not be in order in the House of Representatives or the Senate to consider a concurrent resolution on the budget (or any amendment thereto or conference report thereon) or any bill, joint resolution, amendment, motion, or conference report that would violate or amend this section.''.

(2) SUPER MAJORITY REQUIREMENT.—

(A) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting ''316,'' after ''313,''.

(B) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting ''316,'' after ''313,''.

(b) EXCLUSION OF MEDICARE TRUST FUND FROM CONGRESSIONAL BUDGET.—Section 301(a) of the Congressional Budget Act of 1974 (2 U.S.C. 632(a)) is amended by adding at the end the following: ''The concurrent resolution shall not include the outlays and revenue totals of the Federal Hospital Insurance Trust Fund in the surplus or deficit totals required by this subsection or in any other surplus or deficit totals required by this title.''

(c) BUDGET TOTALS.—Section 301(a) of the Congressional Budget Act of 1974 (2 U.S.C. 632(a)) is amended by inserting after paragraph (7) the following:

''(8) For purposes of Senate enforcement under this title, revenues and outlays of the Federal Hospital Insurance Trust Fund for each fiscal year covered by the budget resolution.''.

(d) BUDGET RESOLUTIONS.—Section 301(i) of the Congressional Budget Act of 1974 (2 U.S.C. 632(i)) is amended by—

(1) striking ''SOCIAL SECURITY POINT OF ORDER.—It shall'' and inserting ''SOCIAL SECURITY AND MEDICARE POINTS OF ORDER.—

''(1) SOCIAL SECURITY.—It shall''; and

(2) inserting at the end the following:

''(2) MEDICARE.—It shall not be in order in the House of Representatives or the Senate to consider any concurrent resolution on the budget (or amendment, motion, or conference report on the resolution) that would decrease the excess of the Federal Hospital Insurance Trust Fund revenues over Federal Hospital Insurance Trust Fund outlays in any of the fiscal years covered by the concurrent resolution. This paragraph shall not apply to amounts to be expended from the Hospital Insurance Trust Fund for purposes relating to programs within part A of Medicare as provided in law on the date of enactment of this paragraph.''.

(e) MEDICARE FIREWALL.—Section 311(a) of the Congressional Budget Act of 1974 (2 U.S.C. 642(a)) is amended by adding after paragraph (3), the following:

''(4) ENFORCEMENT OF MEDICARE LEVELS IN THE SENATE.—After a concurrent resolution on the budget is agreed to, it shall not be in order in the Senate to consider any bill, joint resolution, amendment, motion, or conference report that would cause a decrease in surpluses or an increase in deficits of the Federal Hospital Insurance Trust Fund in any year relative to the levels set forth in the applicable resolution. This paragraph shall not apply to amounts to be expended from the Hospital Insurance Trust Fund for purposes relating to programs within part A of Medicare as provided in law on the date of enactment of this paragraph.''.

(f) BASELINE TO EXCLUDE HOSPITAL INSURANCE TRUST FUND.—Section 257(b)(3) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by striking ''shall be included in all'' and inserting ''shall not be included in any''.

(g) MEDICARE TRUST FUND EXEMPT FROM SEQUESTERS.—Section 255(g)(1)(B) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by adding at the end the following:

''Medicare as funded through the Federal Hospital Insurance Trust Fund.''.

(h) BUDGETARY TREATMENT OF HOSPITAL INSURANCE TRUST FUND.—Section 710(a) of the Social Security Act (42 U.S.C. 911(a)) is amended—

(1) by striking ''and'' the second place it appears and inserting a comma; and

(2) by inserting after ''Federal Disability Insurance Trust Fund'' the following: '', Federal Hospital Insurance Trust Fund''.

SEC. 804. PREVENTING ON-BUDGET DEFICITS. (a) POINTS OF ORDER TO PREVENT ON-BUDGET DEFICITS.—Section 312 of the Congressional Budget Act of 1974 (2 U.S.C. 643) is amended by adding at the end the following:

''(h) POINTS OF ORDER TO PREVENT ON-BUDGET DEFICITS.—

''(1) CONCURRENT RESOLUTIONS ON THE BUDGET.—It shall not be in order in the House of Representatives or the Senate to consider any concurrent resolution on the budget, or conference report thereon or amendment thereto, that would cause or increase an on-budget deficit for any fiscal year.

''(2) SUBSEQUENT LEGISLATION.—Except as provided by paragraph (3), it shall not be in order in the House of Representatives or the Senate to consider any bill, joint resolution, amendment, motion, or conference report if—

''(A) the enactment of that bill or resolution as reported;

''(B) the adoption and enactment of that amendment; or

''(C) the enactment of that bill or resolution in the form recommended in that conference report, would cause or increase an on-budget deficit for any fiscal year.''.

(b) SUPER MAJORITY REQUIREMENT.—

(1) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting ''312(h),'' after ''312(g),''.

(2) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting ''312(h),'' after ''312(g),''.

SEC. 805. SOCIAL SECURITY AND MEDICARE SAFE DEPOSIT BOX ACT OF 2000. (a) SHORT TITLE.—This section may be cited as the ''Social Security and Medicare Safe Deposit Box Act of 2000''.

(b) PROTECTION OF SOCIAL SECURITY AND MEDICARE SURPLUSES.—

(1) MEDICARE SURPLUSES OFF-BUDGET.—Notwithstanding any other provision of law, the net surplus of any trust fund for part A of Medicare shall not be counted as a net surplus for purposes of—

(A) the budget of the United States Government as submitted by the President;

(B) the congressional budget; or

(C) the Balanced Budget and Emergency Deficit Control Act of 1985.

(2) POINTS OF ORDER TO PROTECT SOCIAL SECURITY AND MEDICARE SURPLUSES.—Section 312 of the Congressional Budget Act of 1974 is amended by adding at the end the following new subsection:

''(g) POINTS OF ORDER TO PROTECT SOCIAL SECURITY AND MEDICARE SURPLUSES.—

''(1) CONCURRENT RESOLUTIONS ON THE BUDGET.—It shall not be in order in the House of Representatives or the Senate to consider any concurrent resolution on the budget, or conference report thereon or amendment thereto, that would set forth an on-budget deficit for any fiscal year.

''(2) SUBSEQUENT LEGISLATION.—It shall not be in order in the House of Representatives or the Senate to consider any bill, joint resolution, amendment, motion, or conference report if—

''(A) the enactment of that bill or resolution as reported;

''(B) the adoption and enactment of that amendment; or

''(C) the enactment of that bill or resolution in the form recommended in that conference report, would cause or increase an on-budget deficit for any fiscal year.

''(3) DEFINITION.—For purposes of this section, the term 'on-budget deficit', when applied to a fiscal year, means the deficit in the budget as set forth in the most recently agreed to concurrent resolution on the budget pursuant to section 301(a)(3) for that fiscal year.''.

(3) SUPER MAJORITY REQUIREMENT.—

(A) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting ''312(g),'' after ''310(d)(2),''.

(B) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting ''312(g),'' after ''310(d)(2),''.

(c) PROTECTION OF SOCIAL SECURITY AND MEDICARE SURPLUSES.—

(1) IN GENERAL.—Chapter 11 of subtitle II of title 31, United States Code, is amended by adding before section 1101 the following:

''§1100. Protection of social security and medicare surpluses

''The budget of the United States Government submitted by the President under this chapter shall not recommend an on-budget deficit for any fiscal year covered by that budget.''.

(2) CHAPTER ANALYSIS.—The chapter analysis for chapter 11 of title 31, United States Code, is amended by inserting before the item for section 1101 the following:

''1100. Protection of social security and medicare surpluses.''.

(d) EFFECTIVE DATE.—This section shall take effect upon the date of its enactment and the amendments made by this section shall apply to fiscal year 2001 and subsequent fiscal years.

TITLE IX—GENETIC INFORMATION AND SERVICES

SEC. 901. SHORT TITLE. This title may be cited as the ''Genetic Information Nondiscrimination in Health Insurance Act of 2000''.

SEC. 902. AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974. (a) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION OR GENETIC SERVICES.—

(1) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 702(a)(1)(F) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(a)(1)(F)) is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(2) NO DISCRIMINATION IN GROUP PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—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:

''SEC. 714. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''A group health plan, or a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).''.

(3) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—Section 702(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(b)) is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or receipt of genetic services), see section 714.''.

(B) TABLE OF CONTENTS.—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 713 the following new item:

''Sec. 714. Prohibiting premium discrimination against groups on the basis of predictive genetic information.''.

(b) LIMITATION ON COLLECTION OF PREDICTIVE GENETIC INFORMATION.—Section 702 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182) is amended by adding at the end the following:

''(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require predictive genetic information concerning any individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

''(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan or issuer's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the plan or issuer for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan or issuer.''.

(c) DEFINITIONS.—Section 733(d) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(d)) is amended by adding at the end the following:

''(5) FAMILY MEMBER.—The term 'family member' means with respect to an individual—

''(A) the spouse of the individual;

''(B) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

''(C) all other individuals related by blood to the individual or the spouse or child described in subparagraph (A) or (B).

''(6) GENETIC INFORMATION.—The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member (including information about a request for or receipt of genetic services).

''(7) GENETIC SERVICES.—The term 'genetic services' means health services provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

''(8) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(i) information about an individual's genetic tests;

''(ii) information about genetic tests of family members of the individual; or

''(iii) information about the occurrence of a disease or disorder in family members.

''(B) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

''(i) information about the sex or age of the individual;

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(9) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(d) EFFECTIVE DATE.—Except as provided in this section, this section and the amendments made by this section shall apply with respect to group health plans for plan years beginning 1 year after the date of the enactment of this Act.

SEC. 903. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT. (a) AMENDMENTS RELATING TO THE GROUP MARKET.—

(1) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION IN THE GROUP MARKET.—

(A) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 2702(a)(1)(F) of the Public Health Service Act (42 U.S.C. 300gg–1(a)(1)(F)) is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(B) NO DISCRIMINATION IN PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following new section:

''SEC. 2707. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION IN THE GROUP MARKET.

''A group health plan, or a health insurance issuer offering group health insurance coverage in connection with a group health plan shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).''.

(C) CONFORMING AMENDMENT.—Section 2702(b) of the Public Health Service Act (42 U.S.C. 300gg–1(b)) is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or receipt of genetic services), see section 2707.''.

(D) LIMITATION ON COLLECTION AND DISCLOSURE OF PREDICTIVE GENETIC INFORMATION.—Section 2702 of the Public Health Service Act (42 U.S.C. 300gg–1) is amended by adding at the end the following:

''(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

''(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan or issuer's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the plan or issuer for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan or issuer.''.

(2) DEFINITIONS.—Section 2791(d) of the Public Health Service Act (42 U.S.C. 300gg–91(d)) is amended by adding at the end the following:

''(15) FAMILY MEMBER.—The term 'family member' means, with respect to an individual—

''(A) the spouse of the individual;

''(B) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

''(C) all other individuals related by blood to the individual or the spouse or child described in subparagraph (A) or (B).

''(16) GENETIC INFORMATION.—The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member (including information about a request for or receipt of genetic services).

''(17) GENETIC SERVICES.—The term 'genetic services' means health services provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

''(18) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(i) information about an individual's genetic tests;

''(ii) information about genetic tests of family members of the individual; or

''(iii) information about the occurrence of a disease or disorder in family members.

''(B) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

''(i) information about the sex or age of the individual;

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(19) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(e) AMENDMENTS TO PHSA RELATING TO THE INDIVIDUAL MARKET.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–51 et seq.) (relating to other requirements) (42 U.S.C. 300gg–51 et seq.) is amended by adding at the end the following:

''SEC. 2753. PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''(a) PROHIBITION ON PREDICTIVE GENETIC INFORMATION AS A CONDITION OF ELIGIBILITY.—A health insurance issuer offering health insurance coverage in the individual market may not use predictive genetic information as a condition of eligibility of an individual to enroll in individual health insurance coverage (including information about a request for or receipt of genetic services).

''(b) PROHIBITION ON PREDICTIVE GENETIC INFORMATION IN SETTING PREMIUM RATES.—A health insurance issuer offering health insurance coverage in the individual market shall not adjust premium rates for individuals on the basis of predictive genetic information concerning such an individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a health insurance issuer offering health insurance coverage in the individual market shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a health insurance issuer offering health insurance coverage in the individual market that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the health insurance issuer offering health insurance coverage in the individual market shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

''(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A health insurance issuer offering health insurance coverage in the individual market shall post or provide, in writing and in a clear and conspicuous manner, notice of the issuer's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the issuer for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A health insurance issuer offering health insurance coverage in the individual market shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such issuer.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to—

(1) group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after 1 year after the date of enactment of this Act; and

(2) health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after 1 year after the date of enactment of this Act.

SEC. 904. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986. (a) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION OR GENETIC SERVICES.—

(1) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 9802(a)(1)(F) of the Internal Revenue Code of 1986 is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(2) NO DISCRIMINATION IN GROUP PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is further amended by adding at the end the following:

''SEC. 9813. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''A group health plan shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).''.

(B) CONFORMING AMENDMENT.—Section 9802(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or the receipt of genetic services), see section 9813.''.

(C) AMENDMENT TO TABLE OF SECTIONS.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''Sec. 9813. Prohibiting premium discrimination against groups on the basis of predictive genetic information.''.

(b) LIMITATION ON COLLECTION OF PREDICTIVE GENETIC INFORMATION.—Section 9802 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(d) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a group health plan shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES; DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (e), of such predictive genetic information.

''(e) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A group health plan shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the plan for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan.''.

(c) DEFINITIONS.—Section 9832(d) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(6) FAMILY MEMBER.—The term 'family member' means, with respect to an individual—

''(A) the spouse of the individual;

''(B) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

''(C) all other individuals related by blood to the individual or the spouse or child described in subparagraph (A) or (B).

''(7) GENETIC INFORMATION.—The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member (including information about a request for or receipt of genetic services).

''(8) GENETIC SERVICES.—The term 'genetic services' means health services provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

''(9) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(i) information about an individual's genetic tests;

''(ii) information about genetic tests of family members of the individual; or

''(iii) information about the occurrence of a disease or disorder in family members.

''(B) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

''(i) information about the sex or age of the individual;

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(10) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(d) EFFECTIVE DATE.—Except as provided in this section, this section and the amendments made by this section shall apply with respect to group health plans for plan years beginning after 1 year after the date of the enactment of this Act.

DIVISION B—HEALTH CARE ACCESS AND PROTECTIONS FOR CONSUMERS

SEC. 2001. SHORT TITLE.

This division may be cited as the ''Patients' Bill of Rights Plus Act''.

TITLE XXI—TAX-RELATED HEALTH CARE PROVISIONS

Subtitle A—Health Care and Long-Term Care

SEC. 2101. DEDUCTION FOR HEALTH AND LONG-TERM CARE INSURANCE COSTS OF INDIVIDUALS NOT PARTICIPATING IN EMPLOYER-SUBSIDIZED HEALTH PLANS.

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

''SEC. 222. HEALTH AND LONG-TERM CARE INSURANCE COSTS.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a deduction an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer and the taxpayer's spouse and dependents.

''(b) APPLICABLE PERCENTAGE.—

''(1) IN GENERAL.—For purposes of subsection (a), the applicable percentage shall be determined in accordance with the following table:

''For taxable years beginning in calendar year—	**The applicable percentage is—**
2002 and 2003	25
2004	35
2005	65
2006 and thereafter	100.

''(2) LONG-TERM CARE INSURANCE FOR INDIVIDUALS 60 YEARS OR OLDER.—In the case of amounts paid for a qualified long-term care insurance contract for an individual who has attained age 60 before the close of the taxable year, the applicable percentage is 100.

''(c) LIMITATION BASED ON OTHER COVERAGE.—

''(1) COVERAGE UNDER CERTAIN SUBSIDIZED EMPLOYER PLANS.—

''(A) IN GENERAL.—Subsection (a) shall not apply to any taxpayer for any calendar month for which the taxpayer participates in any health plan maintained by any employer of the taxpayer or of the spouse of the taxpayer if 50 percent or more of the cost of coverage under such plan (determined under section 4980B and without regard to payments made with respect to any coverage described in subsection (e)) is paid or incurred by the employer.

''(B) EMPLOYER CONTRIBUTIONS TO CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND MEDICAL SAVINGS ACCOUNTS.—Employer contributions to a cafeteria plan, a flexible spending or similar arrangement, or a medical savings account which are excluded from gross income under section 106 shall be treated for purposes of subparagraph (A) as paid by the employer.

''(C) AGGREGATION OF PLANS OF EMPLOYER.—A health plan which is not otherwise described in subparagraph (A) shall be treated as described in such subparagraph if such plan would be so described if all health plans of persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 were treated as one health plan.

''(D) SEPARATE APPLICATION TO HEALTH INSURANCE AND LONG-TERM CARE INSURANCE.—Subparagraphs (A) and (C) shall be applied separately with respect to—

''(i) plans which include primarily coverage for qualified long-term care services or are qualified long-term care insurance contracts, and

''(ii) plans which do not include such coverage and are not such contracts.

''(2) COVERAGE UNDER CERTAIN FEDERAL PROGRAMS.—

''(A) IN GENERAL.—Subsection (a) shall not apply to any amount paid for any coverage for an individual for any calendar month if, as of the first day of such month, the individual is covered under any medical care program described in—

''(i) title XVIII, XIX, or XXI of the Social Security Act,

''(ii) chapter 55 of title 10, United States Code,

''(iii) chapter 17 of title 38, United States Code,

''(iv) chapter 89 of title 5, United States Code, or

''(v) the Indian Health Care Improvement Act.

''(B) EXCEPTIONS.—

''(i) QUALIFIED LONG-TERM CARE.—Subparagraph (A) shall not apply to amounts paid for coverage under a qualified long-term care insurance contract.

''(ii) CONTINUATION COVERAGE OF FEHBP.—Subparagraph (A)(iv) shall not apply to coverage which is comparable to continuation coverage under section 4980B.

''(d) LONG-TERM CARE DEDUCTION LIMITED TO QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.—In the case of a qualified long-term care insurance contract, only eligible long-term care premiums (as defined in section 213(d)(10)) may be taken into account under subsection (a).

''(e) DEDUCTION NOT AVAILABLE FOR PAYMENT OF ANCILLARY COVERAGE PREMIUMS.—Any amount paid as a premium for insurance which provides for—

''(1) coverage for accidents, disability, dental care, vision care, or a specified illness, or

''(2) making payments of a fixed amount per day (or other period) by reason of being hospitalized,

shall not be taken into account under subsection (a).

''(f) SPECIAL RULES.—

''(1) COORDINATION WITH DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—The amount taken into account by the taxpayer in computing the deduction under section 162(l) shall not be taken into account under this section.

''(2) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—The amount taken into account by the taxpayer in computing the deduction under this section shall not be taken into account under section 213.

''(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to

carry out this section, including regulations requiring employers to report to their employees and the Secretary such information as the Secretary determines to be appropriate.''.

(b) DEDUCTION ALLOWED WHETHER OR NOT TAXPAYER ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (17) the following new item:

''(18) HEALTH AND LONG-TERM CARE INSURANCE COSTS.—The deduction allowed by section 222.''.

(c) CLERICAL AMENDMENT.—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 new items:

''Sec. 222. Health and long-term care insurance costs.

''Sec. 223. Cross reference.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 2102. DEDUCTION FOR 100 PERCENT OF HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to 100 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer and the taxpayer's spouse and dependents.''.

(b) CLARIFICATION OF LIMITATIONS ON OTHER COVERAGE.—The first sentence of section 162(l)(2)(B) of such Code is amended to read as follows: ''Paragraph (1) shall not apply to any taxpayer for any calendar month for which the taxpayer participates in any subsidized health plan maintained by any employer (other than an employer described in section 401(c)(4)) of the taxpayer or the spouse of the taxpayer.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 2103. LONG-TERM CARE INSURANCE PERMITTED TO BE OFFERED UNDER CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.

(a) CAFETERIA PLANS.—

(1) IN GENERAL.—Subsection (f) of section 125 of the Internal Revenue Code of 1986 (defining qualified benefits) is amended by inserting before the period at the end ''; except that such term shall include the payment of premiums for any qualified long-term care insurance contract (as defined in section 7702B) to the extent the amount of such payment does not exceed the eligible long-term care premiums (as defined in section 213(d)(10)) for such contract''.

(b) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is amended by striking subsection (c).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 2104. ADDITIONAL PERSONAL EXEMPTION FOR TAXPAYER CARING FOR ELDERLY FAMILY MEMBER IN TAXPAYER'S HOME.

(a) IN GENERAL.—Section 151 of the Internal Revenue Code of 1986 (relating to allowance of deductions for personal exemptions) is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

''(e) ADDITIONAL EXEMPTION FOR CERTAIN ELDERLY FAMILY MEMBERS RESIDING WITH TAXPAYER.—

''(1) IN GENERAL.—An exemption of the exemption amount for each qualified family member of the taxpayer.

''(2) QUALIFIED FAMILY MEMBER.—For purposes of this subsection, the term 'qualified family member' means, with respect to any taxable year, any individual—

''(A) who is an ancestor of the taxpayer or of the taxpayer's spouse or who is the spouse of any such ancestor,

''(B) who is a member for the entire taxable year of a household maintained by the taxpayer, and

''(C) who has been certified, before the due date for filing the return of tax for the taxable year (without extensions), by a physician (as defined in section 1861(r)(1) of the Social Security Act) as being an individual with long-term care needs described in paragraph (3) for a period—

''(i) which is at least 180 consecutive days, and

''(ii) a portion of which occurs within the taxable year.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the 39½ month period ending on such due date (or such other period as the Secretary prescribes) a physician (as so defined) has certified that such individual meets such requirements.

''(3) INDIVIDUALS WITH LONG-TERM CARE NEEDS.—An individual is described in this paragraph if the individual—

''(A) is unable to perform (without substantial assistance from another individual) at least two activities of daily living (as defined in section 7702B(c)(2)(B)) due to a loss of functional capacity, or

''(B) requires substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment and is unable to perform, without reminding or cuing assistance, at least one activity of daily living (as so defined) or to the extent provided in regulations prescribed by the Secretary (in consultation with the Secretary of Health and Human Services), is unable to engage in age appropriate activities.

''(4) SPECIAL RULES.—Rules similar to the rules of paragraphs (1), (2), (3), (4), and (5) of section 21(e) shall apply for purposes of this subsection.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 2105. STUDY OF LONG-TERM CARE NEEDS IN THE 21ST CENTURY.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall on or after October 1, 2001, provide, in accordance with this section, for a study in order to determine—

(1) future demand for long-term health care services (including institutional and home and community-based services) in the United States in order to meet the needs in the 21st century; and

(2) long-term options to finance the provision of such services.

(b) DETAILS.—The study conducted under subsection (a) shall include the following:

(1) An identification of the relevant demographic characteristics affecting demand for long-term health care services, at least through the year 2030.

(2) The viability and capacity of community-based and other long-term health care services under different federal programs, including through the medicare and medicaid programs, grants to States, housing services, and changes in tax policy.

(3) How to improve the quality of long-term health care services.

(4) The integration of long-term health care services for individuals between different classes of health care providers (such as hospitals, nursing facilities, and home care agencies) and different Federal programs (such as the medicare and medicaid programs).

(5) The possibility of expanding private sector initiatives, including long-term care insurance, to meet the need to finance such services.

(6) An examination of the effect of enactment of the Health Insurance Portability and Accountability Act of 1996 on the provision and financing of long-term health care services, including on portability and affordability of private long-term care insurance, the impact of insurance options on low-income older Americans, and the options for eligibility to improve access to such insurance.

(7) The financial impact of the provision of long-term health care services on caregivers and other family members.

(c) REPORT AND RECOMMENDATIONS.—

(1) IN GENERAL.—October 1, 2002, the Secretary shall provide for a report on the study under this section.

(2) RECOMMENDATIONS.—The report under paragraph (1) shall include findings and recommendations regarding each of the following:

(A) The most effective and efficient manner that the Federal Government may use its resources to educate the public on planning for needs for long-term health care services.

(B) The public, private, and joint public-private strategies for meeting identified needs for long-term health care services.

(C) The role of States and local communities in the financing of long-term health care services.

(3) INCLUSION OF COST ESTIMATES.—The report under paragraph (1) shall include cost estimates of the various options for which recommendations are made.

(d) CONDUCT OF STUDY.—

(1) USE OF INSTITUTE OF MEDICINE.—The Secretary of Health and Human Services shall seek to enter into an appropriate arrangement with the Institute of Medicine of the National Academy of Sciences to conduct the study under this section. If such an arrangement cannot be made, the Secretary may provide for the conduct of the study by any other qualified non-governmental entity.

(2) CONSULTATION.—The study should be conducted under this section in consultation with experts from a wide-range of groups from the public and private sectors.

Subtitle B—Medical Savings Accounts

SEC. 2111. EXPANSION OF AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(B) Section 138 of such Code is amended by striking subsection (f).

(b) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Section 220(c)(1)(A) of such Code (relating to eligible individual) is amended to read as follows:

''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if—

''(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

''(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

''(I) which is not a high deductible health plan, and

''(II) which provides coverage for any benefit which is covered under the high deductible health plan.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 220(c)(1) of such Code is amended by striking subparagraph (C).

(B) Section 220(c) of such Code is amended by striking paragraph (4) (defining small employer) and by redesignating paragraph (5) as paragraph (4).

(C) Section 220(b) of such Code is amended by striking paragraph (4) (relating to deduction limited by compensation) and by redesignating paragraphs (5), (6), and (7) as paragraphs (4), (5), and (6), respectively.

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:

''(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of the annual deductible (as of the first day of such month) of the individual's coverage under the high deductible health plan.''.

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking ''75 percent of''.

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (4) of section 220(b) of such Code (as redesignated by subsection (b)(2)(C)) is amended to read as follows:

''(4) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includible in the taxpayer's gross income for such taxable year.''.

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking ''$1,500'' in clause (i) and inserting ''$1,000'';

(B) by striking ''$3,000'' in clause (ii) and inserting ''$2,000''; and

(C) by striking the matter preceding subclause (I) in clause (iii) and inserting ''pursuant to which the annual out-of-pocket expenses (including deductibles and co-payments) are required to be paid under the plan (other than for premiums) for covered benefits and may not exceed—''.

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended to read as follows:

''(g) COST-OF-LIVING ADJUSTMENT.—

''(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2002, each dollar amount in subsection (c)(2) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 2001' for 'calendar year 1992' in subparagraph (B) thereof.

''(2) SPECIAL RULES.—In the case of the $1,000 amount in subsection (c)(2)(A)(i) and the $2,000 amount in subsection (c)(2)(A)(ii), paragraph (1)(B) shall be applied by substituting 'calendar year 2002' for 'calendar year 2001'.

''(3) ROUNDING.—If any increase under paragraph (1) or (2) is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.''.

(f) LIMITATION ON ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Section 220(f)(4) of such Code (relating to additional tax on distributions not used for qualified medical expenses) is amended by adding at the end the following:

''(D) EXCEPTION IN CASE OF SUFFICIENT ACCOUNT BALANCE.—Subparagraph (A) shall not apply to any payment or distribution in any taxable year, but only to the extent such payment or distribution does not reduce the fair market value of the assets of the medical savings account to an amount less than the annual deductible for the high deductible health plan of the account holder (determined as of the earlier of January 1 of the calendar year in which the taxable year begins or January 1 of the last calendar year in which the account holder is covered under a high deductible health plan).''.

(g) TREATMENT OF NETWORK-BASED MANAGED CARE PLANS.—Section 220(c)(2)(B) of such Code (relating to special rules for high deductible health plans) is amended by adding at the end the following:

''(iii) TREATMENT OF NETWORK-BASED MANAGED CARE PLANS.—A plan which provides health care services through a network of contracted or affiliated health care providers, if the benefits provided when services are obtained through network providers meet the requirements of subparagraph (A), shall not fail to be treated as a high deductible health plan by reason of providing benefits for services rendered by providers who are not members of the network, so long as the annual deductible and annual limit on out-of-pocket expenses applicable to services received from non-network providers are not lower than those applicable to services received from the network providers.''.

(h) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by striking ''106(b),''.

(i) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided by paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2001.

(2) LIMITATION ON ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—The amendment made by subsection (f) shall apply to taxable years beginning after December 31, 2005.

SEC. 2112. AMENDMENTS TO TITLE 5, UNITED STATES CODE, RELATING TO MEDICAL SAVINGS ACCOUNTS AND HIGH DEDUCTIBLE HEALTH PLANS UNDER FEHBP.

(a) MEDICAL SAVINGS ACCOUNTS.—

(1) CONTRIBUTIONS.—Title 5, United States Code, is amended by redesignating section 8906a as section 8906c and by inserting after section 8906 the following:

''§ 8906a. Government contributions to medical savings accounts

''(a) An employee or annuitant enrolled in a high deductible health plan is entitled, in addition to the Government contribution under section 8906(b) toward the subscription charge for such plan, to have a Government contribution made, in accordance with succeeding provisions of this section, to a medical savings account of such employee or annuitant.

''(b)(1) The biweekly Government contribution under this section shall, in the case of any such employee or annuitant, be equal to the amount (if any) by which—

''(A) the biweekly equivalent of the maximum Government contribution for the contract year involved (as defined by paragraph (2)), exceeds

''(B) the amount of the biweekly Government contribution payable on such employee's or annuitant's behalf under section 8906(b) for the period involved.

''(2) For purposes of this section, the term 'maximum Government contribution' means, with respect to a contract year, the maximum Government contribution that could be made for health benefits for an employee or annuitant for such contract year, as determined under section 8906(b) (disregarding paragraph (2) thereof).

''(3) Notwithstanding any other provision of this section, no contribution under this section shall be payable to any medical savings account of an employee or annuitant for any period—

''(A) if, as of the first day of the month before the month in which such period commences, such employee or annuitant (or the spouse of such employee or annuitant, if coverage is for self and family) is entitled to benefits under part A of title XVIII of the Social Security Act;

''(B) to the extent that such contribution, when added to previous contributions made under this section for that same year with respect to such employee or annuitant, would cause the total to exceed—

''(i) the limitation under paragraph (1) of section 220(b) of the Internal Revenue Code of 1986 (determined without regard to paragraph (3) thereof) which is applicable to such employee or annuitant for the calendar year in which such period commences; or

''(ii) such lower amount as the employee or annuitant may specify in accordance with regulations of the Office, including an election not to receive contributions under this section for a year or the remainder of a year; or

''(C) for which any information (or documentation) under subsection (d) that is needed in order to make such contribution has not been timely submitted.

''(4) Notwithstanding any other provision of this section, no contribution under this section shall be payable to any medical savings account of an employee for any period in a contract year unless that employee was enrolled in a health benefits plan under this chapter as an employee for not less than—

''(A) the 1 year of service immediately before the start of such contract year, or

''(B) the full period or periods of service between the last day of the first period, as prescribed by regulations of the Office of Personnel Management, in which he is eligible to enroll in the plan and the day before the start of such contract year,

whichever is shorter.

''(5) The Office shall provide for the conversion of biweekly rates of contributions specified by paragraph (1) to rates for employees and annuitants whose pay or annuity is provided on other than a biweekly basis, and for this purpose may provide for the adjustment of the converted rate to the nearest cent.

''(c) A Government contribution under this section—

''(1) shall be made at the same time that, and the same frequency with which, Government contributions under section 8906(b) are made for the benefit of the employee or annuitant involved; and

''(2) shall be payable from the same appropriation, fund, account, or other source as would any Government contributions under section 8906(b) with respect to the employee or annuitant involved.

''(d) The Office shall by regulation prescribe the time, form, and manner in which an employee or annuitant shall submit any information (and supporting documentation) necessary to identify any medical savings account to which contributions under this section are requested to be made.

''(e) Nothing in this section shall be considered to entitle an employee or annuitant to any Government contribution under this section with respect to any period for which such employee or annuitant is ineligible for a Government contribution under section 8906(b).

''§ 8906b. Individual contributions to medical savings accounts

''(a) Upon the written request of an employee or annuitant enrolled in a high deductible health plan, there shall be withheld from the pay or annuity of such employee or annuitant and contributed to the medical savings account identified by such employee or annuitant in accordance with applicable regulations under subsection (c) such amount as the employee or annuitant may specify.

''(b) Notwithstanding subsection (a), no withholding under this section may be made from the pay or annuity of an employee or annuitant for any period—

''(1) if, or to the extent that, a Government contribution for such period under section 8906a would not be allowable by reason of subparagraph (A) or (B)(i) of subsection (b)(3) thereof;

''(2) for which any information (or documentation) that is needed in order to make such contribution has not been timely submitted; or

''(3) if the employee or annuitant submits a request for termination of withholdings, beginning on or after the effective date of the request and before the end of the year.

''(c) The Office of Personnel Management shall prescribe any regulations necessary to carry out this section, including provisions relating to the time, form, and manner in which any request for withholdings under this section may be made, changed, or terminated.''.

(2) RULES OF CONSTRUCTION.—Nothing in this section or in any amendment made by this section shall be considered—

(A) to permit or require that any contributions to a medical savings account (whether by the Government or through withholdings from pay or annuity) be paid into the Employees Health Benefits Fund; or

(B) to affect any authority under section 1005(f) of title 39, United States Code, to vary, add to, or substitute for any provision of chapter 89 of title 5, United States Code, as amended by this section.

(3) CONFORMING AMENDMENTS.—

(A) The table of sections at the beginning of chapter 89 of title 5, United States Code, is amended by striking the item relating to section 8906a and inserting the following:

''8906a. Government contributions to medical savings accounts.
''8906b. Individual contributions to medical savings accounts.
''8906c. Temporary employees.''.

(B) Section 8913(b)(4) of title 5, United States Code, is amended by striking ''8906a(a)'' and inserting ''8906c(a)''.

(b) INFORMATIONAL REQUIREMENTS.—Section 8907 of title 5, United States Code, is amended by adding at the end the following:

''(c) In addition to any information otherwise required under this section, the Office shall make available to all employees and annuitants eligible to enroll in a high deductible health plan, information relating to—

''(1) the conditions under which Government contributions under section 8906a shall be made to a medical savings account;

''(2) the amount of any Government contributions under section 8906a to which an employee or annuitant may be entitled (or how such amount may be ascertained);

''(3) the conditions under which contributions to a medical savings account may be made under section 8906b through withholdings from pay or annuity; and

''(4) any other matter the Office considers appropriate in connection with medical savings accounts.''.

(c) HIGH DEDUCTIBLE HEALTH PLAN AND MEDICAL SAVINGS ACCOUNT DEFINED.—Section 8901 of title 5, United States Code, is amended—

(1) in paragraph (10) by striking ''and'' after the semicolon;

(2) in paragraph (11) by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

''(12) the term 'high deductible health plan' means a plan described by section 8903(5) or section 8903a(d); and

''(13) the term 'medical savings account' has the meaning given such term by section 220(d) of the Internal Revenue Code of 1986.''.

(d) AUTHORITY TO CONTRACT FOR HIGH DEDUCTIBLE HEALTH PLANS, ETC.—

(1) CONTRACTS FOR HIGH DEDUCTIBLE HEALTH PLANS.—Section 8902 of title 5, United States Code, is amended by adding at the end the following:

''(p)(1) The Office shall contract under this chapter for a high deductible health plan with any qualified carrier that offers such a plan and, as of the date of enactment of this subsection, offers a health benefits plan under this chapter.

''(2) The Office may contract under this chapter for a high deductible health plan with any qualified carrier that offers such a plan, but does not, as of the date of enactment of this subsection, offer a health benefits plan under this chapter.''.

(2) COMPUTATION OF GOVERNMENT CONTRIBUTIONS TO PLANS UNDER CHAPTER 89 NOT AFFECTED BY HIGH DEDUCTIBLE HEALTH PLANS.—Paragraph (2) of section 8906(a) of title 5, United States Code, is amended by striking ''(2)'' and inserting ''(2)(A)'', and adding at the end the following:

''(B) Notwithstanding any other provision of this section, the subscription charges for, and the number of enrollees enrolled in, high deductible health plans shall be disregarded for purposes of determining any weighted average under paragraph (1).''.

(e) DESCRIPTION OF HIGH DEDUCTIBLE HEALTH PLANS AND BENEFITS TO BE PROVIDED THEREUNDER.—

(1) IN GENERAL.—Section 8903 of title 5, United States Code, is amended by adding at the end the following:

''(5) HIGH DEDUCTIBLE HEALTH PLANS.—(A) One or more plans described by paragraph (1), (2), (3), or (4), which—

''(i) are high deductible health plans (as defined by section 220(c)(2) of the Internal Revenue Code of 1986); and

''(ii) provide benefits of the types referred to by section 8904(a)(5).

''(B) Nothing in this section shall be considered—

''(i) to prevent a carrier from simultaneously offering a plan described by subparagraph (A) and a plan described by paragraph (1) or (2); or

''(ii) to require that a high deductible health plan offer two levels of benefits.''.

(2) TYPES OF BENEFITS.—Section 8904(a) of title 5, United States Code, is amended by inserting after paragraph (4) the following:

''(5) HIGH DEDUCTIBLE HEALTH PLANS.—Benefits of the types named under paragraph (1) or (2) of this subsection or both.''.

(3) CONFORMING AMENDMENTS.—

(A) Section 8903a of title 5, United States Code, is amended by redesignating subsection (d) as subsection (e) and by inserting after subsection (c) the following:

''(d) The plans under this section may include one or more plans, otherwise allowable under this section, that satisfy the requirements of clauses (i) and (ii) of section 8903(5)(A).''.

(B) Section 8909(d) of title 5, United States Code, is amended by striking ''8903a(d)'' and inserting ''8903a(e)''.

(4) REFERENCES.—Section 8903 of title 5, United States Code, is amended by adding after paragraph (5) (as added by paragraph (1) of this subsection) as a flush left sentence, the following:

''The Office shall prescribe regulations in accordance with which the requirements of section 8902(c), 8902(n), 8909(e), and any other provision of this chapter that applies with respect to a plan described by paragraph (1), (2), (3), or (4) of this section shall apply with respect to the corresponding plan under paragraph (5) of this section. Similar regulations shall be prescribed with respect to any plan under section 8903a(d).''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after October 1, 2001. The Office of Personnel Management shall take appropriate measures to ensure that coverage under a high deductible health plan under chapter 89 of title 5, United States Code (as amended by this section) shall be available as of the beginning of the first contract year described in the preceding sentence.

SEC. 2113. RULE WITH RESPECT TO CERTAIN PLANS.

(a) IN GENERAL.—Notwithstanding any other provision of law, health insurance issuers may offer, and eligible individuals may purchase, high deductible health plans described in section 220(c)(2)(A) of the Internal Revenue Code of 1986. Effective for the 5-year period beginning on October 1, 2001, such health plans shall not be required to provide payment for any health care items or services that are exempt from the plan's deductible.

(b) EXISTING STATE LAWS.—A State law relating to payment for health care items and services in effect on the date of enactment of this Act that is preempted under paragraph (1), shall not apply to high deductible health plans after the expiration of the 5-year period described in such paragraph unless the State reenacts such law after such period.

Subtitle C—Other Health-Related Provisions

SEC. 2121. EXPANDED HUMAN CLINICAL TRIALS QUALIFYING FOR ORPHAN DRUG CREDIT.

(a) IN GENERAL.—Subclause (I) of section 45C(b)(2)(A)(ii) of the Internal Revenue Code of 1986 is amended to read as follows:

''(I) after the date that the application is filed for designation under such section 526, and''.

(b) CONFORMING AMENDMENT.—Clause (i) of section 45C(b)(2)(A) of such Code is amended by inserting ''which is'' before ''being'' and by inserting before the comma at the end ''and which is designated under section 526 of such Act''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred after December 31, 2001.

SEC. 2122. CARRYOVER OF UNUSED BENEFITS FROM CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND HEALTH FLEXIBLE SPENDING ACCOUNTS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended by redesignating subsections (h) and (i) as subsections (i) and (j) and by inserting after subsection (g) the following new subsection:

''(h) ALLOWANCE OF CARRYOVERS OF UNUSED BENEFITS TO LATER TAXABLE YEARS.—

''(1) IN GENERAL.—For purposes of this title—

''(A) notwithstanding subsection (d)(2), a plan or other arrangement shall not fail to be treated as a cafeteria plan or flexible spending or similar arrangement, and

''(B) no amount shall be required to be included in gross income by reason of this section or any other provision of this chapter,

solely because under such plan or other arrangement any nontaxable benefit which is unused as of the close of a taxable year may be carried forward to 1 or more succeeding taxable years.

''(2) LIMITATION.—Paragraph (1) shall not apply to amounts carried from a plan to the extent such amounts exceed $500 (applied on an annual basis). For purposes of this paragraph, all plans and arrangements maintained by an employer or any related person shall be treated as 1 plan.

''(3) ALLOWANCE OF ROLLOVER.—

''(A) IN GENERAL.—In the case of any unused benefit described in paragraph (1) which consists of amounts in a health flexible spending account or dependent care flexible spending account, the plan or arrangement shall provide that a participant may elect, in lieu of such carryover, to have such amounts distributed to the participant.

''(B) AMOUNTS NOT INCLUDED IN INCOME.—Any distribution under subparagraph (A) shall not be included in gross income to the extent that such amount is transferred in a trustee-to-trustee transfer, or is contributed within 60 days of the date of the distribution, to—

''(i) a qualified cash or deferred arrangement described in section 401(k),

''(ii) a plan under which amounts are contributed by an individual's employer for an annuity contract described in section 403(b),

''(iii) an eligible deferred compensation plan described in section 457, or

''(iv) a medical savings account (within the meaning of section 220).

Any amount rolled over under this subparagraph shall be treated as a rollover contribution

for the taxable year from which the unused amount would otherwise be carried.

''(C) TREATMENT OF ROLLOVER.—Any amount rolled over under subparagraph (B) shall be treated as an eligible rollover under section 220, 401(k), 403(b), or 457, whichever is applicable, and shall be taken into account in applying any limitation (or participation requirement) on employer or employee contributions under such section or any other provision of this chapter for the taxable year of the rollover.

''(4) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 2002, the $500 amount under paragraph (2) shall be adjusted at the same time and in the same manner as under section 415(d)(2), except that the base period taken into account shall be the calendar quarter beginning October 1, 2001, and any increase which is not a multiple of $50 shall be rounded to the next lowest multiple of $50.

''(5) APPLICABILITY.—This subsection shall apply to taxable years beginning after December 31, 2001.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 2123. REDUCTION IN TAX ON VACCINES.

(a) IN GENERAL.—Paragraph (1) of section 4131(b) of the Internal Revenue Code of 1986 (relating to amount of tax) is amended by striking ''75 cents'' and inserting ''50 cents''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2002.

Subtitle D—Miscellaneous Provisions

SEC. 2131. NO IMPACT ON SOCIAL SECURITY TRUST FUND.

(a) IN GENERAL.—Nothing in this division (or an amendment made by this division) shall be construed to alter or amend the Social Security Act (or any regulation promulgated under that Act).

(b) TRANSFERS.—

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

(2) TRANSFER OF FUNDS.—If, under paragraph (1), the Secretary of the Treasury estimates that the enactment of this division 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 division.

SEC. 2132. CUSTOMS USER FEES.

Section 13031(j)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)) is amended by striking ''2003'' and inserting ''2010''.

SEC. 2133. ESTABLISHMENT OF MEDICARE ADMINISTRATIVE FEE FOR SUBMISSION OF PAPER CLAIMS.

(a) IMPOSITION OF FEE.—Notwithstanding any other provision of law and subject to subsection (b), the Secretary of Health and Human Services shall establish (in the form of a separate fee or reduction of payment otherwise made under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)) an administrative fee of $1 for the submission of a claim in a paper or non-electronic form for items or services for which payment is sought under such title.

(b) EXCEPTION AUTHORITY.—The Secretary of Health and Human Services shall waive the imposition of the fee under subsection (a)—

(1) in cases in which there is no method available for the submission of claims other than in a paper or non-electronic form; and

(2) for rural providers and small providers that the Secretary determines, under procedures established by the Secretary, are unable to purchase the necessary hardware in order to submit claims electronically.

(c) TREATMENT OF FEES FOR PURPOSES OF COST REPORTS.—An entity may not include a fee assessed pursuant to this section as an allowable item on a cost report under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or title XIX of such Act (42 U.S.C. 1396 et seq.).

(d) EFFECTIVE DATE.—The provisions of this section apply to claims submitted on or after January 1, 2002.

SEC. 2134. ESTABLISHMENT OF MEDICARE ADMINISTRATIVE FEE FOR SUBMISSION OF DUPLICATE AND UNPROCESSABLE CLAIMS.

(a) IMPOSITION OF FEE.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall establish (in the form of a separate fee or reduction of payment otherwise made under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)) an administrative fee of $2 for the submission of a claim described in subsection (b).

(b) CLAIMS SUBJECT TO FEE.—A claim described in this subsection is a claim that—

(1) is submitted by an individual or entity for items or services for which payment is sought under title XVIII of the Social Security Act; and

(2) either—

(A) duplicates, in whole or in part, another claim submitted by the same individual or entity; or

(B) is a claim that cannot be processed and must, in accordance with the Secretary of Health and Human Service's instructions, be returned by the fiscal intermediary or carrier to the individual or entity for completion.

(c) TREATMENT OF FEES FOR PURPOSES OF COST REPORTS.—An entity may not include a fee assessed pursuant to this section as an allowable item on a cost report under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or title XIX of such Act (42 U.S.C. 1396 et seq.).

(d) EFFECTIVE DATE.—The provisions of this section apply to claims submitted on or after January 1, 2002.

TITLE XXII—PATIENTS' BILL OF RIGHTS

Subtitle A—Right to Advice and Care

SEC. 2201. 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:

''Subpart C—Patient Right to Medical Advice and Care

''SEC. 721. ACCESS TO EMERGENCY MEDICAL CARE.

''(a) COVERAGE OF EMERGENCY SERVICES.—If a group health plan (other than a fully insured group health plan) provides coverage for any benefits consisting of emergency medical care, except for items or services specifically excluded from coverage, the plan shall, without regard to prior authorization or provider participation—

''(1) provide coverage for emergency medical screening examinations to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary; and

''(2) provide coverage for additional emergency medical care to stabilize an emergency medical condition following an emergency medical screening examination (if determined necessary), pursuant to the definition of stabilize under section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

''(b) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—If a group health plan (other than a fully insured group health plan) provides coverage for any benefits consisting of emergency ambulance services, except for items or services specifically excluded from coverage, the plan shall, without regard to prior authorization or provider participation, provide coverage for emergency ambulance services to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such emergency ambulance services to be necessary.

''(c) CARE AFTER STABILIZATION.—

''(1) IN GENERAL.—In the case of medically necessary and appropriate items or services related to the emergency medical condition that may be provided to a participant or beneficiary by a nonparticipating provider after the participant or beneficiary is stabilized, the nonparticipating provider shall contact the plan as soon as practicable, but not later than 2 hours after stabilization occurs, with respect to whether—

''(A) the provision of items or services is approved;

''(B) the participant or beneficiary will be transferred; or

''(C) other arrangements will be made concerning the care and treatment of the participant or beneficiary.

''(2) FAILURE TO RESPOND AND MAKE ARRANGEMENTS.—If a group health plan fails to respond and make arrangements within 2 hours of being contacted in accordance with paragraph (1), then the plan shall be responsible for the cost of any additional items or services provided by the nonparticipating provider if—

''(A) coverage for items or services of the type furnished by the nonparticipating provider is available under the plan;

''(B) the items or services are medically necessary and appropriate and related to the emergency medical condition involved; and

''(C) the timely provision of the items or services is medically necessary and appropriate.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to apply to a group health plan that does not require prior authorization for items or services provided to a participant or beneficiary after the participant or beneficiary is stabilized.

''(d) REIMBURSEMENT TO A NON-PARTICIPATING PROVIDER.—The responsibility of a group health plan to provide reimbursement to a nonparticipating provider under this section shall cease accruing upon the earlier of—

''(1) the transfer or discharge of the participant or beneficiary; or

''(2) the completion of other arrangements made by the plan and the nonparticipating provider.

''(e) RESPONSIBILITY OF PARTICIPANT.—With respect to items or services provided by a nonparticipating provider under this section, the participant or beneficiary shall not be responsible for amounts that exceed the amounts (including co-insurance, co-payments, deductibles or any other form of cost-sharing) that would be incurred if the care was provided by a participating health care provider with prior authorization.

''(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a group health plan from negotiating reimbursement rates with a nonparticipating provider for items or services provided under this section.

''(g) DEFINITIONS.—In this section:

''(1) EMERGENCY AMBULANCE SERVICES.—The term 'emergency ambulance services' means, with respect to a participant or beneficiary under a group health plan (other than a fully insured group health plan), ambulance services furnished to transport an individual who has an emergency medical condition to a treating facility for receipt of emergency medical care if—

''(A) the emergency services are covered under the group health plan (other than a fully insured group health plan) involved; and

''(B) a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of such transport to result in 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

''(2) EMERGENCY MEDICAL CARE.—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 items or services that—

''(A) are furnished by any provider, including a nonparticipating provider, that is qualified to furnish such items or 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.

''(3) 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 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, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

''SEC. 722. OFFERING OF CHOICE OF COVERAGE OPTIONS.

''(a) REQUIREMENT.—If a group health plan (other than a fully insured group health plan) provides coverage for benefits only through a defined set of participating health care professionals, the plan shall offer the participant the option to purchase point-of-service coverage (as defined in subsection (b)) for all such benefits for which coverage is otherwise so limited. Such option shall be made available to the participant at the time of enrollment under the plan and at such other times as the plan offers the participant a choice of coverage options.

''(b) POINT-OF-SERVICE COVERAGE DEFINED.—In this section, the term 'point-of-service coverage' means, with respect to benefits covered under a group health plan (other than a fully insured group health plan), coverage of such benefits when provided by a nonparticipating health care professional.

''(c) SMALL EMPLOYER EXEMPTION.—

''(1) IN GENERAL.—This section shall not apply to any group health plan (other than a fully insured group health plan) of a small employer.

''(2) SMALL EMPLOYER.—For purposes of paragraph (1), the term 'small employer' means, in connection with a group health plan (other than a fully insured group health plan) with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. For purposes of this paragraph, the provisions of subparagraph (C) of section 712(c)(1) shall apply in determining employer size.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as requiring coverage for benefits for a particular type of health care professional;

''(2) as requiring an employer to pay any costs as a result of this section or to make equal contributions with respect to different health coverage options;

''(3) as preventing a group health plan (other than a fully insured group health plan) from imposing higher premiums or cost-sharing on a participant for the exercise of a point-of-service coverage option; or

''(4) to require that a group health plan (other than a fully insured group health plan) include coverage of health care professionals that the plan excludes because of fraud, quality of care, or other similar reasons with respect to such professionals.

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

''(a) GENERAL RIGHTS.—

''(1) DIRECT ACCESS.—A group health plan described in subsection (b) may not require authorization or referral by the primary care provider described in subsection (b)(2) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating physician who specializes in obstetrics or gynecology.

''(2) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan described in subsection (b) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under paragraph (1), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

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

''(1) provides coverage for obstetric or gynecologic care; and

''(2) requires the designation by a participant or beneficiary of a participating primary care provider other than a physician who specializes in obstetrics or gynecology.

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

''(1) to require that a group health plan approve or provide coverage for—

''(A) any items or services that are not covered under the terms and conditions of the group health plan;

''(B) any items or services that are not medically necessary and appropriate; or

''(C) any items or services that are provided, ordered, or otherwise authorized under subsection (a)(2) by a physician unless such items or services are related to obstetric or gynecologic care;

''(2) to preclude a group health plan from requiring that the physician described in subsection (a) notify the designated primary care professional or case manager of treatment decisions in accordance with a process implemented by the plan, except that the group health plan shall not impose such a notification requirement on the participant or beneficiary involved in the treatment decision;

''(3) to preclude a group health plan from requiring authorization, including prior authorization, for certain items and services from the physician described in subsection (a) who specializes in obstetrics and gynecology if the designated primary care provider of the participant or beneficiary would otherwise be required to obtain authorization for such items or services;

''(4) to require that the participant or beneficiary described in subsection (a)(1) obtain authorization or a referral from a primary care provider in order to obtain obstetrical or gynecological care from a health care professional other than a physician if the provision of obstetrical or gynecological care by such professional is permitted by the group health plan and consistent with State licensure, credentialing, and scope of practice laws and regulations; or

''(5) to preclude the participant or beneficiary described in subsection (a)(1) from designating a health care professional other than a physician as a primary care provider if such designation is permitted by the group health plan and the treatment by such professional is consistent with State licensure, credentialing, and scope of practice laws and regulations.

''SEC. 724. ACCESS TO PEDIATRIC CARE.

''(a) PEDIATRIC CARE.—If a group health plan (other than a fully insured group health plan) requires or provides for a participant or beneficiary to designate a participating primary care provider for a child of such participant or beneficiary, the plan shall permit the participant or beneficiary to designate a physician who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan.

''(b) RULES OF CONSTRUCTION.—With respect to the child of a participant or beneficiary, nothing in subsection (a) shall be construed to—

''(1) require that the participant or beneficiary obtain prior authorization or a referral from a primary care provider in order to obtain pediatric care from a health care professional other than a physician if the provision of pediatric care by such professional is permitted by the plan and consistent with State licensure, credentialing, and scope of practice laws and regulations; or

''(2) preclude the participant or beneficiary from designating a health care professional other than a physician as a primary care provider for the child if such designation is permitted by the plan and the treatment by such professional is consistent with State licensure, credentialing, and scope of practice laws.

''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 receive timely coverage for access to specialists who are appropriate to the medical condition of the participant or beneficiary, when such specialty care is a covered benefit under the plan.

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

''(A) to require the coverage under a group health plan (other than a fully insured group health plan) of benefits or services;

''(B) to prohibit a plan from including providers in the network only to the extent necessary to meet the needs of the plan's participants and beneficiaries;

''(C) to prohibit a plan from establishing measures designed to maintain quality and control costs consistent with the responsibilities of the plan; or

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

''(3) ACCESS TO CERTAIN PROVIDERS.—

''(A) PARTICIPATING PROVIDERS.—Nothing in this section shall be construed to prohibit a group health plan (other than a fully insured group health plan) from requiring that a participant or beneficiary obtain specialty care from a participating specialist.

''(B) NONPARTICIPATING PROVIDERS.—

''(i) IN GENERAL.—With respect to specialty care under this section, if a group health plan (other than a fully insured group health plan) determines that a participating specialist is not available to provide such care to the participant or beneficiary, the plan shall provide for coverage of such care by a nonparticipating specialist.

''(ii) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a group health plan (other than a fully insured group health plan) refers a participant or beneficiary to a nonparticipating specialist pursuant to clause (i), such specialty care shall be provided at no additional cost to the participant or beneficiary beyond what the participant or beneficiary would otherwise pay for such specialty care if provided by a participating specialist.

''(b) REFERRALS.—

''(1) AUTHORIZATION.—Nothing in this section shall be construed to prohibit a group health plan (other than a fully insured group health plan) from requiring an authorization in order to obtain coverage for specialty services so long as such authorization is for an appropriate duration or number of referrals.

''(2) REFERRALS FOR ONGOING SPECIAL CONDITIONS.—

''(A) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall permit a participant or beneficiary who has an ongoing special condition (as defined in subparagraph (B)) to receive a referral to a specialist for the treatment of such condition and

such specialist may authorize such referrals, procedures, tests, and other medical services with respect to such condition, or coordinate the care for such condition, subject to the terms of a treatment plan referred to in subsection (c) with respect to the condition.

''(B) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term 'ongoing 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.

''(c) 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 specialty 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 if the plan requires such approval; 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 plan with regular updates on the specialty care provided, as well as all other necessary medical information.

''(d) SPECIALIST DEFINED.—For purposes of this section, the term 'specialist' means, with respect to the medical condition of the participant or beneficiary, a health care professional, facility, or center (such as a center of excellence) that has adequate expertise (including age-appropriate expertise) through appropriate training and experience.

''(e) RIGHT TO EXTERNAL REVIEW.—Pursuant to the requirements of section 503B, a participant or beneficiary shall have the right to an independent external review if the denial of an item or service or condition that is required to be covered under this section is eligible for such review.

''SEC. 726. CONTINUITY OF CARE.

''(a) TERMINATION OF PROVIDER.—If a contract between a group health plan (other than a fully insured group health plan) and a treating health care provider is terminated (as defined in paragraph (e)(4)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in such plan, and an individual who is a participant or beneficiary in the plan is undergoing an active course of treatment for a serious and complex condition, institutional care, pregnancy, or terminal illness from the provider at the time the plan receives or provides notice of such termination, the plan shall—

''(1) notify the individual, or arrange to have the individual notified pursuant to subsection (d)(2), on a timely basis of such termination;

''(2) provide the individual with an opportunity to notify the plan of the individual's need for transitional care; and

''(3) subject to subsection (c), permit the individual to elect to continue to be covered with respect to the active course of treatment with the provider's consent during a transitional period (as provided for under subsection (b)).

''(b) TRANSITIONAL PERIOD.—

''(1) SERIOUS AND COMPLEX CONDITIONS.—The transitional period under this section with respect to a serious and complex condition shall extend for up to 90 days from the date of the notice described in subsection (a)(1) of the provider's termination.

''(2) INSTITUTIONAL OR INPATIENT CARE.—

''(A) IN GENERAL.—The transitional period under this section for institutional or non-elective inpatient care from a provider shall extend until the earlier of—

''(i) the expiration of the 90-day period beginning on the date on which the notice described in subsection (a)(1) of the provider's termination is provided; or

''(ii) the date of discharge of the individual from such care or the termination of the period of institutionalization.

''(B) SCHEDULED CARE.—The 90 day limitation described in subparagraph (A)(i) shall include post-surgical follow-up care relating to non-elective surgery that has been scheduled before the date of the notice of the termination of the provider under subsection (a)(1).

''(3) PREGNANCY.—If—

''(A) a participant or beneficiary 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 the 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.—If—

''(A) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation; and

''(B) 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 individual's life for care that is directly related to the treatment of the terminal illness.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan (other than a fully insured group health plan) may condition coverage of continued treatment by a provider under this section upon the provider agreeing to the following terms and conditions:

''(1) The treating health care provider agrees to accept reimbursement from the plan and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or at the rates applicable under the replacement plan after the date of the termination of the contract with the group health plan) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in this section had not been terminated.

''(2) The treating health care provider agrees to adhere to the quality assurance standards of the plan responsible for payment under paragraph (1) and to provide to such plan necessary medical information related to the care provided.

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

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

''(1) to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider; or

''(2) with respect to the termination of a contract under subsection (a) to prevent a group health plan from requiring that the health care provider—

''(A) notify participants or beneficiaries of their rights under this section; or

''(B) provide the plan with the name of each participant or beneficiary who the provider believes is eligible for transitional care under this section.

''(e) DEFINITIONS.—In this section:

''(1) CONTRACT.—The term 'contract between a plan and a treating health care provider' shall include a contract between such a plan and an organized network of providers.

''(2) HEALTH CARE PROVIDER.—The term 'health care provider' or 'provider' means—

''(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State; and

''(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

''(3) SERIOUS AND COMPLEX CONDITION.—The term 'serious and complex condition' means, with respect to a participant or beneficiary under the plan, a condition that is medically determinable and—

''(A) in the case of an acute illness, is a condition serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

''(B) in the case of a chronic illness or condition, is an illness or condition that—

''(i) is complex and difficult to manage;

''(ii) is disabling or life-threatening; and

''(iii) requires—

''(I) frequent monitoring over a prolonged period of time and requires substantial on-going specialized medical care; or

''(II) frequent ongoing specialized medical care across a variety of domains of care.

''(4) TERMINATED.—The term 'terminated' includes, with respect to a contract (as defined in paragraph (1)), the expiration or nonrenewal of the contract by the group health plan, but does not include a termination of the contract by the plan for failure to meet applicable quality standards or for fraud.

''(f) RIGHT TO EXTERNAL REVIEW.—Pursuant to the requirements of section 503B, a participant or beneficiary shall have the right to an independent external review if the denial of an item or service or condition that is required to be covered under this section is eligible for such review.

''SEC. 727. PROTECTION OF PATIENT-PROVIDER COMMUNICATIONS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (other than a fully insured group health plan and in relation to a participant or beneficiary) shall not prohibit or otherwise restrict a health care professional from advising such a participant or beneficiary who is a patient of the professional about the health status of the participant or beneficiary or medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether coverage for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

''(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring a group health plan (other than a fully insured group health plan) to provide specific benefits under the terms of such plan.

''SEC. 728. PATIENT'S RIGHT TO PRESCRIPTION DRUGS.

''(a) IN GENERAL.—To the extent that a group health plan (other than a fully insured group health plan) provides coverage for benefits with respect to prescription drugs, and limits such coverage to drugs included in a formulary, the plan shall—

''(1) ensure the participation of physicians and pharmacists in developing and reviewing such formulary; and

''(2) in accordance with the applicable quality assurance and utilization review standards of the plan, provide for exceptions from the formulary limitation when a non-formulary alternative is medically necessary and appropriate.

''(b) RIGHT TO EXTERNAL REVIEW.—Pursuant to the requirements of section 503B, a participant or beneficiary shall have the right to an independent external review if the denial of an item or service or condition that is required to be covered under this section is eligible for such review.

"SEC. 729. SELF-PAYMENT FOR BEHAVIORAL HEALTH CARE SERVICES.

''(a) IN GENERAL.—A group health plan (other than a fully insured group health plan) may not—

''(1) prohibit or otherwise discourage a participant or beneficiary from self-paying for behavioral health care services once the plan has denied coverage for such services; or

''(2) terminate a health care provider because such provider permits participants or beneficiaries to self-pay for behavioral health care services—

''(A) that are not otherwise covered under the plan; or

''(B) for which the group health plan provides limited coverage, to the extent that the group health plan denies coverage of the services.

''(b) RULE OF CONSTRUCTION.—Nothing in subsection (a)(2)(B) shall be construed as prohibiting a group health plan from terminating a contract with a health care provider for failure to meet applicable quality standards or for fraud.

"SEC. 730. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.

''(a) COVERAGE.—

''(1) IN GENERAL.—If a group health plan (other than a fully insured group health plan) provides coverage to a qualified individual (as defined in subsection (b)), the plan—

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

''(B) subject to subsections (b), (c), and (d) 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

''(C) may not discriminate against the individual on the basis of the participant's or beneficiaries participation in such trial.

''(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

''(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

''(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term 'qualified individual' means an individual who is a participant or beneficiary in a group health plan and who meets the following conditions:

''(1)(A) The individual has been diagnosed with cancer for which no standard treatment is effective.

''(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

''(C) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

''(2) Either—

''(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

''(B) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

''(c) PAYMENT.—

''(1) IN GENERAL.—Under this section a group health plan (other than a fully insured group health plan) 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 to be paid for by the sponsors of an approved clinical trial.

''(2) STANDARDS FOR DETERMINING ROUTINE PATIENT COSTS ASSOCIATED WITH CLINICAL TRIAL PARTICIPATION.—

''(A) IN GENERAL.—The Secretary shall, in accordance with this paragraph, establish standards relating to the coverage of routine patient costs for individuals participating in clinical trials that group health plans must meet under this section.

''(B) FACTORS.—In establishing routine patient cost standards under subparagraph (A), the Secretary shall consult with interested parties and take into account —

''(i) quality of patient care;

''(ii) routine patient care costs versus costs associated with the conduct of clinical trials, including unanticipated patient care costs as a result of participation in clinical trials; and

''(iii) previous and on-going studies relating to patient care costs associated with participation in clinical trials.

''(C) APPOINTMENT AND MEETINGS OF NEGOTIATED RULEMAKING COMMITTEE.—

''(i) PUBLICATION OF NOTICE.—Not later than November 15, 2000, the Secretary shall publish notice of the establishment of a negotiated rulemaking committee, as provided for under section 564(a) of title 5, United States Code, to develop the standards described in subparagraph (A), which shall include—

''(I) the proposed scope of the committee;

''(II) the interests that may be impacted by the standards;

''(iii) a list of the proposed membership of the committee;

''(iv) the proposed meeting schedule of the committee;

''(v) a solicitation for public comment on the committee; and

''(vi) the procedures under which an individual may apply for membership on the committee.

''(ii) COMMENT PERIOD.—Notwithstanding section 564(c) of title 5, United States Code, the Secretary shall provide for a period, beginning on the date on which the notice is published under clause (i) and ending on November 30, 2000, for the submission of public comments on the committee under this subparagraph.

''(iii) APPOINTMENT OF COMMITTEE.—Not later than December 30, 2000, the Secretary shall appoint the members of the negotiated rulemaking committee under this subparagraph.

''(iv) FACILITATOR.—Not later than January 10, 2001, the negotiated rulemaking committee shall nominate a facilitator under section 566(c) of title 5, United States Code, to carry out the activities described in subsection (d) of such section.

''(v) MEETINGS.—During the period beginning on the date on which the facilitator is nominated under clause (iv) and ending on March 30, 2001, the negotiated rulemaking committee shall meet to develop the standards described in subparagraph (A).

''(D) PRELIMINARY COMMITTEE REPORT.—

''(i) IN GENERAL.—The negotiated rulemaking committee appointed under subparagraph (C) shall report to the Secretary, by not later than March 30, 2001, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceedings and whether such consensus is likely to occur before the target date described in subsection (F).

''(ii) TERMINATION OF PROCESS AND PUBLICATION OF RULE BY SECRETARY.—If the committee reports under clause (i) that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date described in subsection (F), the Secretary shall terminate such process and provide for the publication in the Federal Register, by not later than June 30, 2001, of a rule under this paragraph through such other methods as the Secretary may provide.

''(E) FINAL COMMITTEE REPORT AND PUBLICATION OR RULE BY SECRETARY.—

''(i) IN GENERAL.—If the rulemaking committee is not terminated under subparagraph (D)(ii), the committee shall submit to the Secretary, by not later than May 30, 2001, a report containing a proposed rule.

''(ii) PUBLICATION OF RULE.—If the Secretary receives a report under clause (i), the Secretary shall provide for the publication in the Federal Register, by not later than June 30, 2001, of the proposed rule.

''(F) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under subparagraph (C)(i), and for purposes of this paragraph, the 'target date for publication' (referred to in section 564(a)(5) of title 5, United States Code) shall be June 30, 2001.

''(G) EFFECTIVE DATE.—The provisions of this paragraph shall apply to group health plans (other than a fully insured group health plan) for plan years beginning on or after January 1, 2002.

''(3) 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 plan would normally pay for comparable services under subparagraph (A).

''(d) APPROVED CLINICAL TRIAL DEFINED.—

''(1) IN GENERAL.—In this section, the term 'approved clinical trial' means a cancer clinical research study or cancer clinical investigation approved or funded (which may include funding through in-kind contributions) by one or more of the following:

''(A) The National Institutes of Health.

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

''(C) The Food and Drug Administration.

''(D) Either of the following if the conditions described in paragraph (2) are met:

''(i) The Department of Veterans Affairs.

''(ii) The Department of Defense.

''(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

''(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

''(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

''(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's coverage with respect to clinical trials.

''(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS; RESPONSIBILITIES OF FIDUCIARIES.—

''(1) IN GENERAL.—For purposes of this section, 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 requirements of this section 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.

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

''(g) STUDY AND REPORT.—

''(1) STUDY.—The Secretary shall study the impact on group health plans for covering routine patient care costs for individuals who are entitled to benefits under this section and who are enrolled in an approved cancer clinical trial program.

''(2) REPORT TO CONGRESS.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains an assessment of—

''(A) any incremental cost to group health plans resulting from the provisions of this section;

''(B) a projection of expenditures to such plans resulting from this section; and

''(C) any impact on premiums resulting from this section.

''(h) RIGHT TO EXTERNAL REVIEW.—Pursuant to the requirements of section 503B, a participant or beneficiary shall have the right to an independent external review if the denial of an item or service or condition that is required to be covered under this section is eligible for such review.

''SEC. 730A. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

''(a) IN GENERAL.—A group health plan (other than a fully insured group health plan) shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

''(b) CONSTRUCTION.—Subsection (a) shall not be construed—

''(1) as requiring the coverage under a group health plan of a particular benefit or service 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;

''(2) to override any State licensure or scope-of-practice law; or

''(3) as requiring a plan that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan.

''SEC. 730B. GENERALLY APPLICABLE PROVISION.

''In the case of a group health plan that provides benefits under 2 or more coverage options, the requirements of this subpart shall apply separately with respect to each coverage option.''.

(b) RULE WITH RESPECT TO CERTAIN PLANS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, health insurance issuers may offer, and eligible individuals may purchase, high deductible health plans described in section 220(c)(2)(A) of the Internal Revenue Code of 1986. Effective for the 5-year period beginning on the date of the enactment of this Act, such health plans shall not be required to provide payment for any health care items or services that are exempt from the plan's deductible.

(2) EXISTING STATE LAWS.—A State law relating to payment for health care items and services in effect on the date of enactment of this Act that is preempted under paragraph (1), shall not apply to high deductible health plans after the expiration of the 5-year period described in such paragraph unless the State reenacts such law after such period.

(c) DEFINITION.—Section 733(a) of the Employee Retirement Income Security Act of 1974 (42 U.S.C. 1191(a)) is amended by adding at the end the following:

''(3) FULLY INSURED GROUP HEALTH PLAN.—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.''.

(d) CONFORMING AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended—

(1) in the item relating to subpart C of part 7 of subtitle B of title I, by striking ''Subpart C'' and inserting ''Subpart D''; and

(2) by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I, the following:

''SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

''Sec. 721. Access to emergency medical care.

''Sec. 722. Offering of choice of coverage options.

''Sec. 723. Patient access to obstetric and gynecological care.

''Sec. 724. Access to pediatric care.

''Sec. 725. Timely access to specialists.

''Sec. 726. Continuity of care.

''Sec. 727. Protection of patient-provider communications.

''Sec. 728. Patient's right to prescription drugs.

''Sec. 729. Self-payment for behavioral health care services.

''Sec. 730. Coverage for individuals participating in approved cancer clinical trials.

''Sec. 730A. Prohibition of discrimination against providers based on licensure.

''Sec. 730B. Generally applicable provision.''.

SEC. 2202. CONFORMING AMENDMENT TO 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 patient's 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 (other than a fully insured group health plan) shall comply with the requirements of subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as added by section 2201 of the Patients' Bill of Rights Plus Act, and such requirements shall be deemed to be incorporated into this section.''.

SEC. 2203. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan has sought to comply in good faith with such requirement.

Subtitle B—Right to Information About Plans and Providers

SEC. 2211. INFORMATION ABOUT PLANS.

(a) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

''SEC. 714. HEALTH PLAN INFORMATION.

''(a) REQUIREMENT—

''(1) DISCLOSURE.—

''(A) IN GENERAL.—A group health plan, and a health insurance issuer that provides coverage in connection with group health insurance coverage, shall provide for the disclosure of the information described in subsection (b) to participants and beneficiaries—

''(i) at the time of the initial enrollment of the participant or beneficiary under the plan or coverage;

''(ii) on an annual basis after enrollment—

''(I) in conjunction with the election period of the plan or coverage if the plan or coverage has such an election period; or

''(II) in the case of a plan or coverage that does not have an election period, in conjunction with the beginning of the plan or coverage year; and

''(iii) in the case of any material reduction to the benefits or information described in paragraphs (1), (2) and (3) of subsection (b), in the form of a summary notice provided not later than the date on which the reduction takes effect.

''(B) PARTICIPANTS AND BENEFICIARIES.—The disclosure required under subparagraph (A) shall be provided—

''(i) jointly to each participant and beneficiary who reside at the same address; or

''(ii) in the case of a beneficiary who does not reside at the same address as the participant, separately to the participant and such beneficiary.

''(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a group health plan sponsor and health insurance issuer from entering into an agreement under which either the plan sponsor or the issuer agrees to assume responsibility for compliance with the requirements of this section, in whole or in part, and the party delegating such responsibility is released from liability for compliance with the requirements that are assumed by the other party, to the extent the party delegating such responsibility did not cause such noncompliance.

''(3) PROVISION OF INFORMATION.—Information shall be provided to participants and beneficiaries under this section at the last known address maintained by the plan or issuer with respect to such participants or beneficiaries, to the extent that such information is provided to participants or beneficiaries via the United States Postal Service or other private delivery service.

''(b) REQUIRED INFORMATION.—The informational materials to be distributed under this section shall include for each option available under the group health plan or health insurance coverage the following:

''(1) BENEFITS.—A description of the covered benefits, including—

''(A) any in- and out-of-network benefits;

''(B) specific preventative services covered under the plan or coverage if such services are covered;

''(C) any benefit limitations, including any annual or lifetime benefit limits and any monetary limits or limits on the number of visits, days, or services, and any specific coverage exclusions; and

''(D) any definition of medical necessity used in making coverage determinations by the plan, issuer, or claims administrator.

''(2) COST SHARING.—A description of any cost-sharing requirements, including—

''(A) any premiums, deductibles, coinsurance, copayment amounts, and liability for balance billing above any reasonable and customary charges, for which the participant or beneficiary will be responsible under each option available under the plan;

''(B) any maximum out-of-pocket expense for which the participant or beneficiary may be liable;

''(C) any cost-sharing requirements for out-of-network benefits or services received from nonparticipating providers; and

''(D) any additional cost-sharing or charges for benefits and services that are furnished without meeting applicable plan or coverage requirements, such as prior authorization or precertification.

''(3) SERVICE AREA.—A description of the plan or issuer's service area, including the provision of any out-of-area coverage.

''(4) PARTICIPATING PROVIDERS.—A directory of participating providers (to the extent a plan or issuer provides coverage through a network of providers) that includes, at a minimum, the name, address, and telephone number of each participating provider, and information about how to inquire whether a participating provider is currently accepting new patients.

''(5) CHOICE OF PRIMARY CARE PROVIDER.—A description of any requirements and procedures to be used by participants and beneficiaries in selecting, accessing, or changing their primary care provider, including providers both within and outside of the network (if the plan or issuer permits out-of-network services), and the right to select a pediatrician as a primary care provider under section 724 for a participant or beneficiary who is a child if such section applies.

''(6) PREAUTHORIZATION REQUIREMENTS.—A description of the requirements and procedures to be used to obtain preauthorization for health services, if such preauthorization is required.

''(7) EXPERIMENTAL AND INVESTIGATIONAL TREATMENTS.—A description of the process for determining whether a particular item, service, or treatment is considered experimental or investigational, and the circumstances under which such treatments are covered by the plan or issuer.

''(8) SPECIALTY CARE.—A description of the requirements and procedures to be used by participants and beneficiaries in accessing specialty care and obtaining referrals to participating and nonparticipating specialists, including the right to timely coverage for access to specialists care under section 725 if such section applies.

''(9) CLINICAL TRIALS.—A description the circumstances and conditions under which participation in clinical trials is covered under the terms and conditions of the plan or coverage, and the right to obtain coverage for approved cancer clinical trials under section 729 if such section applies.

''(10) PRESCRIPTION DRUGS.—To the extent the plan or issuer provides coverage for prescription drugs, a statement of whether such coverage is limited to drugs included in a formulary, a description of any provisions and cost-sharing required for obtaining on- and off-formulary medications, and a description of the rights of participants and beneficiaries in obtaining access to access to prescription drugs under section 727 if such section applies.

''(11) EMERGENCY SERVICES.—A summary of the rules and procedures for accessing emergency services, including the right of a participant or beneficiary to obtain emergency services under the prudent layperson standard under section 721, if such section applies, and any educational information that the plan or issuer may provide regarding the appropriate use of emergency services.

''(12) CLAIMS AND APPEALS.—A description of the plan or issuer's rules and procedures pertaining to claims and appeals, a description of the rights of participants and beneficiaries under sections 503, 503A and 503B in obtaining covered benefits, filing a claim for benefits, and appealing coverage decisions internally and externally (including telephone numbers and mailing addresses of the appropriate authority), and a description of any additional legal rights and remedies available under section 502.

''(13) ADVANCE DIRECTIVES AND ORGAN DONATION.—A description of procedures for advance directives and organ donation decisions if the plan or issuer maintains such procedures.

''(14) INFORMATION ON PLANS AND ISSUERS.—The name, mailing address, and telephone number or numbers of the plan administrator and the issuer to be used by participants and beneficiaries seeking information about plan or coverage benefits and services, payment of a claim, or authorization for services and treatment. The name of the designated decision-maker (or decision-makers) appointed under section 502(n)(2) for purposes of making final determinations under section 503A and approving coverage pursuant to the written determination of an independent medical reviewer under section 503B. Notice of whether the benefits under the plan are provided under a contract or policy of insurance issued by an issuer, or whether benefits are provided directly by the plan sponsor who bears the insurance risk.

''(15) TRANSLATION SERVICES.—A summary description of any translation or interpretation services (including the availability of printed information in languages other than English, audio tapes, or information in Braille) that are available for non-English speakers and participants and beneficiaries with communication disabilities and a description of how to access these items or services.

''(16) ACCREDITATION INFORMATION.—Any information that is made public by accrediting organizations in the process of accreditation if the plan or issuer is accredited, or any additional quality indicators (such as the results of enrollee satisfaction surveys) that the plan or issuer makes public or makes available to participants and beneficiaries.

''(17) NOTICE OF REQUIREMENTS.—A description of any rights of participants and beneficiaries that are established by the Patients' Bill of Rights Plus Act (excluding those described in paragraphs (1) through (16)) if such sections apply. The description required under this paragraph may be combined with the notices required under sections 711(d), 713(b), or 606(a)(1), and with any other notice provision that the Secretary determines may be combined.

''(18) AVAILABILITY OF ADDITIONAL INFORMATION.—A statement that the information described in subsection (c), and instructions on obtaining such information (including telephone numbers and, if available, Internet websites), shall be made available upon request.

''(c) ADDITIONAL INFORMATION.—The informational materials to be provided upon the request of a participant or beneficiary shall include for each option available under a group health plan or health insurance coverage the following:

''(1) STATUS OF PROVIDERS.—The State licensure status of the plan or issuer's participating health care professionals and participating health care facilities, and, if available, the education, training, specialty qualifications or certifications of such professionals.

''(2) COMPENSATION METHODS.—A summary description of the methods (such as capitation, fee-for-service, salary, bundled payments, per diem, or a combination thereof) used for compensating participating health care professionals (including primary care providers and specialists) and facilities in connection with the provision of health care under the plan or coverage. The requirement of this paragraph shall not be construed as requiring plans or issuers to provide information concerning proprietary payment methodology.

''(3) PRESCRIPTION DRUGS.—Information about whether a specific prescription medication is included in the formulary of the plan or issuer, if the plan or issuer uses a defined formulary.

''(4) EXTERNAL APPEALS INFORMATION.—Aggregate information on the number and outcomes of external medical reviews, relative to the sample size (such as the number of covered lives) determined for the plan or issuer's book of business.

''(d) MANNER OF DISCLOSURE.—The information described in this section shall be disclosed in an accessible medium and format that is calculated to be understood by the average participant.

''(e) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a group health plan, or a health insurance issuer in connection with group health insurance coverage, from—

''(1) distributing any other additional information determined by the plan or issuer to be important or necessary in assisting participants and beneficiaries in the selection of a health plan; and

''(2) complying with the provisions of this section by providing information in brochures, through the Internet or other electronic media, or through other similar means, so long as participants and beneficiaries are provided with an opportunity to request that informational materials be provided in printed form.

''(f) CONFORMING REGULATIONS.—The Secretary shall issue regulations to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under part 1, to reduce duplication with respect to any information that is required to be provided under any such requirements.

''(g) SECRETARIAL ENFORCEMENT AUTHORITY.—

''(1) IN GENERAL.—The Secretary may assess a civil monetary penalty against the administrator of a plan or issuer in connection with the failure of the plan or issuer to comply with the requirements of this section.

''(2) AMOUNT OF PENALTY.—

''(A) IN GENERAL.—The amount of the penalty to be imposed under paragraph (1) shall not exceed $100 for each day for each participant and beneficiary with respect to which the failure to comply with the requirements of this section occurs.

''(B) INCREASE IN AMOUNT.—The amount referred to in subparagraph (A) shall be increased or decreased, for each calendar year that ends after December 31, 2000, by the same percentage as the percentage by which the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, for September of the preceding calendar year has increased or decreased from the such Index for September of 2000.

''(3) FAILURE DEFINED.—For purposes of this subsection, a plan or issuer shall have failed to comply with the requirements of this section with respect to a participant or beneficiary if the plan or issuer failed or refused to comply with the requirements of this section within 30 days—

''(A) of the date described in subsection (a)(1)(A)(i);

''(B) of the date described in subsection (a)(1)(A)(ii); or

''(C) of the date on which additional information was requested under subsection (c).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(2) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001) is amended by inserting after the item relating to section 713, the following:

''Sec 714. Health plan comparative information.''.

(3) Section 502(b)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(b)(3)) is amended by striking ''733(a)(1))'' and inserting ''733(a)(1)), except with respect to the requirements of section 714''.

SEC. 2212. INFORMATION ABOUT PROVIDERS.

(a) STUDY.—The Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine for the conduct of a study, and the submission to the Secretary of a report, that includes—

(1) an analysis of information concerning health care professionals that is currently available to patients, consumers, States, and professional societies, nationally and on a State-by-State basis, including patient preferences with respect to information about such professionals and their competencies;

(2) an evaluation of the legal and other barriers to the sharing of information concerning health care professionals; and

(3) recommendations for the disclosure of information on health care professionals, including the competencies and professional qualifications of such practitioners, to better facilitate patient choice, quality improvement, and market competition.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall forward to the appropriate committees of Congress a copy

of the report and study conducted under subsection (a).

Subtitle C—Right to Hold Health Plans Accountable

SEC. 2221. AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

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

"SEC. 503A. CLAIMS AND INTERNAL APPEALS PROCEDURES FOR GROUP HEALTH PLANS.

''(a) INITIAL CLAIM FOR BENEFITS UNDER GROUP HEALTH PLANS.—

''(1) PROCEDURES.—

''(A) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall ensure that procedures are in place for—

''(i) making a determination on an initial claim for benefits by a participant or beneficiary (or authorized representative) regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involved, including any cost-sharing amount that the participant or beneficiary is required to pay with respect to such claim for benefits; and

''(ii) notifying a participant or beneficiary (or authorized representative) and the treating health care professional involved regarding a determination on an initial claim for benefits made under the terms and conditions of the plan or coverage, including any cost-sharing amounts that the participant or beneficiary may be required to make with respect to such claim for benefits, and of the right of the participant or beneficiary to an internal appeal under subsection (b).

''(B) ACCESS TO INFORMATION.—With respect to an initial claim for benefits, the participant or beneficiary (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information necessary to make a determination relating to the claim, not later than 5 business days after the date on which the claim is filed or to meet the applicable timelines under clauses (ii) and (iii) of paragraph (2)(A).

''(C) ORAL REQUESTS.—In the case of a claim for benefits involving an expedited or concurrent determination, a participant or beneficiary (or authorized representative) may make an initial claim for benefits orally, but a group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, may require that the participant or beneficiary (or authorized representative) provide written confirmation of such request in a timely manner.

''(2) TIMELINE FOR MAKING DETERMINATIONS.—

''(A) PRIOR AUTHORIZATION DETERMINATION.—

''(i) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall maintain procedures to ensure that a prior authorization determination on a claim for benefits is made within 14 business days from the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the request for prior authorization, but in no case shall such determination be made later than 28 business days after the receipt of the claim for benefits.

''(ii) EXPEDITED DETERMINATION.—Notwithstanding clause (i), a group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall maintain procedures for expediting a prior authorization determination on a claim for benefits described in such clause when a request for such an expedited determination is made by a participant or beneficiary (or authorized representative) at any time during the process for making a determination and the treating health care professional substantiates, with the request, that a determination under the procedures described in clause (i) would seriously jeopardize the life or health of the participant or beneficiary. Such determination shall be made within 72 hours after a request is received by the plan or issuer under this clause.

''(iii) CONCURRENT DETERMINATIONS.—A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall maintain procedures to ensure that a concurrent determination on a claim for benefits that results in a discontinuation of inpatient care is made within 24 hours after the receipt of the claim for benefits.

''(B) RETROSPECTIVE DETERMINATION.—A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall maintain procedures to ensure that a retrospective determination on a claim for benefits is made within 30 business days of the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the claim, but in no case shall such determination be made later than 60 business days after the receipt of the claim for benefits.

''(3) NOTICE OF A DENIAL OF A CLAIM FOR BENEFITS.—Written notice of a denial made under an initial claim for benefits shall be issued to the participant or beneficiary (or authorized representative) and the treating health care professional not later than 2 business days after the determination (or within the 72-hour or 24-hour period referred to in clauses (ii) and (iii) of paragraph (2)(A) if applicable).

''(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—The written notice of a denial of a claim for benefits determination under paragraph (3) shall include—

''(A) the reasons for the determination (including a summary of the clinical or scientific-evidence based rationale used in making the determination and instruction on obtaining a more complete description written in a manner calculated to be understood by the average participant);

''(B) the procedures for obtaining additional information concerning the determination; and

''(C) notification of the right to appeal the determination and instructions on how to initiate an appeal in accordance with subsection (b).

''(b) INTERNAL APPEAL OF A DENIAL OF A CLAIM FOR BENEFITS.—

''(1) RIGHT TO INTERNAL APPEAL.—

''(A) IN GENERAL.—A participant or beneficiary (or authorized representative) may appeal any denial of a claim for benefits under subsection (a) under the procedures described in this subsection.

''(B) TIME FOR APPEAL.—A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall ensure that a participant or beneficiary (or authorized representative) has a period of not less than 60 days beginning on the date of a denial of a claim for benefits under subsection (a) in which to appeal such denial under this subsection.

''(C) FAILURE TO ACT.—The failure of a plan or issuer to issue a determination on a claim for benefits under subsection (a) within the applicable timeline established for such a determination under such subsection shall be treated as a denial of a claim for benefits for purposes of proceeding to internal review under this subsection.

''(D) PLAN WAIVER OF INTERNAL REVIEW.—A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, may waive the internal review process under this subsection and permit a participant or beneficiary (or authorized representative) to proceed directly to external review under section 503B.

''(2) TIMELINES FOR MAKING DETERMINATIONS.—

''(A) ORAL REQUESTS.—In the case of an appeal of a denial of a claim for benefits under this subsection that involves an expedited or concurrent determination, a participant or beneficiary (or authorized representative) may request such appeal orally, but a group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, may require that the participant or beneficiary (or authorized representative) provide written confirmation of such request in a timely manner.

''(B) ACCESS TO INFORMATION.—With respect to an appeal of a denial of a claim for benefits, the participant or beneficiary (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information necessary to make a determination relating to the appeal, not later than 5 business days after the date on which the request for the appeal is filed or to meet the applicable timelines under clauses (ii) and (iii) of subparagraph (C).

''(C) PRIOR AUTHORIZATION DETERMINATIONS.—

''(i) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall maintain procedures to ensure that a determination on an appeal of a denial of a claim for benefits under this subsection is made within 14 business days after the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the appeal, but in no case shall such determination be made later than 28 business days after the receipt of the request for the appeal.

''(ii) EXPEDITED DETERMINATION.—Notwithstanding clause (i), a group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall maintain procedures for expediting a prior authorization determination on an appeal of a denial of a claim for benefits described in clause (i), when a request for such an expedited determination is made by a participant or beneficiary (or authorized representative) at any time during the process for making a determination and the treating health care professional substantiates, with the request, that a determination under the procedures described in clause (i) would seriously jeopardize the life or health of the participant or beneficiary. Such determination shall be made not later than 72 hours after the request for such appeal is received by the plan or issuer under this clause.

''(iii) CONCURRENT DETERMINATIONS.—A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall maintain procedures to ensure that a concurrent determination on an appeal of a denial of a claim for benefits that results in a discontinuation of inpatient care is made within 24 hours after the receipt of the request for appeal.

''(B) RETROSPECTIVE DETERMINATION.—A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall maintain procedures to ensure that a retrospective determination on an appeal of a claim for benefits is made within 30 business days of the date on which the plan or issuer receives necessary information that is reasonably required by the plan or issuer to make a determination on the appeal, but in no case shall such determination be made later than 60 business days after the receipt of the request for the appeal.

''(3) CONDUCT OF REVIEW.—

''(A) IN GENERAL.—A review of a denial of a claim for benefits under this subsection shall be conducted by an individual with appropriate expertise who was not directly involved in the initial determination.

''(B) REVIEW OF MEDICAL DECISIONS BY PHYSICIANS.—A review of an appeal of a denial of a

claim for benefits that is based on a lack of medical necessity and appropriateness, or based on an experimental or investigational treatment, or requires an evaluation of medical facts, shall be made by a physician with appropriate expertise, including age-appropriate expertise, who was not involved in the initial determination.

''(4) NOTICE OF DETERMINATION.—

''(A) IN GENERAL.—Written notice of a determination made under an internal appeal of a denial of a claim for benefits shall be issued to the participant or beneficiary (or authorized representative) and the treating health care professional not later than 2 business days after the completion of the review (or within the 72-hour or 24-hour period referred to in paragraph (2) if applicable).

''(B) FINAL DETERMINATION.—The decision by a plan or issuer under this subsection shall be treated as the final determination of the plan or issuer on a denial of a claim for benefits. The failure of a plan or issuer to issue a determination on an appeal of a denial of a claim for benefits under this subsection within the applicable timeline established for such a determination shall be treated as a final determination on an appeal of a denial of a claim for benefits for purposes of proceeding to external review under section 503B.

''(C) REQUIREMENTS OF NOTICE.—With respect to a determination made under this subsection, the notice described in subparagraph (A) shall include—

''(i) the reasons for the determination (including a summary of the clinical or scientific-evidence based rationale used in making the determination and instruction on obtaining a more complete description written in a manner calculated to be understood by the average participant);

''(ii) the procedures for obtaining additional information concerning the determination; and

''(iii) notification of the right to an independent external review under section 503B and instructions on how to initiate such a review.

''(c) DEFINITIONS.—The definitions contained in section 503B(i) shall apply for purposes of this section.

''SEC. 503B. INDEPENDENT EXTERNAL APPEALS PROCEDURES FOR GROUP HEALTH PLANS.

''(a) RIGHT TO EXTERNAL APPEAL.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, shall provide in accordance with this section participants and beneficiaries (or authorized representatives) with access to an independent external review for any denial of a claim for benefits.

''(b) INITIATION OF THE INDEPENDENT EXTERNAL REVIEW PROCESS.—

''(1) TIME TO FILE.—A request for an independent external review under this section shall be filed with the plan or issuer not later than 60 business days after the date on which the participant or beneficiary receives notice of the denial under section 503A(b)(4) or the date on which the internal review is waived by the plan or issuer under section 503A(b)(1)(D).

''(2) FILING OF REQUEST.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, a group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may—

''(i) except as provided in subparagraph (B)(i), require that a request for review be in writing;

''(ii) limit the filing of such a request to the participant or beneficiary involved (or an authorized representative);

''(iii) except if waived by the plan or issuer under section 503A(b)(1)(D), condition access to an independent external review under this section upon a final determination of a denial of a claim for benefits under the internal review procedure under section 503A;

''(iv) except as provided in subparagraph (B)(ii), require payment of a filing fee to the plan or issuer of a sum that does not exceed $50; and

''(v) require that a request for review include the consent of the participant or beneficiary (or authorized representative) for the release of medical information or records of the participant or beneficiary to the qualified external review entity for purposes of conducting external review activities.

''(B) REQUIREMENTS AND EXCEPTION RELATING TO GENERAL RULE.—

''(i) ORAL REQUESTS PERMITTED IN EXPEDITED OR CONCURRENT CASES.—In the case of an expedited or concurrent external review as provided for under subsection (e), the request may be made orally. In such case a written confirmation of such request shall be made in a timely manner. Such written confirmation shall be treated as a consent for purposes of subparagraph (A)(v).

''(ii) EXCEPTION TO FILING FEE REQUIREMENT.—

''(I) INDIGENCY.—Payment of a filing fee shall not be required under subparagraph (A)(iv) where there is a certification (in a form and manner specified in guidelines established by the Secretary) that the participant or beneficiary is indigent (as defined in such guidelines). In establishing guidelines under this subclause, the Secretary shall ensure that the guidelines relating to indigency are consistent with the poverty guidelines used by the Secretary of Health and Human Services under title XIX of the Social Security Act.

''(II) FEE NOT REQUIRED.—Payment of a filing fee shall not be required under subparagraph (A)(iv) if the plan or issuer waives the internal appeals process under section 503A(b)(1)(D).

''(III) REFUNDING OF FEE.—The filing fee paid under subparagraph (A)(iv) shall be refunded if the determination under the independent external review is to reverse the denial which is the subject of the review.

''(IV) INCREASE IN AMOUNT.—The amount referred to in subclause (I) shall be increased or decreased, for each calendar year that ends after December 31, 2001, by the same percentage as the percentage by which the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, for September of the preceding calendar year has increased or decreased from the such Index for September of 2001.

''(c) REFERRAL TO QUALIFIED EXTERNAL REVIEW ENTITY UPON REQUEST.—

''(1) IN GENERAL.—Upon the filing of a request for independent external review with the group health plan, or health insurance issuer offering coverage in connection with a group health plan, the plan or issuer shall refer such request to a qualified external review entity selected in accordance with this section.

''(2) ACCESS TO PLAN OR ISSUER AND HEALTH PROFESSIONAL INFORMATION.—With respect to an independent external review conducted under this section, the participant or beneficiary (or authorized representative), the plan or issuer, and the treating health care professional (if any) shall provide the external review entity with access to information that is necessary to conduct a review under this section, as determined by the entity, not later than 5 business days after the date on which a request is referred to the qualified external review entity under paragraph (1), or earlier as determined appropriate by the entity to meet the applicable timelines under clauses (ii) and (iii) of subsection (e)(1)(A).

''(3) SCREENING OF REQUESTS BY QUALIFIED EXTERNAL REVIEW ENTITIES.—

''(A) IN GENERAL.—With respect to a request referred to a qualified external review entity under paragraph (1) relating to a denial of a claim for benefits, the entity shall refer such request for the conduct of an independent medical review unless the entity determines that—

''(i) any of the conditions described in subsection (b)(2)(A) have not been met;

''(ii) the thresholds described in subparagraph (B) have not been met;

''(iii) the denial of the claim for benefits does not involve a medically reviewable decision under subsection (d)(2);

''(iv) the denial of the claim for benefits relates to a decision regarding whether an individual is a participant or beneficiary who is enrolled under the terms of the plan or coverage (including the applicability of any waiting period under the plan or coverage); or

''(v) the denial of the claim for benefits is a decision as to the application of cost-sharing requirements or the application of a specific exclusion or express limitation on the amount, duration, or scope of coverage of items or services under the terms and conditions of the plan or coverage unless the decision is a denial described in subsection (d)(2)(C);

Upon making a determination that any of clauses (i) through (v) applies with respect to the request, the entity shall determine that the denial of a claim for benefits involved is not eligible for independent medical review under subsection (d), and shall provide notice in accordance with subparagraph (D).

''(B) THRESHOLDS.—

''(i) IN GENERAL.—The thresholds described in this subparagraph are that—

''(I) the total amount payable under the plan or coverage for the item or service that was the subject of such denial exceeds a significant financial threshold (as determined under guidelines established by the Secretary); or

''(II) a physician has asserted in writing that there is a significant risk of placing the life, health, or development of the participant or beneficiary in jeopardy if the denial of the claim for benefits is sustained.

''(ii) THRESHOLDS NOT APPLIED.—The thresholds described in this subparagraph shall not apply if the plan or issuer involved waives the internal appeals process with respect to the denial of a claim for benefits involved under section 503A(b)(1)(D).

''(C) PROCESS FOR MAKING DETERMINATIONS.—

''(i) NO DEFERENCE TO PRIOR DETERMINATIONS.—In making determinations under subparagraph (A), there shall be no deference given to determinations made by the plan or issuer under section 503A or the recommendation of a treating health care professional (if any).

''(ii) USE OF APPROPRIATE PERSONNEL.—A qualified external review entity shall use appropriately qualified personnel to make determinations under this section.

''(D) NOTICES AND GENERAL TIMELINES FOR DETERMINATION.—

''(i) NOTICE IN CASE OF DENIAL OF REFERRAL.—If the entity under this paragraph does not make a referral to an independent medical reviewer, the entity shall provide notice to the plan or issuer, the participant or beneficiary (or authorized representative) filing the request, and the treating health care professional (if any) that the denial is not subject to independent medical review. Such notice—

''(I) shall be written (and, in addition, may be provided orally) in a manner calculated to be understood by an average participant;

''(II) shall include the reasons for the determination; and

''(III) include any relevant terms and conditions of the plan or coverage.

''(ii) GENERAL TIMELINE FOR DETERMINATIONS.—Upon receipt of information under paragraph (2), the qualified external review entity, and if required the independent medical reviewer, shall make a determination within the overall timeline that is applicable to the case under review as described in subsection (e), except that if the entity determines that a referral to an independent medical reviewer is not required, the entity shall provide notice of such determination to the participant or beneficiary (or authorized representative) within 2 business days of such determination.

''(d) INDEPENDENT MEDICAL REVIEW.—

''(1) IN GENERAL.—If a qualified external review entity determines under subsection (c) that a denial of a claim for benefits is eligible for independent medical review, the entity shall refer the denial involved to an independent medical reviewer for the conduct of an independent medical review under this subsection.

''(2) MEDICALLY REVIEWABLE DECISIONS.—A denial described in this paragraph is one for which the item or service that is the subject of the denial would be a covered benefit under the terms and conditions of the plan or coverage but for one (or more) of the following determinations:

''(A) DENIALS BASED ON MEDICAL NECESSITY AND APPROPRIATENESS.—The basis of the determination is that the item or service is not medically necessary and appropriate.

''(B) DENIALS BASED ON EXPERIMENTAL OR INVESTIGATIONAL TREATMENT.—The basis of the determination is that the item or service is experimental or investigational.

''(C) DENIALS OTHERWISE BASED ON AN EVALUATION OF MEDICAL FACTS.—A determination that the item or service or condition is not covered but an evaluation of the medical facts by a health care professional in the specific case involved is necessary to determine whether the item or service or condition is required to be provided under the terms and conditions of the plan or coverage.

''(3) INDEPENDENT MEDICAL REVIEW DETERMINATION.—

''(A) IN GENERAL.—An independent medical reviewer under this section shall make a new independent determination with respect to—

''(i) whether the item or service or condition that is the subject of the denial is covered under the terms and conditions of the plan or coverage; and

''(ii) based upon an affirmative determination under clause (i), whether or not the denial of a claim for a benefit that is the subject of the review should be upheld or reversed.

''(B) STANDARD FOR DETERMINATION.—The independent medical reviewer's determination relating to the medical necessity and appropriateness, or the experimental or investigation nature, or the evaluation of the medical facts of the item, service, or condition shall be based on the medical condition of the participant or beneficiary (including the medical records of the participant or beneficiary) and the valid, relevant scientific evidence and clinical evidence, including peer-reviewed medical literature or findings and including expert consensus.

''(C) NO COVERAGE FOR EXCLUDED BENEFITS.—Nothing in this subsection shall be construed to permit an independent medical reviewer to require that a group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, provide coverage for items or services that are specifically excluded or expressly limited under the plan or coverage and that are not covered regardless of any determination relating to medical necessity and appropriateness, experimental or investigational nature of the treatment, or an evaluation of the medical facts in the case involved.

''(D) EVIDENCE AND INFORMATION TO BE USED IN MEDICAL REVIEWS.—In making a determination under this subsection, the independent medical reviewer shall also consider appropriate and available evidence and information, including the following:

''(i) The determination made by the plan or issuer with respect to the claim upon internal review and the evidence or guidelines used by the plan or issuer in reaching such determination.

''(ii) The recommendation of the treating health care professional and the evidence, guidelines, and rationale used by the treating health care professional in reaching such recommendation.

''(iii) Additional evidence or information obtained by the reviewer or submitted by the plan, issuer, participant or beneficiary (or an authorized representative), or treating health care professional.

''(iv) The plan or coverage document.

''(E) INDEPENDENT DETERMINATION.—In making the determination, the independent medical reviewer shall—

''(i) consider the claim under review without deference to the determinations made by the plan or issuer under section 503A or the recommendation of the treating health care professional (if any);

''(ii) consider, but not be bound by the definition used by the plan or issuer of 'medically necessary and appropriate', or 'experimental or investigational', or other equivalent terms that are used by the plan or issuer to describe medical necessity and appropriateness or experimental or investigational nature of the treatment; and

''(iii) notwithstanding clause (ii), adhere to the definition used by the plan or issuer of 'medically necessary and appropriate', or 'experimental or investigational' if such definition is the same as the definition of such term—

''(I) that has been adopted pursuant to a State statute or regulation; or

''(II) that is used for purposes of the program established under titles XVIII or XIX of the Social Security Act or under chapter 89 of title 5, United States Code.

''(F) DETERMINATION OF INDEPENDENT MEDICAL REVIEWER.—An independent medical reviewer shall, in accordance with the deadlines described in subsection (e), prepare a written determination to uphold or reverse the denial under review. Such written determination shall include the specific reasons of the reviewer for such determination, including a summary of the clinical or scientific-evidence based rationale used in making the determination. The reviewer may provide the plan or issuer and the treating health care professional with additional recommendations in connection with such a determination, but any such recommendations shall not be treated as part of the determination.

''(e) TIMELINES AND NOTIFICATIONS.—

''(1) TIMELINES FOR INDEPENDENT MEDICAL REVIEW.—

''(A) PRIOR AUTHORIZATION DETERMINATION.—

''(i) IN GENERAL.—The independent medical reviewer (or reviewers) shall make a determination on a denial of a claim for benefits that is referred to the reviewer under subsection (c)(3) not later than 14 business days after the receipt of information under subsection (c)(2) if the review involves a prior authorization of items or services.

''(ii) EXPEDITED DETERMINATION.—Notwithstanding clause (i), the independent medical reviewer (or reviewers) shall make an expedited determination on a denial of a claim for benefits described in clause (i), when a request for such an expedited determination is made by a participant or beneficiary (or authorized representative) at any time during the process for making a determination, and the treating health care professional substantiates, with the request, that a determination under the timeline described in clause (i) would seriously jeopardize the life or health of the participant or beneficiary. Such determination shall be made not later than 72 hours after the receipt of information under subsection (c)(2).

''(iii) CONCURRENT DETERMINATION.—Notwithstanding clause (i), a review described in such subclause shall be completed not later than 24 hours after the receipt of information under subsection (c)(2) if the review involves a discontinuation of inpatient care.

''(B) RETROSPECTIVE DETERMINATION.—The independent medical reviewer (or reviewers) shall complete a review in the case of a retrospective determination on an appeal of a denial of a claim for benefits that is referred to the reviewer under subsection (c)(3) not later than 30 business days after the receipt of information under subsection (c)(2).

''(2) NOTIFICATION OF DETERMINATION.—The external review entity shall ensure that the plan or issuer, the participant or beneficiary (or authorized representative) and the treating health care professional (if any) receives a copy of the written determination of the independent medical reviewer prepared under subsection (d)(3)(F). Nothing in this paragraph shall be construed as preventing an entity or reviewer from providing an initial oral notice of the reviewer's determination.

''(3) FORM OF NOTICES.—Determinations and notices under this subsection shall be written in a manner calculated to be understood by an average participant.

''(4) TERMINATION OF EXTERNAL REVIEW PROCESS IF APPROVAL OF A CLAIM FOR BENEFITS DURING PROCESS.—

''(A) IN GENERAL.—If a plan or issuer—

''(i) reverses a determination on a denial of a claim for benefits that is the subject of an external review under this section and authorizes coverage for the claim or provides payment of the claim; and

''(ii) provides notice of such reversal to the participant or beneficiary (or authorized representative) and the treating health care professional (if any), and the external review entity responsible for such review,

the external review process shall be terminated with respect to such denial and any filing fee paid under subsection (b)(2)(A)(iv) shall be refunded.

''(B) TREATMENT OF TERMINATION.—An authorization of coverage under subparagraph (A) by the plan or issuer shall be treated as a written determination to reverse a denial under section (d)(3)(F) for purposes of liability under section 502(n)(1)(B).

''(f) COMPLIANCE.—

''(1) APPLICATION OF DETERMINATIONS.—

''(A) EXTERNAL REVIEW DETERMINATIONS BINDING ON PLAN.—The determinations of an external review entity and an independent medical reviewer under this section shall be binding upon the plan or issuer involved.

''(B) COMPLIANCE WITH DETERMINATION.—If the determination of an independent medical reviewer is to reverse the denial, the plan or issuer, upon the receipt of such determination, shall authorize coverage to comply with the medical reviewer's determination in accordance with the timeframe established by the medical reviewer.

''(2) FAILURE TO COMPLY.—If a plan or issuer fails to comply with the timeframe established under paragraph (1)(B)(i) with respect to a participant or beneficiary, where such failure to comply is caused by the plan or issuer, the participant or beneficiary may obtain the items or services involved (in a manner consistent with the determination of the independent external reviewer) from any provider regardless of whether such provider is a participating provider under the plan or coverage.

''(3) REIMBURSEMENT.—

''(A) IN GENERAL.—Where a participant or beneficiary obtains items or services in accordance with paragraph (2), the plan or issuer involved shall provide for reimbursement of the costs of such items of services. Such reimbursement shall be made to the treating health care professional or to the participant or beneficiary (in the case of a participant or beneficiary who pays for the costs of such items or services).

''(B) AMOUNT.—The plan or issuer shall fully reimburse a professional, participant or beneficiary under subparagraph (A) for the total costs of the items or services provided (regardless of any plan limitations that may apply to the coverage of such items of services) so long as—

''(i) the items or services would have been covered under the terms of the plan or coverage if provided by the plan or issuer; and

''(ii) the items or services were provided in a manner consistent with the determination of the independent medical reviewer.

''(4) FAILURE TO REIMBURSE.—Where a plan or issuer fails to provide reimbursement to a professional, participant or beneficiary in accordance with this subsection, the professional, participant or beneficiary may commence a civil action (or utilize other remedies available under law) to recover only the amount of any such reimbursement that is unpaid and any necessary legal costs or expenses (including attorneys' fees) incurred in recovering such reimbursement.

''(g) QUALIFICATIONS OF INDEPENDENT MEDICAL REVIEWERS.—

''(1) IN GENERAL.—In referring a denial to 1 or more individuals to conduct independent medical review under subsection (c), the qualified external review entity shall ensure that—

''(A) each independent medical reviewer meets the qualifications described in paragraphs (2) and (3);

''(B) with respect to each review at least 1 such reviewer meets the requirements described in paragraphs (4) and (5); and

''(C) compensation provided by the entity to the reviewer is consistent with paragraph (6).

''(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician or health care professional who—

''(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

''(B) typically treats the diagnosis or condition or provides the type or treatment under review.

''(3) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

''(i) not be a related party (as defined in paragraph (7));

''(ii) not have a material familial, financial, or professional relationship with such a party; and

''(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

''(B) EXCEPTION.—Nothing in this subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of affiliation with the plan or issuer, from serving as an independent medical reviewer if—

''(I) a non-affiliated individual is not reasonably available;

''(II) the affiliated individual is not involved in the provision of items or services in the case under review; and

''(III) the fact of such an affiliation is disclosed to the plan or issuer and the participant or beneficiary (or authorized representative) and neither party objects;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer if the affiliation is disclosed to the plan or issuer and the participant or beneficiary (or authorized representative), and neither party objects;

''(iii) permit an employee of a plan or issuer, or an individual who provides services exclusively or primarily to or on behalf of a plan or issuer, from serving as an independent medical reviewer; or

''(iv) prohibit receipt of compensation by an independent medical reviewer from an entity if the compensation is provided consistent with paragraph (6).

''(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

''(A) IN GENERAL.—The requirement of this paragraph with respect to a reviewer in a case involving treatment, or the provision of items or services, by—

''(i) a physician, is that the reviewer be a practicing physician of the same or similar specialty, when reasonably available, as a physician who typically treats the diagnosis or condition or provides such treatment in the case under review; or

''(ii) a health care professional (other than a physician), is that the reviewer be a practicing physician or, if determined appropriate by the qualified external review entity, a health care professional (other than a physician), of the same or similar specialty as the health care professional who typically treats the diagnosis or condition or provides the treatment in the case under review.

''(B) PRACTICING DEFINED.—For purposes of this paragraph, the term 'practicing' means, with respect to an individual who is a physician or other health care professional that the individual provides health care services to individual patients on average at least 1 day per week.

''(5) AGE-APPROPRIATE EXPERTISE.—The independent medical reviewer shall have expertise under paragraph (2) that is age-appropriate to the participant or beneficiary involved.

''(6) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified external review entity to an independent medical reviewer in connection with a review under this section shall—

''(A) not exceed a reasonable level; and

''(B) not be contingent on the decision rendered by the reviewer.

''(7) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a denial of a claim under a plan or coverage relating to a participant or beneficiary, any of the following:

''(A) The plan, plan sponsor, or issuer involved, or any fiduciary, officer, director, or employee of such plan, plan sponsor, or issuer.

''(B) The participant or beneficiary (or authorized representative).

''(C) The health care professional that provides the items of services involved in the denial.

''(D) The institution at which the items or services (or treatment) involved in the denial are provided.

''(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

''(F) Any other party determined under any regulations to have a substantial interest in the denial involved.

''(h) QUALIFIED EXTERNAL REVIEW ENTITIES.—

''(1) SELECTION OF QUALIFIED EXTERNAL REVIEW ENTITIES.—

''(A) LIMITATION ON PLAN OR ISSUER SELECTION.—The Secretary shall implement procedures with respect to the selection of qualified external review entities by a plan or issuer to assure that the selection process among qualified external review entities will not create any incentives for external review entities to make a decision in a biased manner.

''(B) STATE AUTHORITY WITH RESPECT TO QUALIFIED EXTERNAL REVIEW ENTITIES FOR HEALTH INSURANCE ISSUERS.—With respect to health insurance issuers offering health insurance coverage in connection with a group health plan in a State, the State may, pursuant to a State law that is enacted after the date of enactment of the Patients' Bill of Rights Plus Act, provide for the designation or selection of qualified external review entities in a manner determined by the State to assure an unbiased determination in conducting external review activities. In conducting reviews under this section, an entity designated or selected under this subparagraph shall comply with the provision of this section.

''(2) CONTRACT WITH QUALIFIED EXTERNAL REVIEW ENTITY.—Except as provided in paragraph (1)(B), the external review process of a plan or issuer under this section shall be conducted under a contract between the plan or issuer and 1 or more qualified external review entities (as defined in paragraph (4)(A)).

''(3) TERMS AND CONDITIONS OF CONTRACT.—The terms and conditions of a contract under paragraph (2) shall—

''(A) be consistent with the standards the Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external review activities; and

''(B) provide that the costs of the external review process shall be borne by the plan or issuer.

Subparagraph (B) shall not be construed as applying to the imposition of a filing fee under subsection (b)(2)(A)(iv) or costs incurred by the participant or beneficiary (or authorized representative) or treating health care professional (if any) in support of the review, including the provision of additional evidence or information.

''(4) QUALIFICATIONS.—

''(A) IN GENERAL.—In this section, the term 'qualified external review entity' means, in relation to a plan or issuer, an entity that is initially certified (and periodically recertified) under subparagraph (C) as meeting the following requirements:

''(i) The entity has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to carry out duties of a qualified external review entity under this section on a timely basis, including making determinations under subsection (b)(2)(A) and providing for independent medical reviews under subsection (d).

''(ii) The entity is not a plan or issuer or an affiliate or a subsidiary of a plan or issuer, and is not an affiliate or subsidiary of a professional or trade association of plans or issuers or of health care providers.

''(iii) The entity has provided assurances that it will conduct external review activities consistent with the applicable requirements of this section and standards specified in subparagraph (C), including that it will not conduct any external review activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

''(iv) The entity has provided assurances that it will provide information in a timely manner under subparagraph (D).

''(v) The entity meets such other requirements as the Secretary provides by regulation.

''(B) INDEPENDENCE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), an entity meets the independence requirements of this subparagraph with respect to any case if the entity—

''(I) is not a related party (as defined in subsection (g)(7));

''(II) does not have a material familial, financial, or professional relationship with such a party; and

''(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

''(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified external review entity of compensation from a plan or issuer for the conduct of external review activities under this section if the compensation is provided consistent with clause (iii).

''(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by a plan or issuer to a qualified external review entity in connection with reviews under this section shall—

''(I) not exceed a reasonable level; and

''(II) not be contingent on the decision rendered by the entity or by any independent medical reviewer.

''(C) CERTIFICATION AND RECERTIFICATION PROCESS.—

''(i) IN GENERAL.—The initial certification and recertification of a qualified external review entity shall be made—

''(I) under a process that is recognized or approved by the Secretary; or

''(II) by a qualified private standard-setting organization that is approved by the Secretary under clause (iii).

''(ii) PROCESS.—The Secretary shall not recognize or approve a process under clause (i)(I) unless the process applies standards (as promulgated in regulations) that ensure that a qualified external review entity—

''(I) will carry out (and has carried out, in the case of recertification) the responsibilities of such an entity in accordance with this section, including meeting applicable deadlines;

''(II) will meet (and has met, in the case of recertification) appropriate indicators of fiscal integrity;

''(III) will maintain (and has maintained, in the case of recertification) appropriate confidentiality with respect to individually identifiable health information obtained in the course of conducting external review activities; and

''(IV) in the case recertification, shall review the matters described in clause (iv).

''(iii) APPROVAL OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—For purposes of clause (i)(II), the Secretary may approve a qualified private standard-setting organization if the Secretary finds that the organization only certifies (or recertifies) external review entities that meet at least the standards required for the certification (or recertification) of external review entities under clause (ii).

''(iv) CONSIDERATIONS IN RECERTIFICATIONS.—In conducting recertifications of a qualified external review entity under this paragraph, the Secretary or organization conducting the recertification shall review compliance of the entity with the requirements for conducting external review activities under this section, including the following:

''(I) Provision of information under subparagraph (D).

''(II) Adherence to applicable deadlines (both by the entity and by independent medical reviewers it refers cases to).

''(III) Compliance with limitations on compensation (with respect to both the entity and independent medical reviewers it refers cases to).

''(IV) Compliance with applicable independence requirements.

''(v) PERIOD OF CERTIFICATION OR RECERTIFICATION.—A certification or recertification provided under this paragraph shall extend for a period not to exceed 5 years.

''(vi) REVOCATION.—A certification or recertification under this paragraph may be revoked by the Secretary or by the organization providing such certification upon a showing of cause.

''(D) PROVISION OF INFORMATION.—

''(i) IN GENERAL.—A qualified external review entity shall provide to the Secretary, in such manner and at such times as the Secretary may require, such information (relating to the denials which have been referred to the entity for the conduct of external review under this section) as the Secretary determines appropriate to assure compliance with the independence and other requirements of this section to monitor and assess the quality of its external review activities and lack of bias in making determinations. Such information shall include information described in clause (ii) but shall not include individually identifiable medical information.

''(ii) INFORMATION TO BE INCLUDED.—The information described in this subclause with respect to an entity is as follows:

''(I) The number and types of denials for which a request for review has been received by the entity.

''(II) The disposition by the entity of such denials, including the number referred to a independent medical reviewer and the reasons for such dispositions (including the application of exclusions), on a plan or issuer-specific basis and on a health care specialty-specific basis.

''(III) The length of time in making determinations with respect to such denials.

''(IV) Updated information on the information required to be submitted as a condition of certification with respect to the entity's performance of external review activities.

''(iii) INFORMATION TO BE PROVIDED TO CERTIFYING ORGANIZATION.—

''(I) IN GENERAL.—In the case of a qualified external review entity which is certified (or recertified) under this subsection by a qualified private standard-setting organization, at the request of the organization, the entity shall provide the organization with the information provided to the Secretary under clause (i).

''(II) ADDITIONAL INFORMATION.—Nothing in this subparagraph shall be construed as preventing such an organization from requiring additional information as a condition of certification or recertification of an entity.

''(iv) USE OF INFORMATION.—Information provided under this subparagraph may be used by the Secretary and qualified private standard-setting organizations to conduct oversight of qualified external review entities, including recertification of such entities, and shall be made available to the public in an appropriate manner.

''(E) LIMITATION ON LIABILITY.—No qualified external review entity having a contract with a plan or issuer, and no person who is employed by any such entity or who furnishes professional services to such entity (including as an independent medical reviewer), shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

''(i) DEFINITIONS.—In this section:

''(1) AUTHORIZED REPRESENTATIVE.—The term 'authorized representative' means, with respect to a participant or beneficiary—

''(A) a person to whom a participant or beneficiary has given express written consent to represent the participant or beneficiary in any proceeding under this section;

''(B) a person authorized by law to provide substituted consent for the participant or beneficiary; or

''(C) a family member of the participant or beneficiary (or the estate of the participant or beneficiary) or the participant's or beneficiary's treating health care professional when the participant or beneficiary is unable to provide consent.

''(2) CLAIM FOR BENEFITS.—The term 'claim for benefits' means any request by a participant or beneficiary (or authorized representative) for benefits (including requests that are subject to authorization of coverage or utilization review), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage offered by a health insurance issuer in connection with a group health plan.

''(3) GROUP HEALTH PLAN.—The term 'group health plan' shall have the meaning given such term in section 733(a). In applying this paragraph, excepted benefits described in section 733(c) shall not be treated as benefits consisting of medical care.

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 733(b)(1). In applying this paragraph, excepted benefits described in section 733(c) shall not be treated as benefits consisting of medical care.

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

''(6) PRIOR AUTHORIZATION DETERMINATION.—The term 'prior authorization determination' means a determination by the group health plan or health insurance issuer offering health insurance coverage in connection with a group health plan prior to the provision of the items and services as a condition of coverage of the items and services under the terms and conditions of the plan or coverage.

''(7) TREATING HEALTH CARE PROFESSIONAL.—The term 'treating health care professional' with respect to a group health plan, health insurance issuer or provider sponsored organization means a physician (medical doctor or doctor of osteopathy) or other health care practitioner who is acting within the scope of his or her State licensure or certification for the delivery of health care services and who is primarily responsible for delivering those services to the participant or beneficiary.

''(8) UTILIZATION REVIEW.—The term 'utilization review' with respect to a group health plan or health insurance coverage means procedures used in the determination of coverage for a participant or beneficiary, such as procedures to evaluate the medical necessity, appropriateness, efficacy, quality, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.''.

(b) CONFORMING 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 503 the following:

''Sec. 503A. Claims and internal appeals procedures for group health plans.

''Sec. 503B. Independent external appeals procedures for group health plans.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after 2 years after the date of enactment of this Act. The Secretary shall issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

SEC. 2222. ENFORCEMENT.

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

''(8) The Secretary may assess a civil penalty against any plan of up to $10,000 for the plan's failure or refusal to comply with any deadline applicable under section 503B or any determination under such section, except that in any case in which treatment was not commenced by the plan in accordance with the determination of an independent external reviewer, the Secretary shall assess a civil penalty of $10,000 against the plan and the plan shall pay such penalty to the participant or beneficiary involved.''.

Subtitle D—Remedies

SEC. 2231. AVAILABILITY OF COURT REMEDIES.

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

''(n) CAUSE OF ACTION RELATING TO DENIAL OF A CLAIM FOR HEALTH BENEFITS.—

''(1) IN GENERAL.—

''(A) FAILURE TO COMPLY WITH EXTERNAL MEDICAL REVIEW.—In any case in which—

''(i) a designated decision-maker described in paragraph (2) fails to exercise ordinary care in

approving coverage pursuant to the written determination of an independent medical reviewer under section 503B(d)(3)(F) that reverses a denial of a claim for benefits; and

''(ii) the failure described in clause (i) is the proximate cause of substantial harm to, or the wrongful death of, the participant or beneficiary;

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

''(B) WRONGFUL DETERMINATION RESULTING IN DELAY IN PROVIDING BENEFITS.—In any case in which—

''(i) a designated decision-maker described in paragraph (2) acts in bad faith in making a final determination denying a claim for benefits under section 503A(b);

''(ii) the denial described in clause (i) is reversed by an independent medical reviewer under section 503B(d); and

''(iii) the delay attributable to the failure described in clause (i) is the proximate cause of substantial harm to, or the wrongful death of, the participant or beneficiary;

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

''(2) DESIGNATED DECISION-MAKERS FOR PURPOSES OF LIABILITY.—An employer or plan sponsor shall not be liable under any cause of action described in paragraph (1) if the employer or plan sponsor complies with the following provisions:

''(A) APPOINTMENT.—A group health plan may designate one or more persons to serve as the designated decision-maker for purposes of paragraph (1). Such designated decision-makers shall have the exclusive authority under the group health plan (or under the health insurance coverage in the case of a health insurance issuer offering coverage in connection with a group health plan) to make determinations described in section 503A with respect to claims for benefits and determination to approve coverage pursuant to written determination of independent medical reviewers under section 503B, except that the plan documents may expressly provide that the designated decision-maker is subject to the direction of a named fiduciary.

''(B) PROCEDURES.—A designated decision-maker shall—

''(i) be a person who is named in the plan or coverage documents, or who, pursuant to procedures specified in the plan or coverage documents, is identified as the designated decision-maker by—

''(I) a person who is an employer or employee organization with respect to the plan or issuer;

''(II) a person who is such an employer and such an employee organization acting jointly; or

''(III) a person who is a named fiduciary;

''(ii) agree to accept appointment as a designated decision-maker; and

''(iii) be identified in the plan or coverage documents as required under section 714(b)(14).

''(C) QUALIFICATIONS.—To be appointed as a designated decision-maker under this paragraph, a person shall be—

''(i) a plan sponsor;

''(ii) a group health plan;

''(iii) a health insurance issuer; or

''(iv) any other person who can provide adequate evidence, in accordance with regulations promulgated by the Secretary, of the ability of the person to—

''(I) carry out the responsibilities set forth in the plan or coverage documents;

''(II) carry out the applicable requirements of this subsection; and

''(III) meet other applicable requirements under this Act, including any financial obligation for liability under this subsection.

''(D) FLEXIBILITY IN ADMINISTRATION.—A group health plan, or health insurance issuer offering coverage in connection with a group health plan, may provide—

''(i) that any person or group of persons may serve in more than one capacity with respect to the plan or coverage (including service as a designated decision-maker, administrator, and named fiduciary); or

''(ii) that a designated decision-maker may employ one or more persons to provide advice with respect to any responsibility of such decision-maker under the plan or coverage.

''(E) FAILURE TO DESIGNATE.—In any case in which a designated decision-maker is not appointed under this paragraph, the group health plan (or health insurance issuer offering coverage in connection with the group health plan), the administrator, or the party or parties that bears the sole responsibility for making the final determination under section 503A(b) (with respect to an internal review), or for approving coverage pursuant to the written determination of an independent medical reviewer under section 503B, with respect to a denial of a claim for benefits shall be treated as the designated decision-maker for purposes of liability under this section.

''(3) REQUIREMENT OF EXHAUSTION OF INDEPENDENT MEDICAL REVIEW.—Paragraph (1) shall apply only if a final determination denying a claim for benefits under section 503A(b) has been referred for independent medical review under section 503B(d) and a written determination by an independent medical reviewer to reverse such final determination has been issued with respect to such review.

''(4) LIMITATIONS ON RECOVERY OF DAMAGES.—

''(A) MAXIMUM AWARD OF NONECONOMIC DAMAGES.—The aggregate amount of liability for noneconomic loss in an action under paragraph (1) may not exceed $350,000.

''(B) INCREASE IN AMOUNT.—The amount referred to in subparagraph (A) shall be increased or decreased, for each calendar year that ends after December 31, 2001, by the same percentage as the percentage by which the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, for September of the preceding calendar year has increased or decreased from the such Index for September of 2001.

''(C) JOINT AND SEVERAL LIABILITY.—In the case of any action commenced pursuant to paragraph (1), the defendant shall be liable only for the amount of noneconomic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the injury suffered by the participant or beneficiary. In all such cases, the liability of a defendant for noneconomic damages shall be several and not joint.

''(D) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

''(i) IN GENERAL.—In the case of any action commenced pursuant to paragraph (1), the total amount of damages received by a participant or beneficiary under such action shall be reduced, in accordance with clause (ii), by any other payment that has been, or will be, made to such participant or beneficiary to compensate such participant or beneficiary for the injury that was the subject of such action.

''(ii) AMOUNT OF REDUCTION.—The amount by which an award of damages to a participant or beneficiary for an injury shall be reduced under clause (i) shall be—

''(I) the total amount of any payments (other than such award) that have been made or that will be made to such participant or beneficiary to pay costs of or compensate such participant or beneficiary for the injury that was the subject of the action; less

''(II) the amount paid by such participant or beneficiary (or by the spouse, parent, or legal guardian of such participant or beneficiary) to secure the payments described in subclause (I).

''(iii) DETERMINATION OF AMOUNTS FROM COLLATERAL SOURCES.—The reduction required under clause (ii) shall be determined by the court in a pretrial proceeding. At the subsequent trial no evidence shall be admitted as to the amount of any charge, payments, or damage for which a participant or beneficiary—

''(I) has received payment from a collateral source or the obligation for which has been assured by a third party; or

''(II) is, or with reasonable certainty, will be eligible to receive from a collateral source which will, with reasonable certainty, be assumed by a third party.

''(5) AFFIRMATIVE DEFENSES.—In the case of any cause of action under paragraph (1), it shall be an affirmative defense that—

''(A) the group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, involved did not receive from the participant or beneficiary (or authorized representative) or the treating health care professional (if any), sufficient information regarding the medical condition of the participant or beneficiary that was necessary to make a final determination on a claim for benefits under section 503A(b);

''(B) the participant or beneficiary (or authorized representative)—

''(i) was in possession of facts that were sufficient to enable the participant or beneficiary (or authorized representative) to know that an expedited review under section 503A or 503B would have prevented the harm that is the subject of the action; and

''(ii) failed to notify the plan or issuer of the need for such an expedited review; or

''(C) the cause of action is based solely on the failure of a qualified external review entity or an independent medical reviewer to meet the timelines applicable under section 503B.

Nothing in this paragraph shall be construed to limit the application of any other affirmative defense that may be applicable to the cause of action involved.

''(6) WAIVER OF INTERNAL REVIEW.—In the case of any cause of action under paragraph (1), the waiver or nonwaiver of internal review under section 503A(b)(1)(D) by the group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall not be used in determining liability.

''(7) LIMITATIONS ON ACTIONS.—Paragraph (1) shall not apply in connection with any action that is commenced more than 1 year after—

''(A) the date on which the last act occurred which constituted a part of the failure referred to in such paragraph; or

''(B) in the case of an omission, the last date on which the decision-maker could have cured the failure.

''(8) LIMITATION ON RELIEF WHERE DEFENDANT'S POSITION PREVIOUSLY SUPPORTED UPON EXTERNAL REVIEW.—In any case in which the court finds the defendant to be liable in an action under this subsection, to the extent that such liability is based on a finding by the court of a particular failure described in paragraph (1) and such finding is contrary to a previous determination by an independent medical reviewer under section 503B(d) with respect to such defendant, no relief shall be available under this subsection in addition to the relief otherwise available under subsection (a)(1)(B).

''(9) CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing a cause of action under paragraph (1) for—

''(A) the failure of a group health plan or health insurance issuer to provide an item or service that is specifically excluded under the plan or coverage; or

''(B) any denial of a claim for benefits that was not eligible for independent medical review under section 503B(d).

''(10) FEDERAL JURISDICTION.—In the case of any action commenced pursuant to paragraph (1) the district courts of the United States shall have exclusive jurisdiction.

''(11) DEFINITIONS.—In this subsection:

''(A) AUTHORIZED REPRESENTATIVE.—The term 'authorized representative' has the meaning given such term in section 503B(i).

''(B) CLAIM FOR BENEFITS.—The term 'claim for benefits' shall have the meaning given such term in section 503B(i), except that such term shall only include claims for prior authorization determinations (as such term is defined in section 503B(i)).

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

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

''(E) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 733(b)(2) (including health maintenance organizations as defined in section 733(b)(3)).

''(F) ORDINARY CARE.—The term 'ordinary care' means the care, skill, prudence, and diligence under the circumstances prevailing at the time the care is provided that a prudent individual acting in a like capacity and familiar with the care being provided would use in providing care of a similar character.

''(G) SUBSTANTIAL HARM.—The term 'substantial harm' means the loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, or severe and chronic physical pain.

''(12) EFFECTIVE DATE.—The provisions of this subsection shall apply to acts and omissions occurring on or after the date of enactment of this subsection.''.

(b) IMMUNITY FROM LIABILITY FOR PROVISION OF INSURANCE OPTIONS.—

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

''(o) IMMUNITY FROM LIABILITY FOR PROVISION OF INSURANCE OPTIONS.—

''(1) IN GENERAL.—No liability shall arise under subsection (n) with respect to a participant or beneficiary against a group health plan (other than a fully insured group health plan) if such plan offers the participant or beneficiary the coverage option described in paragraph (2).

''(2) COVERAGE OPTION.—The coverage option described in this paragraph is one under which the group health plan (other than a fully insured group health plan), at the time of enrollment or as provided for in paragraph (3), provides the participant or beneficiary with the option to—

''(A) enroll for coverage under a fully insured health plan; or

''(B) receive an individual benefit payment, in an amount equal to the amount that would be contributed on behalf of the participant or beneficiary by the plan sponsor for enrollment in the group health plan, for use by the participant or beneficiary in obtaining health insurance coverage in the individual market.

''(3) TIME OF OFFERING OF OPTION.—The coverage option described in paragraph (2) shall be offered to a participant or beneficiary—

''(A) during the first period in which the individual is eligible to enroll under the group health plan; or

''(B) during any special enrollment period provided by the group health plan after the date of enactment of the Patients' Bill of Rights Plus Act for purposes of offering such coverage option.''.

(2) AMENDMENTS TO INTERNAL REVENUE CODE.—

(A) EXCLUSION FROM INCOME.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following:

''(d) TREATMENT OF CERTAIN COVERAGE OPTION UNDER SELF-INSURED PLANS.—No amount shall be included in the gross income of an individual by reason of—

''(1) the individual's right to elect a coverage option described in section 502(o)(2) of the Employee Retirement Income Security Act of 1974, or

''(2) the receipt by the individual of an individual benefit payment described in section 502(o)(2)(A) of such Act.''

(B) NONDISCRIMINATION RULES.—Section 105(h) of such Code (relating to self-insured medical expense reimbursement plans) is amended by adding at the end the following:

''(11) TREATMENT OF CERTAIN COVERAGE OPTIONS.—If a self-insured medical reimbursement plan offers the coverage option described in section 502(o)(2) of the Employee Retirement Income Security Act of 1974, employees who elect such option shall be treated as eligible to benefit under the plan and the plan shall be treated as benefiting such employees.''

(c) CONFORMING AMENDMENT.—Section 502(a)(1)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(a)(1)(A)) is amended by inserting ''or (n)'' after ''subsection (c)''.

SEC. 2232. LIMITATION ON CERTAIN CLASS ACTION LITIGATION.

(a) ERISA.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 2231, is further amended by adding at the end the following:

''(p) LIMITATION ON CLASS ACTION LITIGATION.—A claim or cause of action under section 502(n) may not be maintained as a class action.''.

(b) RICO.—Section 1964(c) of title 18, United States Code, is amended—

(1) by inserting ''(1)'' after the subsection designation; and

(2) by adding at the end the following:

''(2) No action may be brought under this subsection, or alleging any violation of section 1962, against any person where the action seeks relief for which a remedy may be provided under section 502 of the Employee Retirement Income Security Act of 1974.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to all civil actions that are filed on or after the date of enactment of this Act.

(2) PENDING CIVIL ACTIONS.—Notwithstanding section 502(p) of the Employee Retirement Income Security Act of 1974 and section 1964(c)(2) of title 18, United States Code, such sections 502(p) and 1964(c)(2) shall apply to civil actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of this Act if such actions are substantially similar in nature to the claims or causes of actions referred to in such sections 502(p) and 1964(c)(2).

SEC. 2233. SEVERABILITY.

If any provision of this subtitle, an amendment made by this subtitle, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this subtitle, the amendments made by this subtitle, and the application of the provisions of such to any person or circumstance shall not be affected thereby.

TITLE XXIII—WOMEN'S HEALTH AND CANCER RIGHTS

SEC. 2301. WOMEN'S HEALTH AND CANCER RIGHTS.

(a) SHORT TITLE.—This section may be cited as the ''Women's Health and Cancer Rights Act of 2000''.

(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 2211(a), 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, 2001;

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 (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following new section:

''SEC. 2707. 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, 2001;

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.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–51 et seq.) (relating to other requirements) (42 U.S.C. 300gg–51 et seq.) is amended—

(1) by redesignating such subpart as subpart 2; and

(2) by adding at the end the following:

''SEC. 2753. 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 2707 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 2202, is further amended 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 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.—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.''.

TITLE XXIV—GENETIC INFORMATION AND SERVICES

SEC. 2401. SHORT TITLE.

This title may be cited as the ''Genetic Information Nondiscrimination in Health Insurance Act of 2000''.

SEC. 2402. AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION OR GENETIC SERVICES.—

(1) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 702(a)(1)(F) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(a)(1)(F)) is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(2) NO DISCRIMINATION IN GROUP PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 2301(c), is further amended by adding at the end the following:

''SEC. 716. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''A group health plan, or a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).''.

(3) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—Section 702(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(b)) is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or receipt of genetic services), see section 716.''.

(B) TABLE OF CONTENTS.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974, as amended by section 2301, is further amended by inserting after the item relating to section 715 the following new item:

''Sec. 716. Prohibiting premium discrimination against groups on the basis of predictive genetic information.''.

(b) LIMITATION ON COLLECTION OF PREDICTIVE GENETIC INFORMATION.—Section 702 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182) is amended by adding at the end the following:

''(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require predictive genetic information concerning any individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

''(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan or issuer's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the plan or issuer for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan or issuer.''.

(c) DEFINITIONS.—Section 733(d) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(d)) is amended by adding at the end the following:

''(5) FAMILY MEMBER.—The term 'family member' means with respect to an individual—

''(A) the spouse of the individual;

''(B) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

''(C) all other individuals related by blood to the individual or the spouse or child described in subparagraph (A) or (B).

''(6) GENETIC INFORMATION.—The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member (including information about a request for or receipt of genetic services).

''(7) GENETIC SERVICES.—The term 'genetic services' means health services provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

''(8) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(i) information about an individual's genetic tests;

''(ii) information about genetic tests of family members of the individual; or

''(iii) information about the occurrence of a disease or disorder in family members.

''(B) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

''(i) information about the sex or age of the individual;

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(9) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(d) EFFECTIVE DATE.—Except as provided in this section, this section and the amendments made by this section shall apply with respect to group health plans for plan years beginning 1 year after the date of the enactment of this Act.

SEC. 2403. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

(a) AMENDMENTS RELATING TO THE GROUP MARKET.—

(1) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION IN THE GROUP MARKET.—

(A) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 2702(a)(1)(F) of the Public Health Service Act (42 U.S.C. 300gg–1(a)(1)(F)) is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(B) NO DISCRIMINATION IN PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—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 2301(d), is amended by adding at the end the following new section:

''SEC. 2708. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION IN THE GROUP MARKET.

''A group health plan, or a health insurance issuer offering group health insurance coverage in connection with a group health plan shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).''.

(C) CONFORMING AMENDMENT.—Section 2702(b) of the Public Health Service Act (42 U.S.C. 300gg–1(b)) is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or receipt of genetic services), see section 2708.''.

(D) LIMITATION ON COLLECTION AND DISCLOSURE OF PREDICTIVE GENETIC INFORMATION.—Section 2702 of the Public Health Service Act (42 U.S.C. 300gg–1) is amended by adding at the end the following:

''(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

''(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan or issuer's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the plan or issuer for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan or issuer.''.

(2) DEFINITIONS.—Section 2791(d) of the Public Health Service Act (42 U.S.C. 300gg–91(d)) is amended by adding at the end the following:

''(15) FAMILY MEMBER.—The term 'family member' means, with respect to an individual—

''(A) the spouse of the individual;

''(B) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

''(C) all other individuals related by blood to the individual or the spouse or child described in subparagraph (A) or (B).

''(16) GENETIC INFORMATION.—The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member (including information about a request for or receipt of genetic services).

''(17) GENETIC SERVICES.—The term 'genetic services' means health services provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

''(18) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(i) information about an individual's genetic tests;

''(ii) information about genetic tests of family members of the individual; or

''(iii) information about the occurrence of a disease or disorder in family members.

''(B) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

''(i) information about the sex or age of the individual;

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(19) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(e) AMENDMENTS TO PHSA RELATING TO THE INDIVIDUAL MARKET.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–51 et seq.) (relating to other requirements) (42 U.S.C. 300gg–51 et seq.), as amended by section 2301(e), is further amended by adding at the end the following:

''SEC. 2754. PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''(a) PROHIBITION ON PREDICTIVE GENETIC INFORMATION AS A CONDITION OF ELIGIBILITY.—A health insurance issuer offering health insurance coverage in the individual market may not use predictive genetic information as a condition of eligibility of an individual to enroll in individual health insurance coverage (including information about a request for or receipt of genetic services).

''(b) PROHIBITION ON PREDICTIVE GENETIC INFORMATION IN SETTING PREMIUM RATES.—A health insurance issuer offering health insurance coverage in the individual market shall not adjust premium rates for individuals on the basis of predictive genetic information concerning such an individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a health insurance issuer offering health insurance coverage in the individual market shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a health insurance issuer offering health insurance coverage in the individual market that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the health insurance issuer offering health insurance coverage in the individual market shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

''(d) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A health insurance issuer offering health insurance coverage in the individual market shall post or provide, in writing and in a clear and conspicuous manner, notice of the issuer's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the issuer for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A health insurance issuer offering health insurance coverage in the individual market shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such issuer.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to—

(1) group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after 1 year after the date of enactment of this Act; and

(2) health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after 1 year after the date of enactment of this Act.

SEC. 2404. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

(a) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION OR GENETIC SERVICES.—

(1) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—Section 9802(a)(1)(F) of the Internal Revenue Code of 1986 is amended by inserting before the period the following: ''(including information about a request for or receipt of genetic services)''.

(2) NO DISCRIMINATION IN GROUP PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 2301(f), is further amended by adding at the end the following:

''SEC. 9815. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

''A group health plan shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning any individual (including a dependent)

or a family member of the individual (including information about a request for or receipt of genetic services).''.

(B) CONFORMING AMENDMENT.—Section 9802(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or the receipt of genetic services), see section 9815.''.

(C) AMENDMENT TO TABLE OF SECTIONS.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 2301(f), is further amended by adding at the end the following:

''Sec. 9815. Prohibiting premium discrimination against groups on the basis of predictive genetic information.''.

(b) LIMITATION ON COLLECTION OF PREDICTIVE GENETIC INFORMATION.—Section 9802 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(d) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

''(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a group health plan shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

''(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—

''(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES; DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (e), of such predictive genetic information.

''(e) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

''(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

''(A) PREPARATION OF WRITTEN NOTICE.—A group health plan shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan's confidentiality practices, that shall include—

''(i) a description of an individual's rights with respect to predictive genetic information;

''(ii) the procedures established by the plan for the exercise of the individual's rights; and

''(iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

''(B) MODEL NOTICE.—The Secretary, in consultation with the National Committee on Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

''(2) ESTABLISHMENT OF SAFEGUARDS.—A group health plan shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan.''.

(c) DEFINITIONS.—Section 9832(d) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''(6) FAMILY MEMBER.—The term 'family member' means, with respect to an individual—

''(A) the spouse of the individual;

''(B) a dependent child of the individual, including a child who is born to or placed for adoption with the individual; and

''(C) all other individuals related by blood to the individual or the spouse or child described in subparagraph (A) or (B).

''(7) GENETIC INFORMATION.—The term 'genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member (including information about a request for or receipt of genetic services).

''(8) GENETIC SERVICES.—The term 'genetic services' means health services provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

''(9) PREDICTIVE GENETIC INFORMATION.—

''(A) IN GENERAL.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

''(i) information about an individual's genetic tests;

''(ii) information about genetic tests of family members of the individual; or

''(iii) information about the occurrence of a disease or disorder in family members.

''(B) EXCEPTIONS.—The term 'predictive genetic information' shall not include—

''(i) information about the sex or age of the individual;

''(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

''(iii) information about physical exams of the individual.

''(10) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.''.

(d) EFFECTIVE DATE.—Except as provided in this section, this section and the amendments made by this section shall apply with respect to group health plans for plan years beginning after 1 year after the date of the enactment of this Act.

TITLE XXV—PATIENT SAFETY AND ERRORS REDUCTION

SEC. 2501. SHORT TITLE.

This title may be cited as the ''Patient Safety and Errors Reduction Act''.

SEC. 2502. PURPOSES.

It is the purpose of this title to—

(1) promote the identification, evaluation, and reporting of medical errors;

(2) raise standards and expectations for improvements in patient safety;

(3) reduce deaths, serious injuries, and other medical errors through the implementation of safe practices at the delivery level;

(4) develop error reduction systems with legal protections to support the collection of information under such systems;

(5) extend existing confidentiality and peer review protections to the reports relating to medical errors that are reported under such systems that are developed for safety and quality improvement purposes; and

(6) provide for the establishment of systems of information collection, analysis, and dissemination to enhance the knowledge base concerning patient safety.

SEC. 2503. AMENDMENT TO PUBLIC HEALTH SERVICE ACT.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended—

(1) by redesignating part C as part D;

(2) by redesignating sections 921 through 928, as sections 931 through 938, respectively;

(3) in section 938(1) (as so redesignated), by striking ''921'' and inserting ''931''; and

(4) by inserting after part B the following:

''PART C—REDUCING ERRORS IN HEALTH CARE

''SEC. 921. DEFINITIONS.

''In this part:

''(1) ADVERSE EVENT.—The term 'adverse event' means, with respect to the patient of a provider of services, an untoward incident, therapeutic misadventure, or iatrogenic injury directly associated with the provision of health care items and services by a health care provider or provider of services.

''(2) CENTER.—The term 'Center' means the Center for Quality Improvement and Patient Safety established under section 922(b).

''(3) CLOSE CALL.—The term 'close call' means, with respect to the patient of a provider of services, any event or situation that—

''(A) but for chance or a timely intervention, could have resulted in an accident, injury, or illness; and

''(B) is directly associated with the provision of health care items and services by a provider of services.

''(4) EXPERT ORGANIZATION.—The term 'expert organization' means a third party acting on behalf of, or in conjunction with, a provider of services to collect information about, or evaluate, a medical event.

''(5) HEALTH CARE OVERSIGHT AGENCY.—The term 'health care oversight agency' means an agency, entity, or person, including the employees and agents thereof, that performs or oversees the performance of any activities necessary to ensure the safety of the health care system.

''(6) HEALTH CARE PROVIDER.—The term 'health care provider' means—

''(A) any provider of services (as defined in section 1861(u) of the Social Security Act); and

''(B) any person furnishing any medical or other health care services as defined in section 1861(s)(1) and (2) of such Act through, or under the authority of, a provider of services described in subparagraph (A).

''(7) PROVIDER OF SERVICES.—The term 'provider of services' means a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, renal dialysis facility, ambulatory surgical center, or hospice program, and any other entity specified in regulations promulgated by the Secretary after public notice and comment.

''(8) PUBLIC HEALTH AUTHORITY.—The term 'public health authority' means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, and an Indian tribe that is responsible for public health matters as part of its official mandate.

''(9) MEDICAL EVENT.—The term 'medical event' means, with respect to the patient of a provider of services, any sentinel event, adverse event, or close call.

''(10) MEDICAL EVENT ANALYSIS ENTITY.—The term 'medical event analysis entity' means an entity certified under section 923(a).

''(11) ROOT CAUSE ANALYSIS.—

''(A) IN GENERAL.—The term 'root cause analysis' means a process for identifying the basic or contributing causal factors that underlie variation in performance associated with medical events that—

''(i) has the characteristics described in subparagraph (B);

''(ii) includes participation by the leadership of the provider of services and individuals most closely involved in the processes and systems under review;

''(iii) is internally consistent; and

''(iv) includes the consideration of relevant literature.

''(B) CHARACTERISTICS.—The characteristics described in this subparagraph include the following:

''(i) The analysis is interdisciplinary in nature and involves those individuals who are responsible for administering the reporting systems.

''(ii) The analysis focuses primarily on systems and processes rather than individual performance.

''(iii) The analysis involves a thorough review of all aspects of the process and all contributing factors involved.

''(iv) The analysis identifies changes that could be made in systems and processes, through either redesign or development of new processes or systems, that would improve performance and reduce the risk of medical events.

''(12) SENTINEL EVENT.—The term 'sentinel event' means, with respect to the patient of a provider of services, an unexpected occurrence that—

''(A) involves death or serious physical or psychological injury (including loss of a limb); and

''(B) is directly associated with the provision of health care items and services by a health care provider or provider of services.

''SEC. 922. RESEARCH TO IMPROVE THE QUALITY AND SAFETY OF PATIENT CARE.

''(a) IN GENERAL.—To improve the quality and safety of patient care, the Director shall—

''(1) conduct and support research, evaluations and training, support demonstration projects, provide technical assistance, and develop and support partnerships that will identify and determine the causes of medical errors and other threats to the quality and safety of patient care;

''(2) identify and evaluate interventions and strategies for preventing or reducing medical errors and threats to the quality and safety of patient care;

''(3) identify, in collaboration with experts from the public and private sector, reporting parameters to provide consistency throughout the errors reporting system;

''(4) identify approaches for the clinical management of complications from medical errors; and

''(5) establish mechanisms for the rapid dissemination of interventions and strategies identified under this section for which there is scientific evidence of effectiveness.

''(b) CENTER FOR QUALITY IMPROVEMENT AND PATIENT SAFETY.—

''(1) ESTABLISHMENT.—The Director shall establish a center to be known as the Center for Quality Improvement and Patient Safety to assist the Director in carrying out the requirements of subsection (a).

''(2) MISSION.—The Center shall—

''(A) provide national leadership for research and other initiatives to improve the quality and safety of patient care;

''(B) build public-private sector partnerships to improve the quality and safety of patient care; and

''(C) serve as a national resource for research and learning from medical errors.

''(3) DUTIES.—

''(A) IN GENERAL.—In carrying out this section, the Director, acting through the Center, shall consult and build partnerships, as appropriate, with all segments of the health care industry, including health care practitioners and patients, those who manage health care facilities, systems and plans, peer review organizations, health care purchasers and policymakers, and other users of health care research.

''(B) REQUIRED DUTIES.—In addition to the broad responsibilities that the Director may assign to the Center for research and related activities that are designed to improve the quality of health care, the Director shall ensure that the Center—

''(i) builds scientific knowledge and understanding of the causes of medical errors in all health care settings and identifies or develops and validates effective interventions and strategies to reduce errors and improve the safety and quality of patient care;

''(ii) promotes public and private sector research on patient safety by—

''(I) developing a national patient safety research agenda;

''(II) identifying promising opportunities for preventing or reducing medical errors; and

''(III) tracking the progress made in addressing the highest priority research questions with respect to patient safety;

''(iii) facilitates the development of voluntary national patient safety goals by convening all segments of the health care industry and tracks the progress made in meeting those goals;

''(iv) analyzes national patient safety data for inclusion in the annual report on the quality of health care required under section 913(b)(2);

''(v) strengthens the ability of the United States to learn from medical errors by—

''(I) developing the necessary tools and advancing the scientific techniques for analysis of errors;

''(II) providing technical assistance as appropriate to reporting systems; and

''(III) entering into contracts to receive and analyze aggregate data from public and private sector reporting systems;

''(vi) supports dissemination and communication activities to improve patient safety, including the development of tools and methods for educating consumers about patient safety; and

''(vii) undertakes related activities that the Director determines are necessary to enable the Center to fulfill its mission.

''(C) LIMITATION.—Aggregate data gathered for the purposes described in this section shall not include specific patient, health care provider, or provider of service identifiers.

''(c) LEARNING FROM MEDICAL ERRORS.—

''(1) IN GENERAL.—To enhance the ability of the health care community in the United States to learn from medical events, the Director shall—

''(A) carry out activities to increase scientific knowledge and understanding regarding medical error reporting systems;

''(B) carry out activities to advance the scientific knowledge regarding the tools and techniques for analyzing medical events and determining their root causes;

''(C) carry out activities in partnership with experts in the field to increase the capacity of the health care community in the United States to analyze patient safety data;

''(D) develop a confidential national safety database of medical event reports;

''(E) conduct and support research, using the database developed under subparagraph (D), into the causes and potential interventions to decrease the incidence of medical errors and close calls; and

''(F) ensure that information contained in the national database developed under subparagraph (D) does not include specific patient, health care provider, or provider of service identifiers.

''(2) NATIONAL PATIENT SAFETY DATABASE.—The Director shall, in accordance with paragraph (1)(D), establish a confidential national safety database (to be known as the National Patient Safety Database) of reports of medical events that can be used only for research to improve the quality and safety of patient care. In developing and managing the National Patient Safety Database, the Director shall—

''(A) ensure that the database is only used for its intended purpose;

''(B) ensure that the database is only used by the Agency, medical event analysis entities, and other qualified entities or individuals as determined appropriate by the Director and in accordance with paragraph (3) or other criteria applied by the Director;

''(C) ensure that the database is as comprehensive as possible by aggregating data from Federal, State, and private sector patient safety reporting systems;

''(D) conduct and support research on the most common medical errors and close calls, their causes, and potential interventions to reduce medical errors and improve the quality and safety of patient care;

''(E) disseminate findings made by the Director, based on the data in the database, to clinicians, individuals who manage health care facilities, systems, and plans, patients, and other individuals who can act appropriately to improve patient safety; and

''(F) develop a rapid response capacity to provide alerts when specific health care practices pose an imminent threat to patients or health care practitioners, or other providers of health care items or services.

''(3) CONFIDENTIALITY AND PEER REVIEW PROTECTIONS.—Notwithstanding any other provision of law any information (including any data, reports, records, memoranda, analyses, statements, and other communications) developed by or on behalf of a health care provider or provider of services with respect to a medical event, that is contained in the National Patient Safety Database shall be confidential in accordance with section 925.

''(4) PATIENT SAFETY REPORTING SYSTEMS.—The Director shall identify public and private sector patient safety reporting systems and build scientific knowledge and understanding regarding the most effective—

''(A) components of patient safety reporting systems;

''(B) incentives intended to increase the rate of error reporting;

''(C) approaches for undertaking root cause analyses;

''(D) ways to provide feedback to those filing error reports;

''(E) techniques and tools for collecting, integrating, and analyzing patient safety data; and

''(F) ways to provide meaningful information to patients, consumers, and purchasers that will enhance their understanding of patient safety issues.

''(5) TRAINING.—The Director shall support training initiatives to build the capacity of the health care community in the United States to analyze patient safety data and to act on that data to improve patient safety.

''(d) EVALUATION.—The Director shall recommend strategies for measuring and evaluating the national progress made in implementing safe practices identified by the Center through the research and analysis required under subsection (b) and through the voluntary reporting system established under subsection (c).

''(e) IMPLEMENTATION.—In implementing strategies to carry out the functions described in subsections (b), (c), and (d), the Director may contract with public or private entities on a national or local level with appropriate expertise.

''SEC. 923. MEDICAL EVENT ANALYSIS ENTITIES.

''(a) IN GENERAL.—The Director, based on information collected under section 922(c), shall provide for the certification of entities to collect and analyze information on medical errors, and to collaborate with health care providers or providers of services in collecting information about, or evaluating, certain medical events.

''(b) COMPATIBILITY OF COLLECTED DATA.—To ensure that data reported to the National Patient Safety Database under section 922(c)(2) concerning medical errors and close calls are comparable and useful on an analytic basis, the Director shall require that the entities described in subsection (c) follow the recommendations regarding a common set of core measures for reporting that are developed by the National Forum for Health Care Quality Measurement and Reporting, or other voluntary private standard-setting organization that is designated by the Director taking into account existing measurement systems and in collaboration with experts from the public and private sector.

''(c) DUTIES OF CERTIFIED ENTITIES.—

''(1) IN GENERAL.—An entity that is certified under subsection (a) shall collect and analyze information, consistent with the requirement of subsection (b), provided to the entity under section 924(a)(4) to improve patient safety.

''(2) INFORMATION TO BE REPORTED TO THE ENTITY.—A medical event analysis entity shall, on a periodic basis and in a format that is specified by the Director, submit to the Director a report that contains—

''(A) a description of the medical events that were reported to the entity during the period covered under the report;

''(B) a description of any corrective action taken by providers of services with respect to such medical events or any other measures that are necessary to prevent similar events from occurring in the future; and

''(C) a description of the systemic changes that entities have identified, through an analysis of the medical events included in the report, as being needed to improve patient safety.

''(3) COLLABORATION.—A medical event analysis entity that is collaborating with a health care provider or provider of services to address close calls and adverse events may, at the request of the health care provider or provider of services—

''(A) provide expertise in the development of root cause analyses and corrective action plan relating to such close calls and adverse events; or

''(B) collaborate with such provider of services to identify on-going risk reduction activities that may enhance patient safety.

''(d) CONFIDENTIALITY AND PEER REVIEW PROTECTIONS.—Notwithstanding any other provision of law, any information (including any data, reports, records, memoranda, analyses, statements, and other communications) collected by a medical event analysis entity or developed by or on behalf of such an entity under this part shall be confidential in accordance with section 925.

''(e) TERMINATION AND RENEWAL.—

''(1) IN GENERAL.—The certification of an entity under this section shall terminate on the date that is 3 years after the date on which such certification was provided. Such certification may be renewed at the discretion of the Director.

''(2) NONCOMPLIANCE.—The Director may terminate the certification of a medical event analysis entity if the Director determines that such entity has failed to comply with this section.

''(f) IMPLEMENTATION.—In implementing strategies to carry out the functions described in subsection (c), the Director may contract with public or private entities on a national or local level with appropriate expertise.

''SEC. 924. PROVIDER OF SERVICES SYSTEMS FOR REPORTING MEDICAL EVENTS.

''(a) INTERNAL MEDICAL EVENT REPORTING SYSTEMS.—Each provider of services that elects to participate in a medical error reporting system under this part shall—

''(1) establish a system for—

''(A) identifying, collecting information about, and evaluating medical events that occur with respect to a patient in the care of the provider of services or a practitioner employed by the provider of services, that may include—

''(i) the provision of a medically coherent description of each event so identified;

''(ii) the provision of a clear and thorough accounting of the results of the investigation of such event under the system; and

''(iii) a description of all corrective measures taken in response to the event; and

''(B) determining appropriate follow-up actions to be taken with respect to such events;

''(2) establish policies and procedures with respect to when and to whom such events are to be reported;

''(3) take appropriate follow-up action with respect to such events; and

''(4) submit to the appropriate medical event analysis entity information that contains descriptions of the medical events identified under paragraph (1)(A).

''(b) PROMOTING IDENTIFICATION, EVALUATION, AND REPORTING OF CERTAIN MEDICAL EVENTS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law any information (including any data, reports, records, memoranda, analyses, statements, and other communications) developed by or on behalf of a provider of services with respect to a medical event pursuant to a system established under subsection (a) shall be privileged in accordance with section 925.

''(2) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting—

''(A) disclosure of a patient's medical record to the patient;

''(B) a provider of services from complying with the requirements of a health care oversight agency or public health authority; or

''(C) such an agency or authority from disclosing information transferred by a provider of services to the public in a form that does not identify or permit the identification of the health care provider or provider of services or patient.

''SEC. 925. CONFIDENTIALITY.

''(a) CONFIDENTIALITY AND PEER REVIEW PROTECTIONS.—Notwithstanding any other provision of law—

''(1) any information (including any data, reports, records, memoranda, analyses, statements, and other communications) developed by or on behalf of a health care provider or provider of services with respect to a medical event, that is contained in the National Patient Safety Database, collected by a medical event analysis entity, or developed by or on behalf of such an entity, or collected by a health care provider or provider or services for use under systems that are developed for safety and quality improvement purposes under this part—

''(A) shall be privileged, strictly confidential, and may not be disclosed by any other person to which such information is transferred without the authorization of the health care provider or provider of services; and

''(B) shall—

''(i) be protected from disclosure by civil, criminal, or administrative subpoena;

''(ii) not be subject to discovery or otherwise discoverable in connection with a civil, criminal, or administrative proceeding;

''(iii) not be subject to disclosure pursuant to section 552 of title 5, United States Code (the Freedom of Information Act) and any other similar Federal or State statute or regulation; and

''(iv) not be admissible as evidence in any civil, criminal, or administrative proceeding;

without regard to whether such information is held by the provider or by another person to which such information was transferred;

''(2) the transfer of any such information by a provider of services to a health care oversight agency, an expert organization, a medical event analysis entity, or a public health authority, shall not be treated as a waiver of any privilege or protection established under paragraph (1) or established under State law.

''(b) PENALTY.—It shall be unlawful for any person to disclose any information described in subsection (a) other than for the purposes provided in such subsection. Any person violating the provisions of this section shall, upon conviction, be fined in accordance with title 18, United States Code, and imprisoned for not more than 6 months, or both.

''(c) APPLICATION OF PROVISIONS.—The protections provided under subsection (a) and the penalty provided for under subsection (b) shall apply to any information (including any data, reports, memoranda, analyses, statements, and other communications) collected or developed pursuant to research, including demonstration projects, with respect to medical error reporting supported by the Director under this part.

''SEC. 926. AUTHORIZATION OF APPROPRIATIONS.

''There is authorized to be appropriated to carry out this part, $50,000,000 for fiscal year 2001, and such sums as may be necessary for subsequent fiscal years.''.

SEC. 2504. EFFECTIVE DATE.

The amendments made by section 2503 shall become effective on the date of the enactment of this Act.

This Act may be cited as the ''Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2001''.

UNANIMOUS CONSENT AGREEMENT—H.R. 4577

AMENDMENT NO. 3714

Mr. WARNER. Mr. President, during wrap-up of H.R. 4577, the Labor appropriations bill, amendment No. 3714, which had been agreed to, was inadvertently displaced. I ask unanimous consent that the amendment be placed back in its original position in the bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 3633

Mr. WARNER. Mr. President, I ask unanimous consent that with respect to amendment No. 3633, previously agreed to, a correction be made with the following change:

On line 7, strike $1,065,000,000 and insert in lieu thereof $1,075,000,000.

The PRESIDING OFFICER. Without objection, it is so ordered.

DISABLED VETERANS' LIFE MEMORIAL FOUNDATION

Mr. WARNER. Mr. President, I ask unanimous consent that the Senate now proceed to the consideration of Calendar No. 516, S. 311.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 311) to authorize the Disabled Veterans' LIFE Memorial Foundation to establish a memorial in the District of Columbia or its environs, and for other purposes.

The Senate proceeded to consider the bill which had been reported from the Committee on Energy and Natural Resources, with amendments, as follows:.

(The parts of the bill intended to be stricken are shown in boldface brackets and the parts of the bill intended to be inserted are shown in italic.)

S. 311

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

TITLE I—THE DISABLED AMERICAN VETERANS MEMORIAL

[SECTION 1.] *SECTION 101.* AUTHORITY TO ESTABLISH MEMORIAL.

(a) IN GENERAL.—**[**The Disabled**]** *Notwithstanding section 3(c) of Public Law 99–652, as amended (40 U.S.C. 1003(c)), the Disabled* Veterans' LIFE Memorial Foundation is authorized to establish a memorial on Federal land in the District of Columbia or its environs to honor disabled American veterans who have served in the Armed Forces of the United States.

(b) COMPLIANCE WITH STANDARDS FOR COMMEMORATIVE WORKS.—The establishment of the memorial authorized by subsection (a)