

By Mr. FEINGOLD:

S. 272. A bill to rescind fiscal year 2001 procurement funds for the V-22 Osprey aircraft program other than as necessary to maintain the production base and to require certain reports to Congress concerning that program; to the Committee on Appropriations and the Committee on the Budget, jointly, pursuant to the order of January 30, 1975, as modified by the order of April 11, 1986, with instructions that the Budget Committee be authorized to report its views to the Appropriations Committee, and that the latter alone be authorized to report the bill.

By Mr. TORRICELLI (for himself and Mr. CORZINE):

S. 273. A bill to amend title 28, United States Code, to divide New Jersey into 2 judicial districts; to the Committee on the Judiciary.

By Mr. BAUCUS:

S. 274. A bill to establish a Congressional Trade Office; to the Committee on Finance.

By Mr. KYL (for himself, Mr. BREAUX, Mr. GRAMM, Mrs. LINCOLN, and Mr. BAYH):

S. 275. A bill to amend the Internal Revenue Code of 1986 to repeal the Federal estate and gift taxes and the tax on generation-skipping transfers, to preserve a step up in basis of certain property acquired from a decedent, and for other purposes; to the Committee on Finance.

By Mr. SHELBY (for himself, Mr. BOND, Mr. THOMAS, Mr. HAGEL, Mr. SESSIONS, Mr. HELMS, Mr. INHOFE, Mr. BURNS, Mr. KYL, Mr. COCHRAN, Ms. SNOWE, and Mr. ALLARD):

S. 276. A bill to amend chapter 8 of title 5, United States Code, to provide for congressional review of any rule promulgated by the Internal Revenue Service that increases Federal revenue, and for other purposes; to the Committee on Governmental Affairs.

By Mr. KENNEDY (for himself, Mr. AKAKA, Mr. BINGAMAN, Mrs. BOXER, Mrs. CLINTON, Mr. CORZINE, Mr. DASCHLE, Mr. DODD, Mr. DURBIN, Mr. FEINGOLD, Mrs. FEINSTEIN, Mr. HARKIN, Mr. KERRY, Ms. LANDRIEU, Mr. LIEBERMAN, Mr. LEAHY, Mr. LEVIN, Ms. MIKULSKI, Mrs. MURRAY, Mr. REED, Mr. ROCKEFELLER, Mr. SAR-BANES, Mr. SCHUMER, Mr. WELLSTONE, and Mr. WYDEN):

S. 277. A bill to amend the Fair Labor Standards Act of 1938 to provide for an increase in the Federal minimum wage; to the Committee on Health, Education, Labor, and Pensions.

By Mr. JOHNSON (for himself, Mr. BINGAMAN, and Ms. SNOWE):

S. 278. A bill to restore health care coverage to retired members of the uniformed services; to the Committee on Armed Services.

By Mr. LOTT (for himself and Mr. DASCHLE):

S. 279. A bill affecting the representation of the majority and minority membership of the Senate Members of the Joint Economic Committee; considered and passed.

By Mr. JOHNSON (for himself, Mr. GRAHAM, Mr. CAMPBELL, Mr. ENZI, Mr. BAUCUS, Mr. CLELAND, Mr. DASCHLE, and Mr. HOLLINGS):

S. 280. A bill to amend the Agriculture Marketing Act of 1946 to require retailers of beef, lamb, pork, and perishable agricultural commodities to inform consumers, at the final point of sale to consumers, of the country of origin of the commodities; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. HAGEL (for himself, Mr. MCCAIN, Mr. CLELAND, and Mr. KERRY):

S. 281. A bill to authorize the design and construction of a temporary education cen-

ter at the Vietnam Veterans Memorial; to the Committee on Energy and Natural Resources.

By Mr. HARKIN (for himself and Mr. LUGAR):

S. 282. A bill to establish in the Antitrust Division of the Department of Justice a position with responsibility for agriculture antitrust matters; to the Committee on the Judiciary.

By Mr. MCCAIN (for himself, Mr. EDWARDS, Mr. KENNEDY, Mr. CHAFEE, Mr. GRAHAM, Mr. SPECTER, Mrs. LINCOLN, Mr. HARKIN, Mr. BAUCUS, Mr. TORRICELLI, Mr. DODD, Mr. NELSON of Florida, and Mr. SCHUMER):

S. 283. A bill to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue code of 1986 to protect consumers in managed care plans and other health coverage; to the Committee on Health, Education, Labor, and Pensions.

By Mr. MCCAIN (for himself, Mr. EDWARDS, Mr. KENNEDY, Mr. CHAFEE, Mr. GRAHAM, Mr. SPECTER, Mrs. LINCOLN, Mr. HARKIN, Mr. BAUCUS, Mr. TORRICELLI, Mr. DODD, Mr. NELSON of Florida, and Mr. SCHUMER):

S. 284. A bill to amend the Internal Revenue Code of 1986 to provide incentives to expand health care coverage for individuals; to the Committee on Finance.

By Mr. HOLLINGS (for himself, Mr. SPECTER, Mr. CLELAND, and Mr. BYRD):

S.J. Res. 4. A joint resolution proposing an amendment to the Constitution of the United States relating to contributions and expenditures intended to affect elections; to the Committee on the Judiciary.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

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

By Ms. SNOWE (for herself, Mr. LOTT, Mrs. LINCOLN, Mr. COCHRAN, Mr. HUTCHINSON, Mr. THURMOND, Mr. CRAPO, and Mr. CRAIG):

S. Con. Res. 8. A concurrent resolution expressing the sense of Congress regarding subsidized Canadian lumber exports; to the Committee on Finance.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. CLELAND:

S. 269. A bill to ensure that immigrant students and their families receive the services the students and families need to successfully participate in elementary schools, secondary schools, and communities in the United States, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. CLELAND. Mr. President, within the last decade, many States have experienced a wave of immigration that is rivaling the first and second waves of German, Irish, Polish and Scandinavian immigrants who arrived in the U.S. in the late 1800s and early 1900s. In fact, the Census Bureau is estimating that these recently arrived immigrants and refugees will account for 75 percent of the U.S. population growth over the next 50 years. These changing demographics are impacting not just com-

munities accustomed to large immigrant populations like New York, Los Angeles and Miami, but also non-traditional immigrant communities like Gainesville, Georgia and Fremont County, Idaho.

One result of our new wave of immigrants is a significant increase in the number of children with diverse linguistic and cultural backgrounds enrolling in our schools. The Waterloo, Iowa school system, for example, is being challenged to teach 400 Bosnian refugee children, who came here without knowing our language, culture or customs. Schools in Wausau, Wisconsin are filled with Asian children who want to achieve success in the United States. In Dalton, Georgia, over 51 percent of the student population in the public schools are Hispanic children eager to participate in their new schools and communities. In Turner, Maine, the school-aged children of hundreds of recently arrived Latino immigrant families are pouring into this rural town's schools.

It is clear that U.S. schools from Florida to Washington State are being increasingly challenged by these changing demographics. We need to make sure that these children are served appropriately—and that their families are as well. Studies have shown that where quality educational programs are joined with community-based services, immigrants have an increased opportunity to become an integral part of their community and their children are better prepared to achieve success in school.

The recent influx of immigrants into U.S. communities calls for innovative and comprehensive solutions. Today I am reintroducing the Immigrants to New Americans Act. This legislation would establish a competitive grant program within the Department of Education to assist schools and communities which are experiencing an influx of recently arrived immigrant families. Specifically, this grant program would provide funding to partnerships of local school districts and community-based organizations for the purpose of developing model programs with a two-fold purpose: to assist culturally and linguistically diverse children achieve success in America's schools and to provide their families with access to comprehensive community services, including health care, child care, job training and transportation.

It does take a village to raise a child, Mr. President.

I have seen firsthand the benefits of one community's program that brings together teachers, community leaders and businesses in an innovative partnership to aid their linguistically and culturally diverse population. It is the Georgia Project, and its mission is to assist immigrant children from Mexico achieve to higher standards in Dalton, Georgia's public schools.

In recent years, the carpet and poultry industries in Dalton and surrounding Whitfield County experienced

the need for a larger workforce. The city's visionary leaders encouraged immigrants from Mexico to settle in their community to fill that need. The challenge has been in Dalton's public school system where Hispanic enrollment went from being just four percent ten years ago to over 51 percent today.

To deal with this sizable increase, Dalton and Whitfield County public school administrators and business leaders formed a public-private consortium. This consortium, known as The Georgia Project, initiated a teacher exchange program in 1996 with the University of Monterrey in Mexico. Today, twenty teachers from Mexico are helping to bridge the language and culture gap by serving as instructors, counselors and role models and providing Spanish language training to English-speaking students. In addition, Dalton public school teachers spend a month each year in Monterrey, Mexico learning firsthand the culture, language and customs of the Hispanic students they serve.

There are other programs across the United States that address similar challenges experienced by the City of Dalton and Whitfield County. One such example is the Lao Family Project in St. Paul, Minnesota. This is a community-based refugee assistance organization that provides a wide range of parent-student services to Hmong and Vietnamese refugees in St. Paul in an effort to help parents become economically self-sufficient and their children succeed in school. The Lao Family Project's staff are bilingual/bicultural para-professionals who provide services that include adult English-language acquisition programs and preschool literacy activities for children.

In the rural communities of Healdsburg and Windsor, California, the Even Start program provides a variety of instructional and support services to low-income, recently arrived Hispanic immigrant families and their preschool and elementary school children. The program focuses on increasing family involvement in their children's education, helping parents and children with their literacy skills, and offering English as a second language course. Many of the instructional activities for the parents' classes are coordinated with the classroom teachers to ensure consistency with what is being taught to both the parent and child. One focus of these classes is to communicate what the children are learning in their regular classes so that parents can help their children at home.

The Exemplary Multicultural Practices in Rural Education Program, or EMPIRE, operates in the Yakima region of rural Central Washington State, an area with a diverse mix of ethnic groups, including Caucasians, Hispanics, Native Americans, African Americans, and Asian Americans. The program promotes positive race relations and an appreciation for ethnic and cultural differences. It encourages

schools to develop learning environments where children of all backgrounds can be successful in school and in the community. With support from EMPIRE's board of advisors, each school designs and carries out its own projects based on local resources and needs. Schools in which EMPIRE is active plan a wide variety of programs and activities with emphasis on staff development, student awareness, parent involvement and improvement of curriculum and instruction.

The Immigrants to New Americans Act is not a one-size-fits-all approach. It rewards model programs designed by individual communities to address that community's specific needs and challenges. The legislation is endorsed by the National Association for Bilingual Education, the League of United Latin American Citizens, the National Council of La Raza, the Hispanic Education Coalition, the India Abroad Center for Political Awareness, the Southeast Asia Resource Action Center, and the National Korean American Service and Education Consortium.

Our Nation's communities are being transformed by the diverse culture of their citizens. Successfully addressing this change will require leadership, creative thinking and an eagerness to encourage and promote the promise that these new challenges bring. By doing so, we as a Nation will better serve all our children—the best guarantee we have of ensuring America's strength, well into the 21st Century and beyond.

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

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

S. 269

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Immigrants to New Americans Act".

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) In 1997, there were an estimated 25,800,000 foreign-born individuals residing in the United States. That number is the largest number of such foreign-born individuals in United States history and represents a 6,000,000, or 30 percent, increase over the 1990 census figure of 19,800,000 of such foreign-born individuals. The Bureau of the Census estimates that the recently arrived immigrant population (including the refugee population) currently residing in the Nation will account for 75 percent of the population growth in the United States over the next 50 years.

(2) For millions of immigrants settling into the Nation's hamlets, towns, and cities, the dream of "life, liberty, and the pursuit of happiness" has become a reality. The wave of immigrants, of various nationalities, who have chosen the United States as their home, has positively influenced the Nation's image and relationship with other nations. The diverse cultural heritage of the Nation's immigrants has helped define the Nation's culture, customs, economy, and communities.

By better understanding the people who have immigrated to the Nation, individuals in the United States better understand what it means to be an American.

(3) There is a critical shortage of teachers with the skills needed to educate immigrant students and their families in nonconcentrated, nontraditional, immigrant communities as well as communities with large immigrant populations. The large influx of immigrant families over the last decade presents a national dilemma: The number of such families with school-age children requiring assistance to successfully participate in elementary schools, secondary schools, and communities in the United States, is increasing without a corresponding increase in the number of teachers with skills to accommodate their needs.

(4) Immigrants arriving in communities across the Nation generally settle into high-poverty areas, where funding for programs to provide immigrant students and their families with the services the students and families need to successfully participate in elementary schools, secondary schools, and communities in the United States is inadequate.

(5) The influx of immigrant families settling into many United States communities is often the result of concerted efforts by local employers who value immigrant labor. Those employers realize that helping immigrants to become productive, prosperous members of a community is beneficial for the local businesses involved, the immigrants, and the community. Further, local businesses benefit from the presence of the immigrant families because the families present businesses with a committed and effective workforce and help open up new market opportunities. However, many of the communities into which the immigrants have settled need assistance in order to give immigrant students and their families the services the students and families need to successfully participate in elementary schools, secondary schools, and communities in the United States.

SEC. 3. PURPOSE.

The purpose of this Act is to establish a grant program, within the Department of Education, that provides funding to partnerships of local educational agencies and community-based organizations for the development of model programs to provide immigrant students and their families with the services the students and families need to successfully participate in elementary schools, secondary schools, and communities in the United States.

SEC. 4. DEFINITIONS.

(1) IMMIGRANT.—In this Act, the term "immigrant" has the meaning given the term in section 101 of the Immigration and Nationality Act (8 U.S.C. 1101).

(2) OTHER TERMS.—Other terms used in this Act have the meanings given the terms in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801).

SEC. 5. PROGRAM AUTHORIZED.

(a) IN GENERAL.—The Secretary of Education may award not more than 10 grants in a fiscal year to eligible partnerships for the design and implementation of model programs to—

(1) assist immigrant students achieve in elementary schools and secondary schools in the United States by offering such educational services as English as a second language classes, literacy programs, programs for introduction to the education system, and civics education; and

(2) assist parents of immigrant students by offering such services as parent education and literacy development services and by co-ordinating activities with other entities to

provide comprehensive community social services such as health care, job training, child care, and transportation services.

(b) **ELIGIBLE PARTNERSHIPS.**—To be eligible to receive a grant under this Act, a partnership—

(1) shall include—

(A) at least 1 local educational agency; and
(B) at least 1 community-based organization; and

(2) may include another entity such as—

(A) an institution of higher education;
(B) a local or State government agency;

(C) a private sector entity; or

(D) another entity with expertise in working with immigrants.

(c) **DURATION.**—Each grant awarded under this Act shall be awarded for a period of not more than 5 years. A partnership may use funds made available through the grant for not more than 1 year for planning and program design.

SEC. 6. APPLICATIONS FOR GRANTS.

(a) **IN GENERAL.**—Each eligible partnership desiring a grant under this Act shall submit an application to the Secretary at such time and in such manner as the Secretary may require.

(b) **REQUIRED DOCUMENTATION.**—Each application submitted by a partnership under this section for a proposed program shall include documentation that—

(1) the partnership has the qualified personnel required to develop, administer, and implement the proposed program; and

(2) the leadership of each participating school has been involved in the development and planning of the program in the school.

(c) **OTHER APPLICATION CONTENTS.**—Each application submitted by a partnership under this section for a proposed program shall include—

(1) a list of the organizations entering into the partnership;

(2) a description of the need for the proposed program, including data on the number of immigrant students, and the number of such students with limited English proficiency in the schools or school districts to be served through the program and the characteristics of the students described in this paragraph, including—

(A) the native languages of the students to be served;

(B) the proficiency of the students in English and the students' native languages;

(C) achievement data for the students in—

(i) reading or language arts (in English and in the students' native languages, if applicable); and

(ii) mathematics; and

(D) the previous schooling experiences of the students;

(3) a description of the goals of the program;

(4) a description of how the funds made available through the grant will be used to supplement the basic services provided to the immigrant students to be served;

(5) a description of activities that will be pursued by the partnership through the program, including a description of—

(A) how parents, students, and other members of the community, including members of private organizations and nonprofit organizations, will be involved in the design and implementation of the program;

(B) how the activities will further the academic achievement of immigrant students served through the program;

(C) methods of teacher training and parent education that will be used or developed through the program, including the dissemination of information to immigrant parents, that is easily understandable in the language of the parents, about educational programs and the rights of the parents to participate

in educational decisions involving their children; and

(D) methods of coordinating comprehensive community social services to assist immigrant families;

(6) a description of how the partnership will evaluate the progress of the partnership in achieving the goals of the program;

(7) a description of how the local educational agency will disseminate information on model programs, materials, and other information developed under this Act that the local educational agency determines to be appropriate for use by other local educational agencies in establishing similar programs to facilitate the educational achievement of immigrant students;

(8) an assurance that the partnership will annually provide to the Secretary such information as may be required to determine the effectiveness of the program; and

(9) any other information that the Secretary may require.

SEC. 7. SELECTION OF GRANTEES.

(a) **CRITERIA.**—The Secretary, through a peer review process, shall select partnerships to receive grants under this Act on the basis of the quality of the programs proposed in the applications submitted under section 6, taking into consideration such factors as—

(1) the extent to which the program proposed in such an application effectively addresses differences in language, culture, and customs;

(2) the quality of the activities proposed by a partnership;

(3) the extent of parental, student, and community involvement;

(4) the extent to which the partnership will ensure the coordination of comprehensive community social services with the program;

(5) the quality of the plan for measuring and assessing success; and

(6) the likelihood that the goals of the program will be achieved.

(b) **GEOGRAPHIC DISTRIBUTION OF PROGRAMS.**—The Secretary shall approve applications under this Act in a manner that ensures, to the extent practicable, that programs assisted under this Act serve different areas of the Nation, including urban, suburban, and rural areas, with special attention to areas that are experiencing an influx of immigrant groups (including refugee groups), and that have limited prior experience in serving the immigrant community.

SEC. 8. EVALUATION AND PROGRAM DEVELOPMENT.

(a) **REQUIREMENT.**—Each partnership receiving a grant under this Act shall—

(1) conduct a comprehensive evaluation of the program assisted under this Act, including an evaluation of the impact of the program on students, teachers, administrators, parents, and others; and

(2) prepare and submit to the Secretary a report containing the results of the evaluation.

(b) **EVALUATION REPORT COMPONENTS.**—Each evaluation report submitted under this section for a program shall include—

(1) data on the partnership's progress in achieving the goals of the program;

(2) data showing the extent to which all students served by the program are meeting the State's student performance standards, including—

(A) data comparing the students served under this Act with other students, with regard to grade retention and academic achievement in reading and language arts, in English and in the native languages of the students if the program develops native language proficiency, and in mathematics; and

(B) a description of how the activities carried out through the program are coordinated and integrated with the overall school

program of the school in which the program described in this Act is carried out, and with other Federal, State, or local programs serving limited English proficient students;

(3) data showing the extent to which families served by the program have been afforded access to comprehensive community social services; and

(4) such other information as the Secretary may require.

SEC. 9. ADMINISTRATIVE FUNDS.

A partnership that receives a grant under this Act may use not more than 5 percent of the grant funds received under this Act for administrative purposes.

SEC. 10. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this Act \$10,000,000 for fiscal year 2002 and such sums as may be necessary for each of the 4 succeeding fiscal years.

NATIONAL ASSOCIATION FOR BILINGUAL EDUCATION,
Washington, DC, January 29, 2001.

Hon. MAX CLELAND,
U.S. Senate, Senate Dirksen Building, Washington, DC.

DEAR SENATOR CLELAND: On behalf of the National Association for Bilingual Education (NABE), I want to thank you for introducing legislation that will help address one of the greatest challenges facing the American educational system—that of addressing the changing needs of emerging immigrant populations.

The dramatic demographic changes that are taking place in our nation are forcing school districts and communities to reevaluate their ability to integrate America's newcomers. While it was once the case that immigrants settled primarily in urban areas like New York City or Los Angeles, poultry processing plants, meat packing firms, and other businesses are attracting immigrants to states like Georgia, Iowa, Arkansas, North Carolina and Idaho. Often, these communities have no experience in helping immigrant children and families integrate so that they too will attain the American dream and help make our country stronger.

Your bill clearly recognizes the contributions that immigrants have made to the United States over its history, and takes a definitive step forward in the spirit of empowerment through education and community-based collaboration. NABE strongly believes that given the appropriate tools and support immigrant students will rise to the highest of levels of achievement. Our endorsement of this forward-thinking legislation is a reaffirmation of this philosophy, and we hope your colleagues in Congress will grant it prompt approval. Once again, I commend you on the introduction of this important piece of legislation.

Sincerely,

DELIA POMPA,
Executive Director.

LEAGUE OF UNITED LATIN AMERICAN CITIZENS,
Washington, DC, January 26, 2001.

Hon. MAX CLELAND,
U.S. Senate, Dirksen Senate Building, Washington, DC.

DEAR SENATOR CLELAND: The League of United Latin American Citizens (LULAC) wishes to thank you for your efforts at facilitating and enhancing the ability of immigrant children and their families to achieve success in America's schools and communities. We would like to strongly support your legislation, "The Immigrants to New Americans Act."

We believe that this act will greatly enhance the ability for schools and community-based services to develop model programs aimed at helping immigrant students

and their families to receive the tools that they need to be successful in their new homeland.

We find that this closely supports our mission and beliefs that immigrants should be supported in any way possible. LULAC is the oldest and largest Latino civil rights organization in the United States. LULAC advances the economic conditions, educational attainment, political influence, health and civil rights of Hispanic Americans through community-based programs operating at more than 700 LULAC Councils nationwide.

Once again, thank you for putting forth this effort to help those who need a little help getting started in this country. Your legislation will help to carry the United States in a positive way well into the 21st century.

Sincerely,

RICK DOVALINA,
LULAC National President.

NATIONAL COUNCIL OF LA RAZA,
Washington, DC, January 30, 2001.

Senator MAX CLELAND,
Senate Dirksen Office Building,
Washington, DC.

DEAR SENATOR CLELAND: The National Council of La Raza (NCLR) thanks you for your effort to facilitate and enhance the participation of immigrants in American society. In particular, we would like to express our support for your legislation, the "Immigrants to New Americans Act," which would provide education, adult English as a Second Language (ESL), job training, and other important services to immigrants in "emerging" communities.

Over the past decade, dramatic shifts have occurred in the immigrant population in the United States, particularly among Hispanic immigrants. Many Hispanic immigrants have settled in areas where their presence had previously been virtually invisible. For example, the U.S. Census Bureau determined that the South (Alabama, Arkansas, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) experienced a 93% increase in its Hispanic population from 1990 to 1998, far outpacing growth in "traditional" Hispanic states like California, New York, and Texas, where increases hovered around 32%. While the U.S. Census Bureau estimated the total Hispanic population in the South in 1998 to be 640,870, unofficial estimates place the Hispanic population of both Georgia and North Carolina at close to 500,000 in each state. Midwestern states have also experienced significant increases in their Hispanic populations during this period, such as Iowa (74%), Minnesota (61%), and Nebraska (96%). Many of these Hispanics are immigrants in search of employment.

The emergence of new immigrant populations has created a significant need for educational and social services. The search for employment opportunities has historically been the primary impetus for the migration of immigrants. An ever-increasing availability of permanent employment has provided the opportunity for many immigrants to settle with their spouses and children, often in areas where previously there had only been seasonal agricultural work available. However, these opportunities have largely been in unskilled or low-skilled, low-paying jobs, such as the textile, poultry, and construction industries in the South; meat-and vegetable-packing in the Midwest; and light manufacturing and service-sector work in major cities like New York City, Los Angeles, and Houston. As these new immigrant populations form permanent settlements, they often face social isolation and disconnection from mainstream society.

Emerging immigrant communities face a multitude of issues in adapting to their new

environment. Among the needs identified in these communities are access to rigorous standards-based curriculum in the public schools, effective parental involvement in their children's education, adult English-language acquisition programs, quality child care, and employment and training. Your legislation would help local communities to provide services in each of these critical areas.

NCLR believes that the "Immigrants to New Americans Act" can have a significant, positive impact on the lives of many immigrant children and families, and on the communities in which they are settling. That is why we strongly support your legislation and encourage the entire Congress to do the same.

Sincerely,

RAUL YZAGUIRRE,
President.

HISPANIC EDUCATION COALITION,
January 29, 2001.

Hon. MAX CLELAND,
U.S. Senate, Senate Dirksen Building, Washington, DC.

DEAR SENATOR CLELAND: On behalf of the Hispanic Education Coalition (HEC)—an ad hoc coalition of national organizations dedicated to improving educational opportunities for over 30 million Hispanics living in the United States—we are writing to commend you for introducing The Immigrants to New Americans Act. We support this legislation because it will help improve educational opportunities for Hispanic Americans by supporting education and community-based collaboration.

Recent demographic data show that Hispanic children are the fastest growing segment of the school-aged population. While the majority of Hispanic children live in large urban areas in states like California, Texas and Florida, more and more Hispanic families are migrating to states like Arkansas, Iowa, North Carolina and Georgia. Emerging immigrant communities face a multitude of issues in adapting to their new environment such as academic and language support and effective parental involvement in their children's public schools, adult English-language acquisition programs, and employment and training. Communities like Rogers, Arkansas are in dire need of assistance to ensure new Hispanic and immigrant families are integrated in their communities and schools.

The Immigrants to Americans Act recognizes that while local communities may need support, they are ultimately in the best position to address the needs of the newly arrived Hispanic immigrant families. We are particularly supportive of the inclusion of community-based organizations as partners in developing model programs that help immigrant children succeed in schools and provide families with access to community services.

HEC believes that The Immigrants to New Americans Act can have a significant, positive impact on the lives of many immigrant children and families, their local communities and our nation. That is why we strongly support your legislation and encourage the entire Congress to do the same.

Sincerely,

PATRICIA LOERA,
Co-Chair, National Association
For Bilingual Education.

On behalf of: Association for the Advancement of Mexican Americans (AAMA); HEP-CAMP Association; Hispanic Association of Colleges and Universities (HACU); League of United Latin American Citizens (LULAC); Migrant Legal Action Program; National Association for Migrant Education (NAME);

National Association of Latino Elected and Appointed Officials (NALEO); National Council of La Raza (NCLR); National Puerto Rican Coalition (NPRC).

By Mr. BINGAMAN (for himself, Mr. JEFFORDS, Mr. LEVIN, Mr. BROWNBACK, and Mr. HELMS):

S. 270. A bill to amend title XVIII of the Social Security Act to provide a transitional adjustment for certain sole community hospitals in order to limit any decline in payment under the prospective payment system for hospital outpatient department services; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, I rise today to introduce, along with my colleagues Senators JEFFORDS, LEVIN, BROWNBACK, and HELMS the "Rural Hospital and Health Network Preservation Act of 2001."

As you are aware, rural health care providers have operating margins that are often much lower and more dependent upon Medicare and Medicaid reimbursement than suburban or urban providers. The Balanced Budget Refinement Act of 1999 (BBRA 99) allowed rural hospitals of less than 100 beds to be held harmless in the conversion to the new outpatient Prospective Payment System by allowing them to choose to stay essentially under the old fee-for-service program which provided them with increased revenue. However, that 100-bed limit seems arbitrary and will actually result in many slightly larger rural hospitals, that have even higher per patient costs and lower per patient margins, being squeezed even harder under BBA 97 rules.

With passage of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, several additional fixes were put in place for rural providers. While these were steps in the right direction, rural hospitals with between 100 and 400 beds are still not being held harmless in the conversion to the new outpatient Prospective Payment System. This group of hospitals is still suffering under provisions of the BBA of 1997.

Rural hospitals, and all hospitals for that matter, operate on very slim margins yet manage to bring cutting-edge medical care to the communities they serve. But changes in Medicare payments to hospitals have put many institutions in a bind.

The bill I am introducing today will extend the BBRA of 99 hold-harmless provisions to rural hospitals of up to 400 beds that are both Rural Referral Centers and Sole Community Hospitals. This will bring outpatient reimbursement rates for these critical health care providers closer in line to the actual health care costs incurred in rural America by these valued providers.

Rural communities across New Mexico have felt the negative impact of the BBA of 97. The Carlsbad Regional Medical Center, Eastern New Mexico Medical Center, San Juan Regional Medical Center, and Lea Regional Hospital have

all been suffering because of the BBA of 97. They tell me that they are bearing substantially higher expenses per patient due to diseconomies of scale for the technically intensive speciality care that is required at these types of facilities. In addition, they face difficulties in recruiting qualified health professionals, as well as qualified coders and compliance experts that are required under the new outpatient Prospective Payment System given Medicare's complexity. This is not a New Mexico only problem. There are at least sixty-one other rural hospitals that fall in this same category across the United States that are also suffering.

While the positive restorative effects of BBRA of 99 and the recently enacted "Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000" were very helpful, they are not enough to protect rural providers. We must prevent rural hospitals from reducing services or closing completely. When a rural hospital reduces services, or worse yet closes, local residents lose access to preventive, routine, and even emergency services. Doctors and other highly trained professionals move away. Then people must drive a hundred miles or more in some cases to get the care city dwellers take for granted. Local economies suffer when jobs are lost. Existing businesses may have to move, and new businesses won't locate in places where health care is unavailable. Hospital closure can be a death-knell for struggling towns. We must move forward to preserve and strengthen the ability of our Nation's rural hospitals and other Medicare providers to provide adequate health care to their patients.

I urge my colleagues to support and pass the Rural Hospital and Health Network Preservation Act of 2001.

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

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

S. 270

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Rural Hospital and Health Network Preservation Act of 2001".

SEC. 2. TEMPORARY TREATMENT OF CERTAIN SOLE COMMUNITY HOSPITALS TO LIMIT DECLINE IN PAYMENT UNDER THE OPD PPS.

(a) **HOLD HARMLESS PROVISION.**—Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended by inserting "(or not more than 400 beds if such hospital is a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) and is classified as a rural referral center under section 1886(d)(5)(C))" after "100 beds".

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect as if included in the amendments made by section 202(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A-342), as enacted into law by section 1000(a)(6) of Public Law 106-113.

By Mr. FEINGOLD:

S. 272. A bill to rescind fiscal year 2001 procurement funds for the V-22 Osprey aircraft program other than as necessary to maintain the production base and to require certain reports to Congress concerning that program; to the Committee on Appropriations and the Committee on the Budget, concurrently, pursuant to the order of January 30, 1975, as modified by the order of April 11, 1986, with instructions that the Budget Committee be authorized to report its views to the Appropriations Committee, and that the latter alone be authorized to report the bill.

Mr. FEINGOLD. Mr. President, today I am introducing the Osprey Safety, Performance, and Reliability Evaluation Act of 2001. This legislation would delay the procurement of the V-22 Osprey tilt-rotor aircraft for one year, and would require reports from the Secretary of the Navy and the Department of Defense's Inspector General regarding the program.

The Osprey is an experimental tilt-rotor aircraft that takes off and lands like a helicopter, but flies like an airplane by tilting its wing-mounted rotors forward to serve as propellers. The premise for the aircraft is to combine the operational flexibility of a helicopter with the speed, range, and efficiency of a fixed-wing aircraft.

The Marines, Air Force, and Navy all want to purchase versions of this aircraft. The MV-22 would be used by the Marines for missions such as troop and cargo transport and amphibious assault; the CV-22 would be used by the Air Force for special operations; and the HV-22 would be used by the Navy for search and rescue missions.

I want to be very clear. This bill does not terminate the V-22 program. It does not affect the Marine Corps' ability to continue the research, development, testing, and evaluation of this aircraft.

This bill delays the start of full-rate procurement of the MV-22 Osprey, the Marines' version of this aircraft, for one year. It also delays the procurement of four CV-22s, the Air Force's version of this aircraft, for one year.

There are serious allegations and serious questions surrounding the V-22 program. Thirty Marines have died in Osprey crashes since 1991. Many questions regarding the validity of maintenance records and the safety and viability of this aircraft remain unanswered.

We cannot, in good conscience, move forward with the full-scale procurement of the MV-22 until these allegations have been investigated fully and until these questions have been answered.

We should not move forward with the procurement of this aircraft until further testing has been done to address potentially serious design flaws that could continue to endanger the lives of our military personnel.

We owe it to our men and women in uniform to put their safety first. They

are willing to go into harm's way while serving their country. That service should not include being put into harm's way by a potentially unsafe aircraft. We should not move forward with the procurement of an aircraft that crashed as recently as December. We should not procure this aircraft until the Department of Defense is absolutely certain that all major design flaws have been corrected.

The legislation that I am introducing today will delay full-rate production of the MV-22 for one year. This delay is prudent given the ongoing controversy that has loomed over this program during the last weeks and months.

I want to reiterate that this legislation does not require the Department of Defense to terminate the Osprey program. I appreciate the importance of this program to the Marine Corps. I agree that they need to replace the aging CH-46 Sea Knight helicopters that they currently have. However, I am not sure that the Osprey is the safest and most cost-effective alternative to the Sea Knight.

I know that the leaders of the Marines and the Air Force have the greatest concern for the safety of their personnel who are and who will be assigned to the Osprey program. I share that concern. My bill would require the Marine Corps to wait one year to move to full-rate production of the MV-22. Because the airframes for the MV-22 and the CV-22 are 90 percent similar, it follows that the four CV-22s the Air Force plans to buy this year may be subject to many of the same design flaws that have been found in the MV-22. For that reason, my bill would also require the Air Force to wait one year to procure the four CV-22s, which would be used to train their pilots.

I realize that an effort is being made to address the design flaws found during testing of this aircraft resulting in some changes in the new planes that are scheduled to go into production in fiscal year 2001. However, I remain concerned about the many unanswered questions, and the potentially costly retrofits that these aircraft would require as more information about the safety and reliability of the Osprey continues to come to light. In my view, it would be more prudent and more cost effective to wait to move to full-rate production until these questions have been answered.

For those reasons, my bill rescinds most of the fiscal year 2001 procurement funds for the MV-22 and the CV-22, but leaves enough funding in place to maintain the integrity of the production line. These rescissions would return to the taxpayers more than \$1.2 billion dollars. This kind of investment should not go forward until we are sure that the Osprey is safe.

The bill does not affect the \$148 million in research and development funding for this program. During the next year, vigorous research and testing on the problems that remain should continue once the decision has been made to resume test flights.

This program has a troubled history. Thirty Marines have been killed in Osprey crashes since 1991, twenty-three of them in the past eleven months alone. The Osprey program has been grounded since the December crash that killed four Marines. Following that crash, former Secretary of Defense William Cohen appointed a blue ribbon panel to study the Osprey program. That panel's report is due to be presented to Secretary of Defense Rumsfeld in March or April of this year. In addition, two investigations on the December crash are ongoing.

The safety of our men and women in uniform should be the top priority every time the Department of Defense develops and procures new technology, whether it be weapons, ships, or aircraft.

During his tenure as Secretary of Defense, Vice President CHENEY tried to cancel the V-22 program in each of his budget requests from fiscal year 1990 through 1993 because he believed the program was too costly. Congress disagreed, and the program continued to receive funds.

When asked about the Osprey program last month, the Vice President said, "Given the track record and the loss of life so far, it would appear to me that there are very serious questions that can and should be—and I hope will be—raised about the Osprey."

I agree with Vice President CHENEY's statement, and I hope that this legislation will help to get answers to these serious concerns.

One additional concern about this program is its cost. The Marines, the Air Force, and the Navy each want to buy a version of this aircraft, for a total of 458 aircraft at a cost of \$38.1 billion, or about \$83 million per Osprey. Some defense observers have argued that the mission of the Osprey could be performed by less costly helicopters.

Another concern is the safety of the aircraft. One of the newspapers in my home state of Wisconsin, the Milwaukee Journal Sentinel, has called the Osprey a "lemon with wings." Is that a fair description? There is reason to pause and take a good look at the program and find out. In addition to the four crashes that have occurred since 1991, there are also a number of unanswered questions regarding the design and performance of the aircraft.

The MV-22 underwent operational evaluation, OPEVAL, between October 1999 and August 2000. During OPEVAL, in June 2000, a draft DoD Inspector General's report cited 23 major operational effectiveness and suitability requirements that would not be met prior to the scheduled December 2000 Milestone III decision on whether to enter into full-rate production of the MV-22 in June 2001. The Marine Corps conceded that these problems exist, and said they had been aware of these deficiencies prior to the beginning of the OPEVAL.

In October 2000, the Navy announced that the MV-22 had been judged opera-

tionally effective and suitable for land-based operations. In November 2000, the MV-22 was also judged operationally effective and suitable for sea-based operations.

Following the completion of OPEVAL, the Department of Defense's Director of Operational Testing and Evaluation, Philip Coyle, released his report on the MV-22. This report, which was issued on November 17, 2000, makes a number of recommendations regarding further testing that should be conducted on this aircraft, including testing on a number of requirements for the aircraft that were waived during OPEVAL.

Particularly troubling are the MV-22's Mission Capable, MC, and Full Mission Capable, FMC, rates at the end of OPEVAL. These ratings demonstrate the availability of the aircraft—the amount of time that each MV-22 is able to fly versus the amount of time that each MV-22 is unavailable due to maintenance needs.

The Mission Capable rating represents the percentage of time that the test aircraft were able to perform at least one of their assigned missions. The Marine Corps' objective for the MC rate is between 82 and 87 percent. At the end of OPEVAL, the MC rate for the MV-22 was 49 percent. That means, Mr. President, that the MV-22 test fleet was capable of performing at least one of its missions only 49 percent of the time during OPEVAL. From 1995-1999, the entire CH-46 fleet Sea Knight fleet, which the Osprey is supposed to replace, was rated Mission Capable 79 percent of the time.

The Full Mission Capable rate, FMC, is defined as the percentage of time that the aircraft could perform all of its assigned missions. The Marine Corps' objective for FMC is 75 percent. At the end of OPEVAL, the MV-22 had a FMC rate of only 20 percent. From 1995-1999, the CH-46 fleet had a FMC rate of 74 percent.

I want to say this again—at the end of OPEVAL, the MV-22 test fleet was capable of performing all of its assigned missions only 20 percent of the time. The Coyle report says that part of this low rating can be attributed to problems with the blade fold wing stow, BFWS, system, and that measures to address this problem will be incorporated into all new MV-22s.

While both the MC and the FMC both improved over the course of OPEVAL, both rates are still well below the Marines' own requirements. By delaying the full rate production of the MV-22 for one year, the Marines will have the opportunity to further improve these crucial rates, including testing the modifications to the BFWS system, and potentially save countless maintenance hours and costs over the life of this program.

In addition to the problems outlined in the Coyle report, a General Accounting Office report released last month titled "Major Management Challenges and Program Risks: Department of De-

fense" also expresses concern about the Osprey program. The report states that "the DoD . . . begins production on many major and nonmajor weapons without first ensuring that the systems will meet critical performance requirements." The report cites a number of examples, including the Osprey. GAO reports that "the Navy was moving toward a full-rate production decision on the MV-22 Osprey aircraft without having an appropriate level of confidence that the program would meet design parameters as well as cost and schedule objectives."

This finding is just another of the many reasons why the full-rate procurement of the MV-22 and the procurement of four CV-22s should be delayed. I share GAO's concern about the frequency with which DoD moves into full-rate production of systems that may not have been adequately tested. This rush to production often raises safety concerns and costs the taxpayers large sums for costly retrofits to address problems that were often evident—but not fixed—before full-rate production began. And even if the Osprey is proven to be safe, questions still remain about its cost.

I am also deeply troubled by the allegations that the Commander of the Marine Tilt-Rotor Training Squadron 204 may have ordered his team to falsify maintenance records for the MV-22. An anonymous DoD whistle blower released a letter and documentation, including an audio tape on which it is reported that the Commander is heard telling his squadron to "lie" about maintenance reports on the MV-22 until the Milestone III decision to move into full-rate production of the aircraft had been made. This decision was scheduled to be made in December 2000, but has been postponed indefinitely. The Commander has been relieved of his command pending a full investigation by the DoD Inspector General's office.

There have been reports that high-ranking Marine Corps officers may have known about the low MC and FMC rates for the MV-22 in November 2000, and that one of them may have released inaccurate information to the press regarding the Mission Capable rates of the MV-22.

An electronic mail message from one of these officers to a superior officer dated November 11, 2000, states that the information regarding the MV-22 MC and FMC rates for November contained in the message should be "close held" and that the MC and FMC rates for Squadron 204 were 26.7 percent and 7.9 percent, respectively. The message also said that the sender "had hoped to be able to use some recent numbers next month when [his superior] meet[s] with Dr. Buchanan for his Milestone III/FRP decision in December . . . this isn't going to help."

Later that month, on November 30, 2000, the officer who reportedly sent that electronic mail message participated in a DoD press briefing at which

the Osprey was discussed in some detail. During this press briefing, the officer said the following regarding the Mission Capable rates of the MV-22s being tested by Squadron 204: ". . . as I was walking down here [to the briefing], I pulled the first 13 days of November, mission-capable rate on those airplanes, and the average is 73.2 percent for the first 13 days in November of those nine airplanes. So when we start talking about the airplane, even since OPEVAL, improving and getting better, the answer is it is absolutely a resounding yes."

This information is contrary to the electronic mail message that the officer in question reportedly sent to a superior officer only nine days before, which stated that the MC rate for the MV-22s being tested by Squadron 204 for November 2000 was only 26.7 percent. That is a difference of 46.5 percent. News reports last week said that the officer admitted sending the message and attributes the discrepancy in the MC rate figures to a new software system.

I understand that these very serious allegations are still being investigated, and I agree that all of those involved deserve a fair and impartial investigation. We should not rush to judgement about the alleged conduct of any of these personnel, all of whom who have dedicated their lives to serving and protecting this country. However, we must remain cognizant of the fact that the outcome of this investigation could have an enormous impact on the Osprey program.

This still unfolding situation is another reason why the full rate procurement of the MV-22 should be delayed. Until these disturbing allegations have been fully investigated to determine whether records were falsified in order to make the Osprey appear safe and reliable, the Department of Defense should not move ahead with this program.

Because of the safety concerns outlined above, Mr. President, my bill requires the Secretary of the Navy to submit a report to the Congress on the V-22 program that includes: a description of the planned uses for the fiscal year 2001 research and development funding for the Osprey program; a description of the actions taken as a result of the Coyle report; and a description of the manner in which the Navy and the Marine Corps have responded to the allegations of the falsification of maintenance records at Squadron 204. The bill also requires the DoD Inspector General to report to the Congress on the results of its investigation into the alleged falsification of maintenance records at Squadron 204. It would require that these reports be submitted three months after the enactment of this legislation or on the date of the Milestone III decision regarding full-rate production of the MV-22 Osprey, whichever is earlier.

The safety of our men and women in uniform should be the principle that

guides this important decision. We should not begin to procure the MV-22 in mass quantities until we know for certain that this aircraft is safe, that its maintenance records are accurate, and that the design flaws described in the Coyle report have been adequately addressed.

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

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

S. 272

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Osprey Safety, Performance, and Reliability Evaluation Act of 2001".

SEC. 2. RESCISSIONS.

(a) IN GENERAL.—Of the funds made available in the Department of Defense Appropriations Act, 2001 (Public Law 106-259), the following amounts are rescinded from the following accounts:

(1) "Aircraft Procurement, Navy", \$856,618,000, of which \$776,760,000 shall be derived from "V-22 (Medium Lift)" and \$79,858,000 shall be derived from "V-22 (Medium Lift) (AP-CY)".

(2) "Aircraft Procurement, Air Force", \$358,440,000, of which \$335,766,000 shall be derived from "V-22 Osprey" and \$22,674,000 shall be derived from "V-22 Osprey (AP-CY)".

(b) LIMITATION ON USE OF REMAINING FUNDS.—Following the rescission made by subsection (a)(1), the balance of the funds remaining available for obligation in the account involved for "V-22 (Medium Lift)" may be used only to carry out activities necessary to maintain the production base for such aircraft program.

SEC. 3. REPORTS TO CONGRESS.

(a) SECRETARY OF THE NAVY REPORT.—The Secretary of the Navy shall submit to Congress a report on the V-22 Osprey aircraft program. The report shall include the following:

(1) A description of the activities carried out, and programmed to be carried out, using funds appropriated for that program for research, development, test, and evaluation for fiscal year 2001.

(2) A description of the actions taken by the Secretary as a result of the report on that program issued by the Director of Operational Test and Evaluation of the Department of Defense dated November 17, 2000.

(3) A description of the manner in which the Marine Corps and the Department of the Navy have responded to the reports of data falsification concerning the Osprey aircraft by Marine Corps personnel assigned to Marine Medium Tilt-Rotor Training Squadron 204.

(b) INSPECTOR GENERAL REPORT.—The Inspector General of the Department of Defense shall submit to Congress a report on the results, as of the submission of the report, of the investigation of the Inspector General into the V-22 Osprey aircraft program.

(c) TIME FOR SUBMISSION OF REPORTS.—The reports under subsections (a) and (b) shall each be submitted not later than the earlier of the following:

(1) The date that is three months after the date of the enactment of this Act.

(2) The date of the Milestone III decision for the V-22 Osprey aircraft program approving the entry of that program into full-rate production.

By Mr. TORRICELLI (for himself and Mr. CORZINE):

S. 273 A bill to amend title 28, United States Code, to divide New Jersey into 2 judicial districts; to the Committee on the Judiciary.

Mr. TORRICELLI. Mr. President, I rise today to introduce, on behalf of myself and my distinguished colleague, Senator CORZINE, a bill that will help bring more criminals to justice and create a better federal judicial system in New Jersey. This legislation will divide the federal District of New Jersey into the Southern and Northern Districts of New Jersey thus enabling federal courts and federal law enforcement to better serve the State's approximately eight million residents.

Currently, the District of New Jersey has 17 judges. This bill does not increase the number of judges, but divides them between the Southern and Northern Districts giving the South 7 judges and the North 10. The bill will also result in the creation of several new federal positions for the Southern District including a Clerk of the Court, U.S. Attorney, U.S. Marshal, and a Federal Public Defender.

The creation of two districts in New Jersey is called for by the additional crime-fighting resources a split will bring to the State and by the sheer size of the State. The current District of New Jersey is the third most populous federal judicial district in the nation. Of the 25 states that have a single federal judicial district, New Jersey has the largest population. More than a dozen states with smaller populations have multiple judicial districts. In fact, with more than 2 million residents in the southern counties, the population of the proposed Southern District of New Jersey would exceed that of almost half of the current judicial districts. The proposed Northern District would rank even higher.

And while the bill would not create any new judgeships, it would mean that, for the first time, the judges of the Southern District would necessarily come from and be part of the unique community they serve. This can only lead to enhanced sensitivity to the community's needs.

The bill will also take a significant step towards addressing the disparity in crime-fighting resources allocated to northern and southern New Jersey. In 1998, southern New Jersey accounted for 25 percent of the state's urban murders, 32 percent of the state's murder arrests and 33 percent of the state's arrests for violent crimes. Despite these statistics, only 10 percent of the FBI agents, 15 percent of U.S. Marshals and 18 percent of DEA agents in New Jersey are assigned to the southern counties.

The bill will also ensure that crime-fighting decisions are made locally instead of by officials who are based elsewhere in the state. This too would result in a government more sensitive and responsive to the people it serves.

Given these facts, it is not surprising that the bill has received a ringing endorsement from many in New Jersey's

legal and law enforcement community. In the last Congress, the House version of this bill was cosponsored by the entire southern New Jersey Congressional delegation. I hope to have their support again. It is also supported by the New Jersey State Bar Association, all of the southern county bar associations, the South Jersey Police Chief's Association, the Chamber of Commerce of Southern New Jersey, and various former county prosecutors and former federal law enforcement officials.

While the process of reviewing and deliberating the merits of this legislation will be lengthy and time consuming, this is a change that is long overdue. The citizens of New Jersey deserve a better federal judicial system and their fair share of federal crime-fighting resources. I look forward to working with my colleagues to secure passage of this legislation.

I ask unanimous consent that a copy of the legislation be printed in the RECORD.

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

S. 273

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

SECTION 1. FINDINGS.

The Congress finds the following:

(1) In 1978, the Judicial Conference of the United States established a procedure for creating new Federal judicial districts, which is still in force. According to the "Proceedings of the Judicial Conference, September 21–22, 1978", this procedure requires that 4 principal criteria be taken into consideration in evaluating the establishment of a new Federal judicial district: caseload, judicial administration, geography, and community convenience.

(2) The criterion of "caseload" is found to include the total number of Federal court cases and the number of cases per Federal judge, for both criminal and civil Federal cases.

(3)(A) The 13 southern counties of New Jersey, consisting of Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Hunterdon, Mercer, Monmouth, Ocean, Salem, Somerset, and Warren Counties, have a substantial criminal caseload which requires the creation of a separate judicial district.

(B) 463 Federal criminal cases originated in the 13 southern New Jersey counties in fiscal year 1999 and were handled principally by the 5 judges of the Camden vicinage and the 3 judges of the Trenton vicinage.

(C) In fiscal year 1999, the criminal cases originating in the 13 southern New Jersey counties exceeded that of 57 of the current 93 Federal judicial districts other than the District of New Jersey. Only 36 of the other current Federal judicial districts had more criminal cases than the southern region of New Jersey.

(D) For example, in the District of Massachusetts (19 judges), 434 criminal cases were filed in fiscal year 1999. In the District of Connecticut (14 judges), only 250 criminal cases were filed in fiscal year 1999.

(4)(A) The substantial civil caseload concentrated in the southern counties of New Jersey requires the creation of a separate judicial district.

(B) Approximately 2,983 Federal civil cases originated in the 13 southern New Jersey

counties in fiscal year 1999 and were handled principally by the 5 judges of the Camden vicinage and the 3 judges of the Trenton vicinage.

(C) In the fiscal year 1999, the civil cases originating in the 13 southern New Jersey counties exceeded that of 68 of the current Federal judicial districts other than the District of New Jersey. Only 25 of the other Federal judicial districts had more civil cases than the southern region of New Jersey.

(D) For example, in the Southern District of West Virginia, a separate judicial district with 8 judges, only 1,203 civil cases were commenced in fiscal year 1999. The Western District of Tennessee, with 6 judges, had only 1,512 civil cases commenced in fiscal year 1999.

(5) The criterion of "judicial administration" is found to include the backlog of pending cases in a Federal judicial district, which hinders the effective resolution of pending business before the court.

(6)(A) The size of the backlog of pending cases concentrated in the 13 southern counties of New Jersey requires the creation of a separate judicial district.

(B) In fiscal year 1999, the pending criminal cases attributed to the 13 southern New Jersey counties exceeded that of 62 of the current 93 Federal judicial districts other than the District of New Jersey. Only 31 of the other current Federal judicial districts had more pending criminal cases than the southern region of New Jersey.

(C) In fiscal year 1999, the pending civil cases attributed to the 13 southern New Jersey counties exceeded that of 66 of the current 93 Federal judicial districts other than the District of New Jersey. Only 27 of the other current Federal judicial districts had more pending civil cases than the southern region of New Jersey.

(D) The number of pending cases in the Camden vicinage of New Jersey exceeds the number of cases pending before entire judicial districts with similar numbers of judges, clearly indicating that southern New Jersey merits a separate Federal judicial district. For example, as of October 1, 1999, there were 1,431 civil cases pending before the Camden vicinage, and only 113 of those were commenced in fiscal year 1999. The Western District of Tennessee, with 6 judges, had only 1,079 civil cases pending in fiscal year 1999. The Western District of Oklahoma had only 1,356 civil cases pending in fiscal year 1999 before 9 judges. Finally, there are 161 criminal cases pending before the Camden vicinage, while the entire Southern District of Indiana, with 7 judges, had only 117 criminal cases pending in fiscal year 1999.

(7) The criterion of "geography" is found to mean the accessibility of the central administration of the Federal judicial district to officers of the court, parties with business before the court, and other citizens living within the Federal judicial district.

(8)(A) The distance between the northern and southern regions of New Jersey and the density of New Jersey's population create a substantial barrier to the efficient administration of justice.

(B) The distance from Newark, New Jersey to Camden, New Jersey is more than 85 miles.

(C) When a new Federal court district was created in Louisiana in 1971, the distance between New Orleans and Baton Rouge (nearly 80 miles) was cited as a major factor in creating a new district court, as travel difficulties were impeding the timely administration of justice.

(9) The criterion of "community convenience" is found to mean the extent to which creating a new Federal judicial district will allow the court to better serve the population and diverse communities of the area.

(10)(A) New Jersey's culturally and regionally diverse population of over 8,000,000 citizens, widely distributed across a densely populated State, is inconvenienced by having only 1 judicial district.

(B) The District of New Jersey is the third most populous Federal judicial district in the United States.

(C) The population of the 13 southern New Jersey counties exceeds the population of 67 of the current 93 Federal judicial districts other than the District of New Jersey. The population of the 8 northern New Jersey counties (consisting of Bergen, Essex, Hudson, Middlesex, Morris, Passaic, Sussex, and Union) exceeds the population of 73 of the current 93 Federal judicial districts other than the District of New Jersey.

(D) Of the 25 States that have only a single Federal judicial district (including Puerto Rico, the United States territories, and the District of Columbia), New Jersey has the highest population.

(E) More than a dozen States have smaller populations than New Jersey, yet they have multiple Federal judicial districts, including Washington, Oklahoma, Iowa, Georgia, West Virginia, and Missouri.

(11) In evaluating the creation of a new Southern District of New Jersey, the Judicial Conference should seek the views of the chief judge of the affected district, the judicial council for the affected circuit court, and the affected United States Attorney as representative of the views of the Department of Justice, as required in the procedure established by the "Proceedings of the Judicial Conference, September 21–22, 1978".

SEC. 2. ESTABLISHMENT OF 2 DISTRICTS IN NEW JERSEY.

(a) **CREATION.**—Section 110 of title 28, United States Code, is amended to read as follows:

“§ 110. New Jersey

“New Jersey is divided into 2 judicial districts to be known as the Northern and Southern Districts of New Jersey.

“Northern District

“(a) The Northern District comprises the counties of Bergen, Essex, Hudson, Middlesex, Morris, Passaic, Sussex, and Union.

“Court for the Northern District shall be held at Newark.

“Southern District

“(b) The Southern District comprises the counties of Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Hunterdon, Mercer, Monmouth, Ocean, Salem, Somerset, and Warren.

“Court for the Southern District shall be held at Camden and Trenton.”

(b) **JUDGESHIPS.**—The item relating to New Jersey in the table set forth in section 133(a) of title 28, United States Code, is amended to read as follows:

“New Jersey:

“Northern 10
“Southern 7”.

(c) **BANKRUPTCY JUDGESHIPS.**—The item relating to New Jersey in the table set forth in section 152(a)(1) of title 28, United States Code, is amended to read as follows:

“New Jersey:

“Northern 4
“Southern 4”.

SEC. 3. DISTRICT JUDGES, BANKRUPTCY JUDGES, MAGISTRATE JUDGES, UNITED STATES ATTORNEY, UNITED STATES MARSHAL, AND FEDERAL PUBLIC DEFENDER.

(a) **TRANSFER OF DISTRICT JUDGES.**—(1) Any district judge of the District Court of New Jersey who is holding office on the day before the effective date of this Act and whose official duty station is in Bergen, Essex, Hudson, Middlesex, Morris, Passaic, Sussex,

or Union County shall, on or after such effective date, be a district judge for the Northern District of New Jersey. Any district judge of the District Court of New Jersey who is holding office on the day before the effective date of this Act and whose official duty station is in Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Hunterdon, Mercer, Monmouth, Ocean, Salem, Somerset, or Warren County shall, on and after such effective date, be a district judge of the Southern District of New Jersey.

(2) Whenever a vacancy occurs in a judgeship in either judicial district of New Jersey, the vacancy shall first be offered to those judges appointed before the enactment of this Act and in active service in the other judicial district of New Jersey at the time of the vacancy, and of those judges wishing to fill the vacancy, the judge most senior in service shall fill that vacancy. In such a case, the President shall appoint a judge to fill the vacancy resulting in the district of New Jersey from which such judge left office.

(b) TRANSFER OF BANKRUPTCY AND MAGISTRATE JUDGES.—Any bankruptcy judge or magistrate judge of the District Court of New Jersey who is holding office on the day before the effective date of this Act and whose official duty station is in Bergen, Essex, Hudson, Middlesex, Morris, Passaic, Sussex, or Union County shall, on or after such effective date, be a bankruptcy judge or magistrate judge, as the case may be, for the Northern District of New Jersey. Any bankruptcy judge or magistrate judge of the District Court of New Jersey who is holding office on the day before the effective date of this Act and whose official duty station is in Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Hunterdon, Mercer, Monmouth, Ocean, Salem, Somerset, or Warren County shall, on and after such effective date, be a bankruptcy judge or magistrate judge, as the case may be, of the Southern District of New Jersey.

(c) UNITED STATES ATTORNEY, UNITED STATES MARSHAL, AND FEDERAL PUBLIC DEFENDER.—

(1) THOSE IN OFFICE.—This Act and the amendments made by this Act shall not affect the tenure of office of the United States attorney, the United States marshal, and the Federal Public Defender, for the District of New Jersey who are in office on the effective date of this Act, except that such individuals shall be the United States attorney, the United States marshal, and the Federal Public Defender, respectively, for the Northern District of New Jersey as of such effective date.

(2) APPOINTMENTS.—The President shall appoint, by and with the advice and consent of the Senate, a United States attorney and a United States marshal for the Southern District of New Jersey. The Court of Appeals for the Third Circuit shall appoint a Federal Public Defender for the Southern District of New Jersey.

(d) PENDING CASES NOT AFFECTED.—This Act and the amendments made by this Act shall not affect any action commenced before the effective date of this Act and pending in the United States District Court for the District of New Jersey on such date.

(e) JURIES NOT AFFECTED.—This Act and the amendments made by this Act shall not affect the composition, or preclude the service, of any grand or petit jury summoned, empaneled, or actually serving in the Judicial District of New Jersey on the effective date of this Act.

SEC. 4. EFFECTIVE DATE.

(a) IN GENERAL.—This Act and the amendments made by this Act shall take effect 180 days after the date of the enactment of this Act.

(b) APPOINTMENTS.—Notwithstanding subsection (a), the President and the Court of Appeals for the Third Circuit may make the appointments under section 3(c)(2) at any time after the date of the enactment of this Act.

By Mr. BAUCUS:

S. 274. A bill to establish a Congressional Trade Office; to the Committee on Finance.

Mr. BAUCUS. Mr. President, I am introducing a bill today to create a Congressional Trade Office. It is similar to the bill I offered in the last session of Congress. This legislation is designed to assist the Congress in fulfilling our Constitutional responsibility for trade policy by creating an entity that can provide us with the expertise we need to get independent, non-partisan, and neutral analysis and information about trade.

Over the past three decades, the role of trade in our economy has grown enormously. In 1970, trade was equal to only eleven percent of our Gross Domestic Product. In contrast, today exports and imports are equivalent to 27 percent of our economy.

I have been in Congress for 26 years. During that time, I have watched a continuing transfer of authority and responsibility for trade policy from the Congress to the Executive Branch. The trend has been subtle, but it has been clear and constant. We need to reverse this trend.

Article I, Section 8, of the U.S. Constitution says: “The Congress shall have power . . . To regulate commerce with foreign nations.” It is our responsibility to set the direction for the Executive Branch in its Formulation of trade policy. It is our responsibility to ensure that agreements with our trading partners are followed and that there is full compliance. It is our responsibility to provide more effective and active oversight of our nation’s trade policy. I believe strongly that we must re-assert Congress’ constitutionally defined responsibility for international commerce.

The Congressional Trade Office I am proposing will provide the entire Congress, through the Senate Finance Committee and the House Ways and Means Committee, with the additional trade expertise that will allow us to meet these responsibilities.

The trade issues that the Congress may face this session are many and complex: Fast track; incorporating legitimate labor and environmental issues into trade policy; the U.S./Jordan Free Trade Agreement; the U.S./Vietnam Bilateral Trade Agreement; Free Trade Area for the Americas; possible free trade agreements with Singapore, Chile, and others; Chinese accession to WTO and then compliance with its WTO commitments; and a new comprehensive multilateral trade round.

Congress needs to be much better prepared to deal with these issues responsibly and authoritatively. That means we need access to more and better information, independently arrived

at, from people whose commitment is to the Congress, and only to the Congress.

The Congressional Trade Office would help us meet these responsibilities through its four core functions.

First, it will monitor compliance with major bilateral, regional, and multilateral trade agreements. Congress needs the independent ability to look more closely at agreements with other countries. The Congressional Trade Office will analyze the performance under key agreements and evaluate success based on commercial results. It will do this in close consultation with the affected industries. The Congressional Trade Office will recommend to the Congress actions necessary to ensure that commitments made to the United States are fully implemented. It will also provide annual assessments of the extent to which agreements comply with labor and environmental goals.

The General Accounting Office has reported on the deficiencies in the Executive Branch in following trade agreements and monitoring compliance. Often more energy goes into negotiating new agreements than into ensuring that existing agreements work. The Administration has increased the resources it devotes to compliance, and I supported that. But an independent and neutral assessment in the Congress of compliance is necessary. It is unrealistic to expect an agency that negotiated an agreement to provide a totally objective and dispassionate assessment of that agreement’s success or failure. Human nature, and institutional nature, does not lead to such an outcome.

Second, observing trade negotiations first hand is critical to the ability of Congress to provide meaningful oversight of trade policy. Congressional Trade Office staff will participate in selected negotiations as observers and report back to the Committees.

Third, the Congressional Trade Office will be active in dispute settlement deliberations. It will evaluate each WTO decision where the U.S. is a participant. In the case of a U.S. loss, it will explain why it lost. In the case of a U.S. win, it will measure the commercial results from that decision. Congressional Trade Office staff should participate as observers on the U.S. delegation at appropriate dispute settlement panel meetings at the WTO.

I don’t think we even know whether the WTO dispute settlement process has been successful or not from the perspective of U.S. commercial interests. A count of wins versus losses tells us nothing. The Congressional Trade Office will give us the facts we need to evaluate this process properly.

Fourth, the Congressional Trade Office will have an analytic function. For example, after the Administration delivers its annual National Trade Estimates report, the NTE, to Congress, it will analyze the major outstanding trade barriers based on the cost to the

U.S. economy. It will also provide an analysis of the Administration's Trade Policy Agenda.

The Congressional Trade Office will analyze proposed trade agreements. It will examine the impact of Administration trade policy actions. And it will analyze the trade accounts every quarter, including the global current account, the global trade account, and key bilateral trade accounts.

The Congressional Trade Office is designed to service the Congress. Its Director will report to the Senate Finance Committee and the House Ways and Means Committee. It will also advise other committees on both the impact of trade negotiations and the impact of the Administration's trade policy on those committees' areas of jurisdiction. Trade rules increasingly affect domestic regulations. Expertise on the implications of trade policy on domestic regulatory issues will be vitally necessary. The Congressional Trade Office can provide that assistance.

The staff of the Congressional Trade Office will consist of professionals who have a mix of expertise in economics and trade law, plus in various industries and geographic regions. My expectation is that staff members will see this as a career position, thus, providing the Congress with long-term institutional memory.

I encourage my colleagues to support this innovative proposal.

By Mr. KYL (for himself, Mr. BREAX, Mr. GRAMM, Mrs. LINCOLN, and Mr. BAYH):

S. 275. A bill to amend the Internal Revenue Code of 1986 to repeal the Federal estate and gift taxes and the tax on generation-skipping transfers, to preserve a step up in basis of certain property acquired from a decedent, and for other purposes; to the Committee on Finance.

Mr. KYL. Mr. President, today, Senators BREAX, GRAMM, LINCOLN, and BAYH and I are introducing the Estate Tax Elimination Act, a bill to replace the federal estate tax with a tax on capital gains earned from inherited assets due when those assets are sold.

This is the approach that won the support of bipartisan majorities in both houses of Congress last year. Instead of levying an estate tax at death, Congress agreed that a tax should be imposed when income is actually realized from inherited property—that is, when it is sold. The bipartisan consensus that already exists in support of this plan means that Congress and President Bush—who, unlike his predecessor, supports repeal of the death tax—can come together and quickly dispose of the issue this year.

Mr. President, the beauty of this approach is that it removes death as the trigger for any tax. Whether an asset is sold by the decedent during his or her lifetime, or by someone who later inherits the property, the gain is taxed the same. Death neither confers a benefit, nor results in a punitive, confis-

catory tax. Senators on both sides of the aisle accepted this arrangement last year, and should support it again this year.

Mr. President, we know that many Americans are troubled by the estate tax's complexity and high rates, and by the mere fact that it is triggered by a person's death rather than the realization of income. For a long time, I have advocated repeal, because I believe death should not be a taxable event.

Others agree that the tax is problematic, but are concerned that the unrealized appreciation in certain assets might escape taxation forever if the death tax were repealed while the step-up in basis allowed by under current law remained in effect. That is a legitimate concern.

We address this by recommending the elimination of both the death tax and the step-up in basis, and attributing a carryover basis to inherited property so that all gains are taxed at the time the property is sold and income is realized.

The concept of a carryover basis is not new. It exists in current law with respect to gifts, property transferred in cases of divorce, and in connection with involuntary conversions of property relating to theft, destruction, seizure, requisition, or condemnation.

In the latter case, when an owner receives compensation for involuntarily converted property, a taxable gain normally results to the extent that the value of the compensation exceeds the basis of the converted property. However, Section 1033 of the Internal Revenue Code allows the taxpayer to defer the recognition of the gain until the property is sold. The concept recommended in this amendment would treat the transfer of property at death—perhaps the most involuntary conversion of all—the same way, deferring recognition of any gain until the inherited property is sold.

Small estates, which currently pay no estate tax by virtue of the unified credit, and no capital-gains tax by virtue of the step up, would be unaffected by the basis changes being proposed here. The estate tax would be eliminated for them, and a limited step-up in basis would be preserved. Each person could still step up the basis in his or her assets by up to \$2.8 million. Beyond that, a carryover basis would apply.

I want to stress to colleagues, particularly colleagues on the Democratic side of the aisle, that this measure would not allow unrealized appreciation in inherited assets—beyond the limited step-up amount—to go untaxed, as other death-tax repeal proposals would do. We are merely saying that if a tax is imposed, it should be imposed when income is realized.

Mr. President, some people may ask whether the American people want this kind of tax relief. I will answer that question. Although most Americans will probably never pay a death tax, most still sense that there is some-

thing terribly wrong with a system that allows Washington to seize more than half of whatever is left after someone dies—a system that prevents hard-working Americans from passing the bulk of their nest eggs to their children or grandchildren.

Fairness, Mr. President. That is what the effort to repeal the death tax is all about. A June 22–25, 2000 Gallup poll found that 60 percent of the people support repeal, even though about three-quarters of those supporters do not think they will ever have to pay a death tax themselves.

A poll conducted by Zogby International on July 6, 2000, found that, given a choice between a candidate who believes that a large estate left to heirs should be taxed at a rate of 50 percent for anything over \$2 million, and a candidate who believes that the estate tax is unfair to heirs and should be eliminated, 75 percent of the people prefer the person supporting death-tax repeal.

Other polls similarly put support for repeal at between 70 and 80 percent.

Voters in two states approved referenda last November to repeal their state death tax: South Dakota by a vote of 79 to 21 percent, and Montana by a vote of 68 to 32 percent. Many other states have already done the same.

Mr. President, the significant majorities in the House and Senate that voted for repeal last year means that we have finally found a formula for taxing inherited assets in a fair and commonsense way. Appreciated value will be taxed, but only when income is actually realized—that is, when the assets are sold. And then, the gains would be treated by the Tax Code no better, and no worse, than the gains from the sale of any other kind of asset.

I invite our Senate colleagues to join in support of this bipartisan initiative again this year.

By Mr. SHELBY (for himself, Mr. BOND, Mr. THOMAS, Mr. HAGEL, Mr. SESSIONS, Mr. HELMS, Mr. INHOFE, Mr. BURNS, Mr. KYL, Mr. COCHRAN, Ms. SNOWE, and Mr. ALLARD):

S. 276. A bill to amend chapter 8 of title 5, United States Code, to provide for congressional review of any rule promulgated by the Internal Revenue Service that increases Federal revenue, and for other purposes; to the Committee on Governmental Affairs.

Mr. SHELBY. Mr. President, I rise today with my colleague Senator BOND, to introduce the Stealth Tax Prevention Act. Perhaps the most important power given to Congress by the Constitution of the United States, is the responsibility of taxation. The Founding Fathers rationale behind bestowing this power on Congress is that as elected representatives, Congress remains accountable to the people when they levy and collect taxes. Members of Congress, unlike Federal agency bureaucrats, are rightly held responsible to the public for producing fair and prudent tax legislation.

In 1996, Mr. President, Congress passed the Congressional Review Act, which provides that when a major agency rule takes effect, Congress has 60 days to review it. During this time period, Congress has the option to pass a disapproval resolution. If no such resolution is passed, the rule then goes into effect.

As you know, Mr. President, the Internal Revenue Service maintains an enormous amount of power over the lives and the livelihoods of the American taxpayers through their authority to implement and enforce the Tax Code. Even though Congress, and only Congress, has the authority to tax, the Internal Revenue Service has found a “backdoor” way to increase our federal tax burden through their interpretive authority. The Stealth Tax Prevention Act, that Senator BOND and I are introducing along with Mr. THOMAS, Mr. HAGEL, Mr. KYL, Mr. BURNS, Mr. HELMS, Mr. INHOFE, Mr. SESSIONS, Mr. COCHRAN, Ms. SNOWE, and Mr. ALLARD, will return the authority of taxation to the United States Congress by expanding the definition of a major rule to include any IRS regulation which increases Federal revenue.

For example, if the Office of Management and Budget finds that the implementation and enforcement of a rule would result in an increase of Federal revenues over current practices or revenues anticipated from the rule on the date of the enactment of the statute, the Stealth Tax Prevention Act would allow Congress to review the regulations and take appropriate measures to avoid raising taxes on hard working Americans and small businesses.

The discretionary authority of the Internal Revenue Service exposes small businesses, farmers, and individual taxpayers to the sometimes arbitrary actions of bureaucrats, creating an uncertain and, in many instances, a hostile environment in which to conduct day-to-day activities. The Stealth Tax Prevention Act will be particularly helpful in lowering the tax burden on small business which suffers disproportionately, Mr. President, from IRS regulations. This tax burden discourages the startup of new firms and ultimately the creation of new jobs in the economy, which has really made America great.

Average American families and small businesses are saddled with the highest tax burden in our country's history. Americans pay federal income taxes, they pay state income taxes and they pay property taxes. On the way to work in the morning they pay a gasoline tax when they fill up their car and a sales tax when they buy a cup of coffee. Allowing federal bureaucrats to increase taxes even further at their own discretion through interpretation of the tax code is intolerable. The Stealth Tax Prevention Act will leave tax policy where it belongs—to elected members of Congress—not an unelected and unaccountable IRS.

Mr. BURNS. Mr. President, I rise today with my colleague from Alabama

to introduce the Stealth Tax Prevention Act. I sponsored this bill in the 105th and again in the 106th Congress. I felt strongly enough about this bill to sponsor it again this year.

One of the most common concerns I hear from my constituents is regarding the Federal Government's authority to levy and collect taxes. This is an important role that we in Congress do not take lightly as we are accountable to the voters who pay those taxes.

Three years ago, Congress passed the Congressional Review Act, which provides that when a major agency rule takes effect, Congress has 60 days to review it. During this time period, Congress has the option to pass a disapproval resolution. If no such resolution is passed, the rule then goes into effect.

The Stealth Tax Prevention Act will expand the definition of a major rule to include any IRS regulation which increases taxes. It is not the role of the IRS to make decisions that will result in increased taxes.

For example, if the Office of Management and Budget finds that the implementation and enforcement of a rule would result in an increase of Federal revenues over current practices or revenues anticipated from the rule on the date of the enactment of the statute, the Stealth Tax Prevention Act would allow Congress to review the regulations and take appropriate measures to avoid raising taxes on hard working Americans, in most cases, small businesses.

Bureaucrats are not directly accountable to taxpayers—I am.

Under the bill introduced today, an IRS implemented stealth tax could not go into effect for at least 60 days following its publication in the Federal Register. This window would allow Congress the opportunity to review the rule and vote on a resolution to disapprove the tax increase before it is applied to a single taxpayer.

I urge my colleagues to join us in supporting this important legislation to ensure that the IRS neither usurps the proper role of Congress—nor skirts its obligations to identify the impact of its proposed and final rules. When the Department of the Treasury issues a final IRS rule that increases taxes, Congress should have the ability to exercise its discretion to enact a resolution of disapproval before the rule is applicable to a single taxpayer.

The Stealth Tax Prevention Act will leave tax policy where it belongs, to elected Members of the Congress, not unelected and unaccountable IRS bureaucrats.

Thank you, Mr. President, I yield the floor.

By Mr. KENNEDY (for himself, Mr. AKAKA, Mr. BINGAMAN, Mrs. BOXER, Mrs. CLINTON, Mr. CORZINE, Mr. DASCHLE, Mr. DODD, Mr. DURBIN, Mr. FEINGOLD, Mrs. FEINSTEIN, Mr. HARKIN, Mr. KERRY, Ms. LANDRIEU,

Mr. LIEBERMAN, Mr. LEAHY, Mr. LEVIN, Ms. MIKULSKI, Mrs. MURRAY, Mr. REED, Mr. ROCKEFELLER, Mr. SARBANES, Mr. SCHUMER, Mr. WELLSTONE, and Mr. WYDEN):

S. 277. A bill to amend the Fair Labor Standards Act of 1938 to provide for an increase in the Federal minimum wage; to the Committee on Health, Education, Labor, and Pensions.

Mr. KENNEDY. Mr. President, this afternoon I and others will be introducing legislation to increase the minimum wage. We will increase the minimum wage by 60 cents this year, 50 cents next year, and 40 cents the year after.

The reason we are doing this is to recognize that over the last 8 years, we have had the most extraordinary economic expansion, but there are a number of Americans, about 11 million to 13 million Americans, who have not benefited from our economic expansion.

They are the individuals who are on the lowest rung of the economic ladder. This is an attempt to make an adjustment in their income, and this increase in the minimum wage will provide an extremely modest increase in that income.

This issue is a women's issue because the great majority of those who receive the minimum wage are women.

This is a children's issue because the great majority of the women who are receiving the minimum wage have children and their lives are directly affected by the amount of income their mother or their parents make, and if they are making the minimum wage, often it is not just one job, but two jobs, and their lives are dramatically affected.

It is a civil rights issue because so many of those who are earning the minimum wage are men and women of color.

Most of all, it is a fairness issue. Men and women in this country who work 40 hours a week, 52 weeks a year should not have to live in poverty.

This is about rewarding work. It is a recognition that people in our country who are playing by the rules attempting to provide for their family, if they are making a minimum wage today with a family of three, they are still falling \$3,400 below the poverty line in the United States of America. This minimum wage will reduce that, but they will still fall within the definition of poverty.

With this extraordinary expansion we have seen, with the extraordinary benefits that have gone to so many millions of Americans, it is time that we ought to give some attention to those who have been left out and left behind.

Who are these minimum wage workers? First of all, they are men and women of dignity; men and women who take pride in the work they do; men and women who are proud to go to work and understand the value of work, frustrated as others might be, but nonetheless are willing to put their

shoulder to the wheel because they want to take care of their families and because they have a sense of pride.

What do they do? By and large, minimum wage workers work in child care centers. They are helping to look after the children of others who are working hard in American industry. Many of them are assistants to teachers in our schools and, again, are working with children all across this country. Many others are working in nursing homes looking after those who have retired, those who need nursing home attention. These are men and women who are doing very important work, in many instances helping to make sure that the major buildings that house our industries and corporations are attended to during the nighttime. These are hard-working people, and they are people who take great pride in what they do, as they should.

Let's look at what their situation has come to. This chart says: Working hard, but losing ground. The real value of the minimum wage. If we look at constant dollars, the purchasing power of the minimum wage was \$7.66 in 1968. Over the years, we have seen how that has fallen, with just a few interruptions when there was an increase in the minimum wage in 1988 and another increase in 1994. We can see what has happened with the purchasing power of the minimum wage. Without an increase in the minimum wage, in the year 2002, it would be down to \$4.75, just about the lowest that it has been since the mid-1960s. This is in real purchasing power.

If we raise the minimum wage 60 cents, 50 cents, and 40 cents, and add that \$1.50 on top of the \$5.15 an hour now, the purchasing power would only be \$6.14, which is identical to what it would be if we actually increased the minimum wage in the last 2 years by 50 cents and 50 cents, which was our proposal. Since we lost a year, there has been further deterioration in the purchasing power of the minimum wage. Even with the step-up of 60 cents, 50 cents, and 40 cents, its purchasing power will still only be \$6.14.

This is an extremely modest increase. Historically, the percentage increase in the minimum wage we are asking for is extremely modest. Most other times, the percentage has been a good deal higher than it is in this proposal. This is a modest increase, but a very important increase.

What has been happening to our minimum wage workers? This chart indicates what has happened to average hourly earnings from 1969 to the year 2000.

You can see from the chart that the average hourly earnings have been constantly going up. Going back to 1969, the minimum wage was 53 percent of average hourly earnings. In the year 2000, do you think it has even held at 53 percent? No. It has dropped to 37 percent of average hourly earnings—a dramatic reduction, even in comparison to what has been happening to the aver-

age American workers across the country. They are falling further and further behind.

This chart is very interesting in that it shows what is happening out there in the workplace among those who have families with children who are in the bottom 40 percent of U.S. family incomes from 1979 to 1999.

All workers are averaging 416 hours more a year. Do we understand that? In 1999, they are working more than 400 hours a year more than they were working in 1979, even when their amount of income proportionately was a good deal better. Now we find American workers are working longer and harder than any other workers in any other industrial country in the world. And this is true about minimum wage workers, who, in most instances, have not just one job but have two jobs.

So for all those from whom we are going to hear in this Chamber about the importance of rewarding people who work, here we have some of the hardest workers in the world who are making pitiful little and find it enormously difficult to be able to provide for their families.

Four hundred sixteen hours, what does that translate into? What it translates into is this: The average minimum wage worker today gets to spend 25 hours a week less with his or her children than they did 15 years ago. When we are talking about family values—and we will hear a great deal about family values—one of the most important and basic and fundamental family values is having an adequate income to provide for one's children. The minimum wage does not provide it.

We see from this chart that working families are increasingly living in poverty. The red line indicates what the poverty line represents here in the United States. What we have seen for many years—in the 1960s, 1970s, right up to about 1980—is that the minimum wage was effectively the poverty wage. That was the bare minimum to be able to live with some degree of dignity in terms of providing the housing, the food, the shelter, the clothing, the essentials for families. What we have seen is this spread has been growing and increasing. Minimum wage workers are falling further and further behind.

Now, this is against a very important chart here which reflects the changes in family incomes from 1979 to 1999. The top fifth of families' incomes have increased by 42 percent in the last 20 years; middle-income families by about 11 percent over the last 20 years; the bottom fifth has actually declined in terms of their quality of life and in terms of what their income is. It shows they are going down, working longer, working harder, providing important kinds of services at a time of extraordinary economic prosperity. They are falling further and further and further behind. We have an opportunity to do something about that.

We provided an increase in the earned-income tax credit in the recent

times, which is helpful for those with larger families who have a number of children; but still, for the single mom, or the mother and father with a single child, the minimum wage is the way to go when you are talking about benefiting and increasing the income for families.

We often hear on the Senate floor we cannot do that because if we do do it, we are going to have an adverse impact in terms of our employment situation. That is a lot of hogwash.

Let's look at what has happened since the last time we increased the minimum wage. Since 1996, when we increased the minimum wage in two steps, we heard: We do not want to do that because it is going to have an adverse impact on teens. That is wrong. The unemployment rate for teens has actually gone down with our two-step increase in the minimum wage.

For those who are lacking high school diplomas—they said: They will not be able to get employment at the McDonald's in order to gain work habits—wrong again. We found that the unemployment rate has gone down even for those lacking a high school diploma.

How about, we often heard: This isn't fair to African Americans. Wrong again. We found out the unemployment rate has still declined. It is certainly more than double what it is for the national average, but the employment level has dropped over what it was previously. The same is true with regard to Hispanics. And the same is true with regard to women.

So we believe this is an issue of fairness. We believe it is a matter of urgency. We have tried, over the period of recent years, to get this measure up before the Senate. We were denied that opportunity to have an up-or-down vote. We were told by the Republican leadership at the end of the last Congress: You can have this if you provide \$73 billion in tax breaks for American companies and corporations. Effectively, they were saying: We are going to hold this hostage. They were going to hold this hostage until they got the \$73 billion. They did not hold their own pay increase hostage. They did not hold hostage increasing Members' pay \$3,800 a year in order to benefit businesses and corporations. But they are holding hostage those who are at the lowest level, the most vulnerable people, working hard, trying to make ends meet for their families. They are holding them hostage until they get additional tax breaks for companies and corporations at an unparalleled level.

The last time we had the increase we had a modest tax break for small business. Small business may need help and assistance, I am for that. But at that time, it was \$20 billion. Now that they have that up at \$73 billion, and they refuse to let us give consideration to an increase in the minimum wage, they are saying to all of those women, all of those children, all of those workers who are minimum wage workers: No,

you can just wait there. You can stay at \$5.15 an hour. You can continue to work at \$5.15 until we get around to developing our package in order for the \$73 billion in tax breaks. And then at that time, when we are ready to get that \$73 billion, the Senate of the United States better take all \$73 billion or we are not going to increase your minimum wage.

I think that is an outrageous position to take in terms of a contemptible attitude toward our fellow Americans.

I want to indicate, we welcome the support we have. This issue is not going to go away. We are going to have to face this issue. We want to have a fair opportunity. It is not one of those issues that needs a great deal of study. All of us remember the situation where people tap us on the shoulder and say: Will you support H.R. 222 or S. 444? and we are unfamiliar with the details of a particular program. This one is very simple. Increase in the minimum wage: Three steps, 60, 50, 40 cents. You don't need to have a lot of hearings.

To reiterate, Mr. President, the minimum wage is one of the Nation's fundamental workplace protections. It is a bedrock right of every working man and woman. For over 60 years, this country has been committed to the principle that employees are entitled to a fair minimum wage that guarantees a fair day's pay for a fair day's work and protects the dignity of their employment.

In recent years, the country as a whole and most Americans have benefitted from unprecedented prosperity—the longest period of economic growth in the Nation's history and the lowest unemployment rate in three decades. But minimum wage workers have been left out and left behind. A fair increase in the minimum wage is long overdue.

The real value of the minimum wage is now nearly \$3 below what it was in 1968. To have the purchasing power it had in that year, the minimum wage would have to be \$8.05 an hour today, not \$5.15 an hour.

At the same time, poverty has almost doubled among full-time, year-round workers. Since the late 1970s, it has climbed from about 1.5 million to almost 2.5 million in 1999. An unacceptably low minimum wage is part of the problem. Minimum wage employees working 40 hours a week, 52 weeks a year, earn only \$10,700 a year—\$3,400 below the poverty line for a family of three. Minimum wage workers today fail to earn enough to afford adequate housing in any area of this country. No one who works for a living should have to live in poverty.

In too many cases, minimum wage workers are forced to work longer and longer hours to make ends meet, with less and less time to spend with their families—still without sharing fairly in the Nation's prosperity. In fact, the lowest paid American families worked 416 more hours in 1999 than they did in 1979. Since 1969, the ratio of the minimum wage to average hourly earnings

has dropped from 53 percent to 37 percent.

It is shameful that Congress acted to raise its own pay by \$3,800 last year—the third pay increase in 4 years—yet we did not find time to provide any pay increase at all to the lowest paid workers.

The increase in the legislation we are introducing today—the Fair Minimum Wage Act of 2001—will directly benefit over 11 million workers. It will raise the minimum wage by \$1.50 in three installments: 60 cents on the 30th day after the bill's enactment; another 50 cents on January 1, 2002; and 40 more cents on January 1, 2003. The bill will also apply the federal minimum wage to the Mariana Islands, which now has an unacceptably low level of \$3.05 an hour.

The \$1.50 increase is necessary to make up for lost time. In real value, the \$1.50 increase will bring the minimum wage up to the same level it would have been if our proposed one dollar increase had gone into effect last year.

Raising the minimum wage is a labor issue, because it guarantees that American workers will be paid fairly for their contribution to building a strong Nation and a strong economy. It is a women's issue, since 60 percent of minimum wage earners are women. It is a children's issue, because 33 percent of minimum wage earners are parents with children—and 4.3 million children live in poverty, despite being in a family where a bread-winner works full-time, year-round. And it is a civil rights issue, because 16 percent of those who will benefit from a minimum wage increase are African Americans, and 20 percent are Hispanic.

The record of past increases clearly shows that raising the minimum wage has not had a negative impact on jobs, employment, or inflation. After the last increases in the minimum wage in 1996 and 1997, the economy continued to grow with impressive strength. The unemployment rate has fallen from 5.2 percent to 4.2 percent. Twelve million new jobs have been created, at a pace of 230,000 per month, with more than 6 million new service industry jobs, including one and a half million new retail jobs, and over a half a million new restaurant jobs. Similarly, the minimum wage increase during the recession in 1991 provided needed support for low-income workers and caused no loss of jobs.

President Bush supports raising the minimum wage, but suggests that states should be able to opt out of the increase. But allowing states to opt out of the minimum wage would violate the basic principle, which we have stood by for over 60 years, that working men and women are entitled to a fair minimum wage. Millions of workers across the country deserve a pay raise, and they deserve it now.

The Federal minimum wage guarantees a floor, but it also allows States to set wage rates higher than the Federal

minimum. Massachusetts recently raised its minimum wage to \$6.75 an hour, one of the highest levels in the country. Other states, such as California, Connecticut, Vermont and Rhode Island, have also set their State minimums higher than the Federal minimum.

In other States, however, the State minimum wage is far below the Federal level. In these States, the Federal level applies to the vast majority of workers. But for those not covered by the Federal law, the State level is often extremely low. It is \$1.60 in Wyoming, \$2.65 in Kansas, and \$3.35 in Texas. Clearly, Congress should not leave the minimum wage to the tender mercy of the States.

A fair increase in the federal minimum wage is long overdue. I urge Congress to act as quickly as possible to pass this long overdue increase.

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

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

S. 277

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Fair Minimum Wage Act of 2001".

SEC. 2. MINIMUM WAGE.

(a) IN GENERAL.—Section 6(a)(1) of the Fair Labor Standards Act of 1938 (29 U.S.C. 206(a)(1)) is amended to read as follows:

“(1) except as otherwise provided in this section, not less than—

“(A) \$5.75 an hour beginning 30 days after the date of enactment of the Fair Minimum Wage Act of 2001;

“(B) \$6.25 an hour during the year beginning January 1, 2002; and

“(C) \$6.65 an hour beginning January 1, 2003.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect 30 days after the date of enactment of this Act.

SEC. 3. APPLICABILITY OF MINIMUM WAGE TO THE COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS.

(a) IN GENERAL.—Section 6 of the Fair Labor Standards Act of 1938 (29 U.S.C. 206) shall apply to the Commonwealth of the Northern Mariana Islands.

(b) TRANSITION.—Notwithstanding subsection (a), the minimum wage applicable to the Commonwealth of the Northern Mariana Islands under section 6(a)(1) of the Fair Labor Standards Act of 1938 (29 U.S.C. 206(a)(1)) shall be—

(1) \$5.55 an hour beginning 30 days after the date of enactment of this Act; and

(2) increased by \$0.50 an hour (or such lesser amount as may be necessary to equal the minimum wage under section 6(a)(1) of such Act), beginning 6 months after the date of enactment of this Act and every 6 months thereafter until the minimum wage applicable to the Commonwealth of the Northern Mariana Islands under this subsection is equal to the minimum wage set forth in such section.

By Mr. JOHNSON (for himself, Mr. BINGAMAN, and Ms. SNOWE):

S. 278. A bill to restore health care coverage to retired members of the uniformed services; to the Committee on Armed Services.

Mr. JOHNSON. Mr. President, our country must honor its commitments to military retirees and veterans, not only because it's the right thing to do, but also because it's the smart thing to do. We all know the history: for decades, men and women who joined the military were promised lifetime health care coverage for themselves and their families. They were told, in effect, if you disrupt your family, if you work for low pay, if you endanger your life and limb, we will in turn guarantee lifetime health benefits.

In my own family, my oldest son is in the Army and has served tours of duty in Bosnia and Kosovo. I fully appreciate what inadequate health care and broken promises can do to the morale of military families.

Military retirees and veterans are our nation's most effective recruiters. Unfortunately, poor health care options make it difficult for these men and women to encourage the younger generation to make a career of the military. In fact, in South Dakota, I was talking to military personnel and talking to retirees who are loyal and patriotic, who have paid a price second to none for our nation's liberty, and they told me: "Tim, I can't in good faith tell my nephews, my children, young people whom I encounter, that they ought to serve in the U.S. military, that they ought to make a career of that service because I see what the Congress has done to its commitment to me, to my family, to my neighbors."

I am pleased that last year we made historic improvements in health care coverage for the approximately 12,600 military retirees living in South Dakota. In the 106th Congress, I introduced the Keep Our Promise to America's Military Retirees Act to restore the broken promise of lifetime health care for military retirees and dependents. My bipartisan legislation received the endorsement from most military retiree and veterans organizations and called for military retirees to have the option of staying in their TRICARE military health care program or electing to participate in the Federal Employees Health Benefit Program, FEHBP.

I offered my legislation as an amendment to last year's defense bill and received 52 votes. Although the amendment failed on a procedural motion, I was able to convince my colleagues to include one part of my bill—the expansion of TRICARE to Medicare-eligible military retirees—in both the Senate defense bill and the final version signed into law.

While I am pleased that last year's defense bill begins to address problems with military retiree health care, there is more work that needs to be done. That is why I am once again working with fellow Democrats and Republicans in the Senate to continue the progress we've made at living up to our country's commitment to those who serve in the military.

Today, I am reintroducing the Keep Our Promise to America's Military Re-

tirees Act to finish the job we started last year. I am pleased to be joined by Senator JEFF BINGAMAN and Senator OLYMPIA SNOWE. Similar legislation introduced in the House of Representatives by Representative RONNIE SHOWS and Representative CHARLIE NORWOOD already has overwhelming bipartisan support, and I expect a number of Democrats and Republicans here in the Senate to once again support my bill.

My legislation addresses the pressing health care needs of military retirees under age 65. Thanks to our efforts last year, retirees over 65 soon will be able to choose their own doctor and be covered by Medicare and TRICARE as a secondary payer. However, retirees under age 65 must continue coverage under a TRICARE program that offers care at military treatment facilities on a space available basis. Nationwide, base closures and downsizing have made access to these military bases difficult. For many military retirees in South Dakota and other rural states, it is next to impossible to find a doctor participating in TRICARE, and these men and women are forced to drive hundreds of miles just for basic health care.

In addition, retirees who entered the service prior to June 7, 1956, when space-available care for military retirees was enacted, actually have seen much of their promised benefits taken away. Under the Keep Our Promise to America's Military Retirees Act, the United States government would pay the full cost of FEHBP enrollment to this most elderly group of retirees.

Congress has the unique opportunity to use a portion of the budget surplus to improve the quality of life for our military retirees, veterans, and active duty personnel. I have always believed that our nation's defense is only as good as the men and women who serve in our armed forces. Broken promises of health care, retirement benefits, education incentives, and pay have eroded the morale of the most valuable assets to our national security. I am hopeful that members of both parties will join me once again making these issues a priority—instead of an afterthought—during this session of Congress.

By Mr. JOHNSON (for himself, Mr. GRAHAM, Mr. CAMPBELL, Mr. ENZI, Mr. BAUCUS, Mr. CLELAND, Mr. DASCHLE, and Mr. HOLLINGS):

S. 280. A bill to amend the Agriculture Marketing Act of 1946 to require retailers of beef, lamb, pork, and perishable agricultural commodities to inform consumers, at the final point of sale to consumers, of the country of origin of the commodities; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. GRAHAM. Mr. President, I rise today with my colleagues Senator JOHNSON, Senator CAMPBELL, Senator CRAIG, and Senator CLELAND to introduce the Consumer Right to Know Act of 2001.

This bill would require country of origin labeling of perishable agricultural commodities and meat products sold in retail establishments. I offer this legislation to ensure that Americans know the origin of every orange, banana, tomato, cucumber, and green pepper on display in the grocery store.

For two decades, Floridians shopping at their local grocery stores have been able to make educated choices about the food products they purchase for their families. In 1979, during my first year as governor, I proudly signed legislation to make country-of-origin labels mandatory for produce sold in Florida. This labeling requirement has proven to be neither complicated nor burdensome for Florida's farmers or retailers.

Country of origin labeling is not new to the American marketplace. For decades, "Made In" labels have been as visible as price tags on clothes, toys, television sets, watches, and many other products. It makes little sense that such labels are nowhere to be found in the produce or meat sections of grocery stores in the vast majority of states. The current lack of identifying information on produce means that Americans who wish to heed government health warnings about foreign products don't have the information they need to protect themselves. Nor can Americans show justifiable concerns about other nations' labor, environmental, and agricultural standards by choosing other perishables.

According to nationwide surveys, between 74 and 83 percent of consumers favor mandatory country of origin labeling for fresh produce. This is a low-cost, common sense method of informing consumers, as retailers will simply be asked to provide this information by means of a label, stamp, or placard. It is estimated that implementing produce labeling would take about two hours per grocery store per week. At the current minimum wage, this equates to about \$10.30 per store per week. This is a remarkable small price to pay to provide American consumers with the information they need to make informed produce purchases.

In addition, a study by the General Accounting Office found that all of the 28 countries that account for most of the U.S. produce imports and exports have requirements for fruit and vegetable labeling. By adopting this legislation, our law will become more consistent with the laws of our trading partners.

Consumers have the right to know basic information about the fruits and vegetables that they bring home to their families. Congress can take a major step toward achieving this simple goal by adopting this amendment, thereby restoring American shoppers' ability to make an informed decision.

Both Senator Johnson and I have worked on this legislation for several Congresses. I am very pleased to be introducing one legislative package this year which contains both fruit and vegetable and meat labeling requirements.

Both have passed the Senate in the 105th and 106th Congress.

I urge my colleagues who have supported this concept in the past to co-sponsor our legislation. I urge those of you who are new to this issue to review this legislation and ask yourselves if American consumers deserve this basic level of information about their food supply—the country of origin.

I ask for your support, and I look forward to working with my colleagues on the Senate Agriculture Committee to move this legislation expeditiously through the Committee process.

By Mr. HARKIN (for himself and Mr. LUGAR):

S. 282. A bill to establish in the Antitrust Division of the Department of Justice a position with responsibility for agriculture antitrust matters; to the Committee on the Judiciary.

Mr. HARKIN. Mr. President, I am pleased to introduce today, along with Senator LUGAR, legislation that would ensure that there is in the Antitrust Division of the Department of Justice a position with the primary responsibility of providing advice and assistance to further effective enforcement of the antitrust laws in the food and agricultural sectors of our economy.

As so many of my colleagues understand, we are in a period of very rapid change in the economic structure of agriculture and of our food system from the farm on through retail distribution. Those changes include sweeping consolidation and greatly increased economic concentration in many segments of our nation's food and agriculture system that have profoundly affected agricultural producers and rural communities and raised serious questions about impacts on consumers.

The purpose of this bill is to ensure that our nation's antitrust laws are fully enforced during this time of rapid change in our food and agriculture system. This is the same legislation as Senator LUGAR and I introduced late in 1999. Following that introduction, the Clinton Administration did appoint a person to fill the position required by this legislation. While that action obviated the necessity of enacting the legislation at that time, we do not know for certain what the present or future administrations may do in assigning personnel at the Department of Justice to antitrust enforcement in agriculture. This bill is an important safeguard to ensure that we have a person who is devoted full-time at Justice to the critical task of enforcing our antitrust laws in the food and agriculture sector.

I urge my colleagues to support this important legislation.

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

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

S. 282

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

SECTION 1. ESTABLISHMENT.

(a) IN GENERAL.—There shall be established within the Antitrust Division of the Department of Justice a position the primary responsibility of which shall be to provide assistance and advice to the Assistant Attorney General of the Antitrust Division to further the effective enforcement of the antitrust laws with respect to the food and agricultural sectors.

(b) APPOINTMENT.—Not later than 180 days after the date of enactment of this Act, the Attorney General shall appoint a person to the position described in subsection (a).

(c) FUNCTIONS.—The responsibilities of the position established under subsection (a) shall include all actions appropriate to furthering effective enforcement of the antitrust laws with respect to the food and agricultural sectors, including—

(1) assisting and advising with respect to the investigation of possible restraints of trade;

(2) assisting and advising with respect to the investigation of mergers and acquisitions; and

(3) ensuring that any investigation described in paragraphs (1) or (2) takes into account the effects of the conduct or transaction under investigation on consumers, agricultural producers and rural communities.

SEC. 2. ENFORCEMENT AUTHORITY.

Nothing in this Act shall affect or limit the authority of the Attorney General or the Assistant Attorney General of the Antitrust Division to delegate or assign functions relating to the enforcement of any provision of law.

SEC. 3. EFFECTIVE PERIOD.

This Act shall be effective until the date that is 5 years after the date of enactment of this Act.

Mr. LUGAR. Mr. President, I rise today to join my esteemed colleague and Ranking Democratic Member of the Agriculture Committee from Iowa, Senator HARKIN, in once again introducing legislation to help ensure that antitrust laws impacting agriculture are properly enforced.

Mr. President, the face of rural America is rapidly changing. Ever-changing technologies, developments in biotechnology and concentration in production agriculture and agribusiness are developing a new profile in rural areas. Farmers in my home state of Indiana have many questions and concerns related to these rapid changes. Many remain to be convinced that appropriate oversight of merger and acquisition activity in ag business is a reality.

The intent of this legislation is to establish the Office of Special Counsel for Agriculture in the Antitrust Division of the Justice Department. While this office will focus on reviewing ag business mergers and acquisition activity, it will also serve as an information resource for American agriculture producers wanting to provide input on antitrust-related issues.

It is important to note, Mr. President, that shortly after introduction of this legislation in 1999, Attorney General Reno, on her own initiative, established the Office of Special Counsel for

Agriculture and appointed Mr. Doug Ross to that position. While the perspective of Attorney General Ashcroft is not yet known on this matter, this legislation is a signal, a strong statement, that the Chairman and the Ranking Democratic Member of the Senate Agriculture Committee are in favor of greater transparency and consideration to those issues surrounding ag business mergers in the United States.

By Mr. McCAIN (for himself, Mr. EDWARDS, Mr. KENNEDY, Mr. L. CHAFEE, Mr. GRAHAM, Mr. SPEC-
TER, Mrs. LINCOLN, Mr. HARKIN, Mr. BAUCUS, Mr. TORRICELLI, Mr. DODD, Mr. NELSON of Florida, and Mr. SCHUMER):

S. 283. A bill to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage; to the Committee on Health, Education, Labor, and Pensions.

S. 284. A bill to amend the Internal Revenue Code of 1986 to provide incentives to expand health care coverage for individuals; to the Committee on Finance.

Mr. McCAIN. Mr. President, I ask unanimous consent that the text of S. 283 and S. 284 be printed in the RECORD.

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

S. 283

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Bipartisan Patient Protection Act of 2001".

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

Sec. 1. Short title; table of contents.

TITLE I—IMPROVING MANAGED CARE
Subtitle A—Utilization Review; Claims; and Internal and External Appeals

Sec. 101. Utilization review activities.

Sec. 102. Procedures for initial claims for benefits and prior authorization determinations.

Sec. 103. Internal appeals of claims denials.

Sec. 104. Independent external appeals procedures.

Subtitle B—Access to Care

Sec. 111. Consumer choice option.

Sec. 112. Choice of health care professional.

Sec. 113. Access to emergency care.

Sec. 114. Timely access to specialists.

Sec. 115. Patient access to obstetrical and gynecological care.

Sec. 116. Access to pediatric care.

Sec. 117. Continuity of care.

Sec. 118. Access to needed prescription drugs.

Sec. 119. Coverage for individuals participating in approved clinical trials.

Sec. 120. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.

Subtitle C—Access to Information

Sec. 121. Patient access to information.

Subtitle D—Protecting the Doctor-Patient Relationship
 Sec. 131. Prohibition of interference with certain medical communications.
 Sec. 132. Prohibition of discrimination against providers based on licensure.
 Sec. 133. Prohibition against improper incentive arrangements.
 Sec. 134. Payment of claims.
 Sec. 135. Protection for patient advocacy.

Subtitle E—Definitions

Sec. 151. Definitions.
 Sec. 152. Preemption; State flexibility; construction.
 Sec. 153. Exclusions.
 Sec. 154. Coverage of limited scope plans.
 Sec. 155. Regulations.
 Sec. 156. Incorporation into plan or coverage documents.

TITLE II—APPLICATION OF QUALITY CARE STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT

Sec. 201. Application to group health plans and group health insurance coverage.
 Sec. 202. Application to individual health insurance coverage.

TITLE III—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Sec. 301. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.

Sec. 302. Availability of civil remedies.
 Sec. 303. Limitations on actions.

TITLE IV—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Sec. 401. Application of requirements to group health plans under the Internal Revenue Code of 1986.
 Sec. 402. Conforming enforcement for women's health and cancer rights.

TITLE V—EFFECTIVE DATES: COORDINATION IN IMPLEMENTATION

Sec. 501. Effective dates.
 Sec. 502. Coordination in implementation.
 Sec. 503. Severability.

TITLE I—IMPROVING MANAGED CARE

Subtitle A—Utilization Review; Claims; and Internal and External Appeals

SEC. 101. UTILIZATION REVIEW ACTIVITIES.

(a) COMPLIANCE WITH REQUIREMENTS.—
 (1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section and section 102.

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

(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms “utilization review” and “utilization review activities” mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, 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) WRITTEN POLICIES AND CRITERIA.—

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

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate actively practicing health care professionals, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

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

(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for a periodic evaluation of the clinical appropriateness of at least a sample of denials of claims for benefits.

(c) CONDUCT OF PROGRAM ACTIVITIES.—

(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

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

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

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

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

SEC. 102. PROCEDURES FOR INITIAL CLAIMS FOR BENEFITS AND PRIOR AUTHORIZATION DETERMINATIONS.

(a) PROCEDURES OF INITIAL CLAIMS FOR BENEFITS.—

(1) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage, shall—

(A) make a determination on an initial claim for benefits by a participant, beneficiary, or enrollee (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, beneficiary, or enrollee is required to pay with respect to such claim for benefits; and

(B) notify a participant, beneficiary, or enrollee (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, beneficiary, or enrollee may be required to make with respect to such claim for benefits, and of the right of the participant, beneficiary, or enrollee to an internal appeal under section 103.

(2) ACCESS TO INFORMATION.—

(A) TIMELY PROVISION OF NECESSARY INFORMATION.—With respect to an initial claim for benefits, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information requested by the plan or issuer that is necessary to make a determination relating to the claim. Such access shall be provided not later than 5 days after the date on which the request for information is received, or, in a case described in subparagraph (B) or (C) of subsection (b)(1), by such earlier time as may be necessary to comply with the applicable timeline under such subparagraph.

(B) LIMITED EFFECT OF FAILURE ON PLAN OR ISSUER'S OBLIGATIONS.—Failure of the participant, beneficiary, or enrollee to comply with the requirements of subparagraph (A) shall not remove the obligation of the plan or issuer to make a decision in accordance with the medical exigencies of the case and as soon as possible, based on the available information, and failure to comply with the time limit established by this paragraph shall not remove the obligation of the plan or issuer to comply with the requirements of this section.

(3) ORAL REQUESTS.—In the case of a claim for benefits involving an expedited or concurrent determination, a participant, beneficiary, or enrollee (or authorized representative) may make an initial claim for benefits orally, but a group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for benefits, the making of such request (and the timing of such request) shall be treated as the making at that time of a claims for such benefits without regard to whether and when a written confirmation of such request is made.

(b) TIMELINE FOR MAKING DETERMINATIONS.—

(1) PRIOR AUTHORIZATION DETERMINATION.—

(A) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage, shall make a prior authorization determination on a claim for benefits (whether oral or written) in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14

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 and in no case later than 28 days after the date of the claim for benefits is received.

(B) EXPEDITED DETERMINATION.—Notwithstanding subparagraph (A), a group health plan, or health insurance issuer offering health insurance coverage, shall expedite a prior authorization determination on a claim for benefits described in such subparagraph when a request for such an expedited determination is made by a participant, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination and a health care professional certifies, with the request, that a determination under the procedures described in subparagraph (A) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain or regain maximum function. Such determination shall be made in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the request is received by the plan or issuer under this subparagraph.

(C) ONGOING CARE.—

(1) CONCURRENT REVIEW.—

(I) IN GENERAL.—Subject to clause (ii), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan or issuer must provide by telephone and in printed form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider in accordance with the medical exigencies of the case and as soon as possible, with sufficient time prior to the termination or reduction to allow for an appeal under section 103(b)(3) to be completed before the termination or reduction takes effect.

(II) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

(ii) RULE OF CONSTRUCTION.—Clause (i) shall not be construed as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(2) RETROSPECTIVE DETERMINATION.—A group health plan, or health insurance issuer offering health insurance coverage, shall make a retrospective determination on a claim for benefits in accordance with the medical exigencies of the case and as soon as possible, but not later than 30 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 claim, or, if earlier, 60 days after the date of receipt of the claim for benefits.

(c) 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, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of the determination (or, in the case described in subparagraph (B) or (C) of subsection (b)(1), within the 72-hour or applicable period referred to in such subparagraph).

(d) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—The written notice of a denial of a claim for benefits determination under subsection (c) shall be provided in printed form and written in a manner calculated to be understood by the average participant, beneficiary, or enrollee and shall include—

(1) the specific reasons for the determination (including a summary of the clinical or scientific evidence used in making the determination);

(2) the procedures for obtaining additional information concerning the determination; and

(3) notification of the right to appeal the determination and instructions on how to initiate an appeal in accordance with section 103.

(e) DEFINITIONS.—For purposes of this part:

(1) AUTHORIZED REPRESENTATIVE.—The term “authorized representative” means, with respect to an individual who is a participant, beneficiary, or enrollee, any health care professional or other person acting on behalf of the individual with the individual's consent or without such consent if the individual is medically unable to provide such consent.

(2) CLAIM FOR BENEFITS.—The term “claim for benefits” means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(3) DENIAL OF CLAIM FOR BENEFITS.—The term “denial” means, with respect to a claim for benefits, a denial (in whole or in part) of, or a failure to act on a timely basis upon, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this title.

(4) TREATING HEALTH CARE PROFESSIONAL.—The term “treating health care professional” means, with respect to services to be provided to a participant, beneficiary, or enrollee, a health care professional who is primarily responsible for delivering those services to the participant, beneficiary, or enrollee.

SEC. 103. INTERNAL APPEALS OF CLAIMS DENIALS.

(a) RIGHT TO INTERNAL APPEAL.—

(1) IN GENERAL.—A participant, beneficiary, or enrollee (or authorized representative) may appeal any denial of a claim for benefits under section 102 under the procedures described in this section.

(2) TIME FOR APPEAL.—

(A) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage, shall ensure that a participant, beneficiary, or enrollee (or authorized representative) has a period of not less than 180 days beginning on the date of a denial of a claim for benefits under section 102 in which to appeal such denial under this section.

(B) DATE OF DENIAL.—For purposes of subparagraph (A), the date of the denial shall be deemed to be the date as of which the participant, beneficiary, or enrollee knew of the denial of the claim for benefits.

(3) FAILURE TO ACT.—The failure of a plan or issuer to issue a determination on a claim for benefits under section 102 within the applicable timeline established for such a determination under such section is a denial of a claim for benefits for purposes this subtitle as of the date of the applicable deadline.

(4) PLAN WAIVER OF INTERNAL REVIEW.—A group health plan, or health insurance issuer offering health insurance coverage, may waive the internal review process under this section. In such case the plan or issuer shall provide notice to the participant, beneficiary, or enrollee (or authorized representative) involved, the participant, beneficiary,

or enrollee (or authorized representative) involved shall be relieved of any obligation to complete the internal review involved, and may, at the option of such participant, beneficiary, enrollee, or representative proceed directly to seek further appeal through external review under section 104 or otherwise.

(b) TIMELINES FOR MAKING DETERMINATIONS.—

(1) ORAL REQUESTS.—In the case of an appeal of a denial of a claim for benefits under this section that involves an expedited or concurrent determination, a participant, beneficiary, or enrollee (or authorized representative) may request such appeal orally. A group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for an appeal of a denial, the making of the request (and the timing of such request) shall be treated as the making at that time of a request for an appeal without regard to whether and when a written confirmation of such request is made.

(2) ACCESS TO INFORMATION.—

(A) TIMELY PROVISION OF NECESSARY INFORMATION.—With respect to an appeal of a denial of a claim for benefits, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information requested by the plan or issuer that is necessary to make a determination relating to the appeal. Such access shall be provided not later than 5 days after the date on which the request for information is received, or, in a case described in subparagraph (B) or (C) of paragraph (3), by such earlier time as may be necessary to comply with the applicable timeline under such subparagraph.

(B) LIMITED EFFECT OF FAILURE ON PLAN OR ISSUER'S OBLIGATIONS.—Failure of the participant, beneficiary, or enrollee to comply with the requirements of subparagraph (A) shall not remove the obligation of the plan or issuer to make a decision in accordance with the medical exigencies of the case and as soon as possible, based on the available information, and failure to comply with the time limit established by this paragraph shall not remove the obligation of the plan or issuer to comply with the requirements of this section.

(3) PRIOR AUTHORIZATION DETERMINATIONS.—

(A) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage, shall make a determination on an appeal of a denial of a claim for benefits under this subsection in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 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 appeal and in no case later than 28 days after the date the request for the appeal is received.

(B) EXPEDITED DETERMINATION.—Notwithstanding subparagraph (A), a group health plan, or health insurance issuer offering health insurance coverage, shall expedite a prior authorization determination on an appeal of a denial of a claim for benefits described in subparagraph (A), when a request for such an expedited determination is made by a participant, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination and a health care professional certifies, with the request, that a determination under the procedures described in subparagraph (A)

would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain or regain maximum function. Such determination shall be made in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the request for such appeal is received by the plan or issuer under this subparagraph.

(C) ONGOING CARE DETERMINATIONS.—

(1) IN GENERAL.—Subject to clause (ii), in the case of a concurrent review determination described in section 102(b)(1)(C)(i)(I), which results in a termination or reduction of such care, the plan or issuer must provide notice of the determination on the appeal under this section by telephone and in printed form to the individual or the individual's designee and the individual's health care provider in accordance with the medical exigencies of the case and as soon as possible, with sufficient time prior to the termination or reduction to allow for an external appeal under section 104 to be completed before the termination or reduction takes effect.

(ii) RULE OF CONSTRUCTION.—Clause (i) shall not be construed as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(4) RETROSPECTIVE DETERMINATION.—A group health plan, or health insurance issuer offering health insurance coverage, shall make a retrospective determination on an appeal of a claim for benefits in no case later than 30 days after the date on which the plan or issuer receives necessary information that is reasonably necessary to enable the plan or issuer to make a determination on the appeal and in no case later than 60 days after the date the request for the appeal is received.

(c) CONDUCT OF REVIEW.—

(1) IN GENERAL.—A review of a denial of a claim for benefits under this section shall be conducted by an individual with appropriate expertise who was not involved in the initial determination.

(2) 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 (allopathic or osteopathic) with appropriate expertise (including, in the case of a child, appropriate pediatric expertise) who was not involved in the initial determination.

(d) NOTICE OF DETERMINATION.—

(1) 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, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of completion of the review (or, in the case described in subparagraph (B) or (C) of subsection (b)(3), within the 72-hour or applicable period referred to in such subparagraph).

(2) FINAL DETERMINATION.—The decision by a plan or issuer under this section 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 section 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 104.

(3) REQUIREMENTS OF NOTICE.—With respect to a determination made under this section,

the notice described in paragraph (1) shall be provided in printed form and written in a manner calculated to be understood by the average participant, beneficiary, or enrollee and shall include—

(A) the specific reasons for the determination (including a summary of the clinical or scientific evidence used in making the determination);

(B) the procedures for obtaining additional information concerning the determination; and

(C) notification of the right to an independent external review under section 104 and instructions on how to initiate such a review.

SEC. 104. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

(a) RIGHT TO EXTERNAL APPEAL.—A group health plan, and a health insurance issuer offering health insurance coverage, shall provide in accordance with this section participants, beneficiaries, and enrollees (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 180 days after the date on which the participant, beneficiary, or enrollee receives notice of the denial under section 103(d) or notice of waiver of internal review under section 103(a)(4) or the date on which the plan or issuer has failed to make a timely decision under section 103(d)(2) and notifies the participant or beneficiary that it has failed to make a timely decision and that the beneficiary must file an appeal with an external review entity within 180 days if the participant or beneficiary desires to file such an appeal.

(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, 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, beneficiary, or enrollee involved (or an authorized representative);

(iii) except if waived by the plan or issuer under section 103(a)(4), 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 103;

(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 \$25; and

(v) require that a request for review include the consent of the participant, beneficiary, or enrollee (or authorized representative) for the release of necessary medical information or records of the participant, beneficiary, or enrollee to the qualified external review entity only for purposes of conducting external review activities.

(B) REQUIREMENTS AND EXCEPTION RELATING TO GENERAL RULE.—

(1) 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. A group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. Such written confirmation shall be treated as a consent for purposes of subparagraph (A)(v). In the

case of such an oral request for such a review, the making of the request (and the timing of such request) shall be treated as the making at that time of a request for such an external review without regard to whether and when a written confirmation of such request is made.

(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 appropriate Secretary) that the participant, beneficiary, or enrollee is indigent (as defined in such guidelines).

(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 103(a)(4).

(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 or modify the denial which is the subject of the review.

(IV) COLLECTION OF FILING FEE.—The failure to pay such a filing fee shall not prevent the consideration of a request for review but, subject to the preceding provisions of this clause, shall constitute a legal liability to pay.

(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 health insurance coverage, the plan or issuer shall immediately refer such request, and forward the plan or issuer's initial decision (including the information described in section 103(d)(3)(A)), 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, beneficiary, or enrollee (or authorized representative), the plan or issuer, and the treating health care professional (if any) shall provide the external review entity with information that is necessary to conduct a review under this section, as determined and requested by the entity. Such information shall be provided not later than 5 days after the date on which the request for information is received, or, in a case described in clause (ii) or (iii) of subsection (e)(1)(A), by such earlier time as may be necessary to comply with the applicable timeline under such clause.

(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 clauses (ii) or (iii) of subsection (b)(2)(A) have not been met;

(ii) the denial of the claim for benefits does not involve a medically reviewable decision under subsection (d)(2);

(iii) the denial of the claim for benefits relates to a decision regarding whether an individual is a participant, beneficiary, or enrollee who is enrolled under the terms and conditions of the plan or coverage (including the applicability of any waiting period under the plan or coverage); or

(iv) 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). Upon making a determination that any of clauses (i) through (iv) 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 (C).

(B) 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 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.

(C) 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, beneficiary, or enrollee (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 or enrollee;

(II) shall include the reasons for the determination;

(III) include any relevant terms and conditions of the plan or coverage; and

(IV) include a description of any further recourse available to the individual.

(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, beneficiary, or enrollee (or authorized representative) within such timeline and within 2 days of the date 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 of a claim for benefits is eligible for independent medical review if the benefit for the item or service for which the claim is made 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.—A determination that the item or service is not covered because it is not medically necessary and appropriate or based on the application of substantially equivalent terms.

(B) DENIALS BASED ON EXPERIMENTAL OR INVESTIGATIONAL TREATMENT.—A determination that the item or service is not covered because it is experimental or investigational

or based on the application of substantially equivalent terms.

(C) DENIALS OTHERWISE BASED ON AN EVALUATION OF MEDICAL FACTS.—A determination that the item or service or condition is not covered based on grounds that require an evaluation of the medical facts by a health care professional in the specific case involved to determine the coverage and extent of coverage of the item or service or condition.

(3) INDEPENDENT MEDICAL REVIEW DETERMINATION.—

(A) IN GENERAL.—An independent medical reviewer under this section shall make a new independent determination with respect to whether or not the denial of a claim for a benefit that is the subject of the review should be upheld, reversed, or modified.

(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, beneficiary, or enrollee (including the medical records of the participant, beneficiary, or enrollee) and valid, relevant scientific evidence and clinical evidence, including peer-reviewed medical literature or findings and including expert opinion.

(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, provide coverage for items or services for which benefits are specifically excluded or expressly limited under the plan or coverage in the plain language of the plan document (and which are disclosed under section 121(b)(1)(C)) except to the extent that the application or interpretation of the exclusion or limitation involves a determination described in paragraph (2).

(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, guidelines, or rationale 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 relevant evidence or information obtained by the reviewer or submitted by the plan, issuer, participant, beneficiary, or enrollee (or an authorized representative), or treating health care professional.

(iv) The plan or coverage document.

(E) INDEPENDENT DETERMINATION.—In making determinations under this subtitle, a qualified external review entity and an independent medical reviewer shall—

(i) consider the claim under review without deference to the determinations made by the plan or issuer or the recommendation of the treating health care professional (if any); and

(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 substantially equivalent terms that are used by the plan or issuer to describe medical necessity and appropriateness or experimental or investigational nature of the treatment.

(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, reverse, or modify the denial under review. Such written determination shall include—

(i) the determination of the reviewer;

(ii) the specific reasons of the reviewer for such determination, including a summary of the clinical or scientific evidence used in making the determination; and

(iii) with respect to a determination to reverse or modify the denial under review, a timeframe within which the plan or issuer must comply with such determination.

(G) NONBINDING NATURE OF ADDITIONAL RECOMMENDATIONS.—In addition to the determination under subparagraph (F), 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 affect (or be treated as part of) the determination and shall not be binding on the plan or issuer.

(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) in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days after the date of receipt of information under subsection (c)(2) if the review involves a prior authorization of items or services and in no case later than 21 days after the date the request for external review is received.

(ii) EXPEDITED DETERMINATION.—Notwithstanding clause (i) and subject to clause (iii), 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, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination, and a health care professional certifies, with the request, that a determination under the timeline described in clause (i) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain or regain maximum function. Such determination shall be made as soon in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the request for external review is received by the qualified external review entity.

(iii) ONGOING CARE DETERMINATION.—Notwithstanding clause (i), in the case of a review described in such subclause that involves a termination or reduction of care, the notice of the determination shall be completed not later than 24 hours after the time the request for external review is received by the qualified external review entity and before the end of the approved period of 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) in no case later than 30 days after the date of receipt of information under subsection (c)(2) and in no case later than 60 days after the date the request for external review is received by the qualified external review entity.

(2) NOTIFICATION OF DETERMINATION.—The external review entity shall ensure that the plan or issuer, the participant, beneficiary, or enrollee (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.

(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 or modify 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.—

(A) IN GENERAL.—If a plan or issuer fails to comply with the timeframe established under paragraph (1)(B) with respect to a participant, beneficiary, or enrollee, where such failure to comply is caused by the plan or issuer, the participant, beneficiary, or enrollee 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.

(B) REIMBURSEMENT.—

(i) IN GENERAL.—Where a participant, beneficiary, or enrollee obtains items or services in accordance with subparagraph (A), the plan or issuer involved shall provide for reimbursement of the costs of such items or services. Such reimbursement shall be made to the treating health care professional or to the participant, beneficiary, or enrollee (in the case of a participant, beneficiary, or enrollee who pays for the costs of such items or services).

(ii) AMOUNT.—The plan or issuer shall fully reimburse a professional, participant, beneficiary, or enrollee under clause (i) for the total costs of the items or services provided (regardless of any plan limitations that may apply to the coverage of such items or services) so long as the items or services were provided in a manner consistent with the determination of the independent medical reviewer.

(C) FAILURE TO REIMBURSE.—Where a plan or issuer fails to provide reimbursement to a professional, participant, beneficiary, or enrollee in accordance with this paragraph, the professional, participant, beneficiary, or enrollee may commence a civil action (or utilize other remedies available under law) to recover only the amount of any such reimbursement that is owed by the plan or issuer and any necessary legal costs or expenses (including attorney's fees) incurred in recovering such reimbursement.

(D) AVAILABLE REMEDIES.—The remedies provided under this paragraph are in addition to any other available remedies.

(3) PENALTIES AGAINST AUTHORIZED OFFICIALS FOR REFUSING TO AUTHORIZE THE DETERMINATION OF AN EXTERNAL REVIEW ENTITY.—

(A) MONETARY PENALTIES.—

(i) IN GENERAL.—In any case in which the determination of an external review entity is not followed by a group health plan, or by a

health insurance issuer offering health insurance coverage, any person who, acting in the capacity of authorizing the benefit, causes such refusal may, in the discretion in a court of competent jurisdiction, be liable to an aggrieved participant, beneficiary, or enrollee for a civil penalty in an amount of up to \$1,000 a day from the date on which the determination was transmitted to the plan or issuer by the external review entity until the date the refusal to provide the benefit is corrected.

(ii) ADDITIONAL PENALTY FOR FAILING TO FOLLOW TIMELINE.—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, beneficiary, or enrollee involved.

(B) CEASE AND DESIST ORDER AND ORDER OF ATTORNEY'S FEES.—In any action described in subparagraph (A) brought by a participant, beneficiary, or enrollee with respect to a group health plan, or a health insurance issuer offering health insurance coverage, in which a plaintiff alleges that a person referred to in such subparagraph has taken an action resulting in a refusal of a benefit determined by an external appeal entity to be covered, or has failed to take an action for which such person is responsible under the terms and conditions of the plan or coverage and which is necessary under the plan or coverage for authorizing a benefit, the court shall cause to be served on the defendant an order requiring the defendant—

(i) to cease and desist from the alleged action or failure to act; and

(ii) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

(C) ADDITIONAL CIVIL PENALTIES.—

(i) IN GENERAL.—In addition to any penalty imposed under subparagraph (A) or (B), the appropriate Secretary may assess a civil penalty against a person acting in the capacity of authorizing a benefit determined by an external review entity for one or more group health plans, or health insurance issuers offering health insurance coverage, for—

(I) any pattern or practice of repeated refusal to authorize a benefit determined by an external appeal entity to be covered; or

(II) any pattern or practice of repeated violations of the requirements of this section with respect to such plan or coverage.

(ii) STANDARD OF PROOF AND AMOUNT OF PENALTY.—Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice and shall be in an amount not to exceed the lesser of—

(I) 25 percent of the aggregate value of benefits shown by the appropriate Secretary to have not been provided, or unlawfully delayed, in violation of this section under such pattern or practice; or

(II) \$500,000.

(D) REMOVAL AND DISQUALIFICATION.—Any person acting in the capacity of authorizing benefits who has engaged in any such pattern or practice described in subparagraph (C)(i) with respect to a plan or coverage, upon the petition of the appropriate Secretary, may be removed by the court from such position, and from any other involvement, with respect to such a plan or coverage, and may be precluded from returning to any such position or involvement for a period determined by the court.

(4) PROTECTION OF LEGAL RIGHTS.—Nothing in this subsection or subtitle shall be construed as altering or eliminating any cause of action or legal rights or remedies of participants, beneficiaries, enrollees, and others under State or Federal law (including sec-

tions 502 and 503 of the Employee Retirement Income Security Act of 1974), including the right to file judicial actions to enforce rights.

(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 (allopathic or osteopathic) 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 condition, makes the diagnosis, or provides the type of 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 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;

(III) the fact of such an affiliation is disclosed to the plan or issuer and the participant, beneficiary, or enrollee (or authorized representative) and neither party objects; and

(IV) the affiliated individual is not an employee of the plan or issuer and does not provide services exclusively or primarily to or on behalf of the plan or issuer;

(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the plan or issuer and the participant, beneficiary, or enrollee (or authorized representative), and neither party objects; or

(iii) 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.—In a case involving treatment, or the provision of items or services—

(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

(ii) by a health care professional (other than a physician), a reviewer shall be a practicing physician (allopathic or osteopathic) or, if determined appropriate by the qualified external review entity, a practicing

health care professional (other than such a physician), of the same or similar specialty as the health care professional who typically treats the condition, makes the diagnosis, or provides the type of treatment 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 2 days per week.

(5) PEDIATRIC EXPERTISE.—In the case of an external review relating to a child, a reviewer shall have expertise under paragraph (2) in pediatrics.

(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, beneficiary, or enrollee, 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, beneficiary, or enrollee (or authorized representative).

(C) The health care professional that provides the items or 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 appropriate Secretary shall implement procedures—

(i) 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; and

(ii) for auditing a sample of decisions by such entities to assure that no such decisions are made in a biased manner.

No such selection process under the procedures implemented by the appropriate Secretary may give either the patient or the plan or issuer any ability to determine or influence the selection of a qualified external review entity to review the case of any participant, beneficiary, or enrollee.

(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 a State, the State may provide for external review activities to be conducted by a qualified external appeal entity that is designated by the State or that is selected by the State in a manner determined by the State to assure an unbiased determination.

(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 appropriate 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, beneficiary, or enrollee (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 appropriate 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 any 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 appropriate Secretary; or

(II) by a qualified private standard-setting organization that is approved by the appropriate Secretary under clause (iii).

In taking action under subclause (I), the appropriate Secretary shall give deference to entities that are under contract with the Federal Government or with an applicable State authority to perform functions of the type performed by qualified external review entities.

(ii) **PROCESS.**—The appropriate 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 of recertification, shall review the matters described in clause (iv).

(iii) **APPROVAL OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.**—For purposes of clause (i)(II), the appropriate Secretary may approve a qualified private standard-setting organization if such 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 appropriate 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 2 years.

(vi) **REVOCATION.**—A certification or recertification under this paragraph may be revoked by the appropriate Secretary or by the organization providing such certification upon a showing of cause.

(vii) **SUFFICIENT NUMBER OF ENTITIES.**—The appropriate Secretary shall certify and recertify a number of external review entities which is sufficient to ensure the timely and efficient provision of review services.

(D) **PROVISION OF INFORMATION.**—

(i) **IN GENERAL.**—A qualified external review entity shall provide to the appropriate Secretary, in such manner and at such times as such 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 such 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 appropriate 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 appropriate 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.

Subtitle B—Access to Care

SEC. 111. CONSUMER CHOICE OPTION.

(a) IN GENERAL.—If—

(1) a health insurance issuer providing health insurance coverage in connection with a group health plan offers to enrollees health insurance coverage which provides for coverage of services only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the issuer to provide such services, or

(2) a group health plan offers to participants or beneficiaries health benefits which provide for coverage of services only if such services are furnished through health care professionals and providers who are members of a network of health care professionals and

providers who have entered into a contract with the plan to provide such services,

then the issuer or plan shall also offer or arrange to be offered to such enrollees, participants, or beneficiaries (at the time of enrollment and during an annual open season as provided under subsection (c)) the option of health insurance coverage or health benefits which provide for coverage of such services which are not furnished through health care professionals and providers who are members of such a network unless such enrollees, participants, or beneficiaries are offered such non-network coverage through another group health plan or through another health insurance issuer in the group market.

(b) ADDITIONAL COSTS.—The amount of any additional premium charged by the health insurance issuer or group health plan for the additional cost of the creation and maintenance of the option described in subsection (a) and the amount of any additional cost sharing imposed under such option shall be borne by the enrollee, participant, or beneficiary unless it is paid by the health plan sponsor or group health plan through agreement with the health insurance issuer.

(c) OPEN SEASON.—An enrollee, participant, or beneficiary, may change to the offering provided under this section only during a time period determined by the health insurance issuer or group health plan. Such time period shall occur at least annually.

SEC. 112. CHOICE OF HEALTH CARE PROFESSIONAL.

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

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

(2) LIMITATION.—Paragraph (1) shall not apply to specialty care if the plan or issuer clearly informs participants, beneficiaries, and enrollees of the limitations on choice of participating health care professionals with respect to such care.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the application of section 114 (relating to access to specialty care).

SEC. 113. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization, or

(ii) by a participating health care provider without prior authorization,

the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION.—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term “emergency services” means, with respect to an emergency medical condition—

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

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

(C) STABILIZE.—The term “to stabilize”, with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—A group health plan, and health insurance coverage offered by a health insurance issuer, must provide reimbursement for maintenance care and post-stabilization care in accordance with the requirements of section 1852(d)(2) of the Social Security Act (42 U.S.C. 1395w-22(d)(2)). Such reimbursement shall be provided in a manner consistent with subsection (a)(1)(C).

(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage provided by a health insurance issuer, provides any benefits with respect to ambulance services and emergency services, the plan or issuer shall cover emergency ambulance services (as defined in paragraph (2)) furnished under the plan or coverage under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term “emergency ambulance services” means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan or coverage pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious

impairment of bodily function, or serious dysfunction of any bodily organ or part.

SEC. 114. TIMELY ACCESS TO SPECIALISTS.

(a) **TIMELY ACCESS.**—

(1) **IN GENERAL.**—A group health plan or health insurance issuer offering health insurance coverage shall ensure that participants, beneficiaries, and enrollees receive timely access to specialists who are appropriate to the condition of, and accessible to, the participant, beneficiary, or enrollee, when such specialty care is a covered benefit under the plan or coverage.

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

(A) to require the coverage under a group health plan or health insurance coverage of benefits or services;

(B) to prohibit a plan or issuer from including providers in the network only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees; or

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

(3) **ACCESS TO CERTAIN PROVIDERS.**—

(A) **IN GENERAL.**—With respect to specialty care under this section, if a participating specialist is not available and qualified to provide such care to the participant, beneficiary, or enrollee, the plan or issuer shall provide for coverage of such care by a non-participating specialist.

(B) **TREATMENT OF NONPARTICIPATING PROVIDERS.**—If a participant, beneficiary, or enrollee receives care from a nonparticipating specialist pursuant to subparagraph (A), such specialty care shall be provided at no additional cost to the participant, beneficiary, or enrollee beyond what the participant, beneficiary, or enrollee would otherwise pay for such specialty care if provided by a participating specialist.

(b) **REFERRALS.**—

(1) **AUTHORIZATION.**—A group health plan or health insurance issuer may require an authorization in order to obtain coverage for specialty services under this section. Any such authorization—

(A) shall be for an appropriate duration of time or number of referrals; and

(B) may not be refused solely because the authorization involves services of a non-participating specialist (described in subsection (a)(3)).

(2) **REFERRALS FOR ONGOING SPECIAL CONDITIONS.**—

(A) **IN GENERAL.**—A group health plan or health insurance issuer shall permit a participant, beneficiary, or enrollee 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 (if any) 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, potentially disabling, or congenital; and

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

(c) **TREATMENT PLANS.**—

(1) **IN GENERAL.**—A group health plan or health insurance issuer may require that the specialty care be provided—

(A) pursuant to a treatment plan, but only if the treatment plan—

(i) is developed by the specialist, in consultation with the case manager or primary care provider, and the participant, beneficiary, or enrollee, and

(ii) is approved by the plan or issuer in a timely manner, if the plan or issuer requires such approval; and

(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

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

(d) **SPECIALIST DEFINED.**—For purposes of this section, the term “specialist” means, with respect to the condition of the participant, beneficiary, or enrollee, a health care professional, facility, or center that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

SEC. 115. PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

(a) **GENERAL RIGHTS.**—

(1) **DIRECT ACCESS.**—A group health plan, or health insurance issuer offering health insurance coverage, described in subsection (b) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in subsection (b)(2)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.

(2) **OBSTETRICAL AND GYNECOLOGICAL CARE.**—A group health plan or health insurance issuer 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, or health insurance issuer offering health insurance coverage, described in this subsection is a group health plan or coverage that—

(1) provides coverage for obstetric or gynecologic care; and

(2) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(c) **CONSTRUCTION.**—Nothing in subsection (a) shall be construed to—

(1) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(2) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

SEC. 116. ACCESS TO PEDIATRIC CARE.

(a) **PEDIATRIC CARE.**—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

(b) **CONSTRUCTION.**—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(c) **TERMINATION OF PROVIDER.**—

(1) **IN GENERAL.**—If—

(A) a contract between a group health plan, or a health insurance issuer offering health insurance coverage, and a treating health care provider is terminated (as defined in paragraph (e)(4)), or

(B) benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in such plan or coverage,

the plan or issuer shall meet the requirements of paragraph (3) with respect to each continuing care patient.

(2) **TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.**—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

(3) **REQUIREMENTS.**—The requirements of this paragraph are that the plan or issuer—

(A) notify the continuing care patient involved, or arrange to have the patient notified pursuant to subsection (d)(2), on a timely basis of the termination described in paragraph (1) (or paragraph (2), if applicable) and the right to elect continued transitional care from the provider under this section;

(B) provide the patient with an opportunity to notify the plan or issuer of the patient's need for transitional care; and

(C) subject to subsection (c), permit the patient to elect to continue to be covered with respect to the course of treatment by such provider with the provider's consent during a transitional period (as provided for under subsection (b)).

(4) **CONTINUING CARE PATIENT.**—For purposes of this section, the term “continuing care patient” means a participant, beneficiary, or enrollee who—

(A) is undergoing a course of treatment for a serious and complex condition from the provider at the time the plan or issuer receives or provides notice of provider, benefit, or coverage termination described in paragraph (1) (or paragraph (2), if applicable);

(B) is undergoing a course of institutional or inpatient care from the provider at the time of such notice;

(C) is scheduled to undergo non-elective surgery from the provider at the time of such notice;

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider at the time of such notice; or

(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of such notice, but only with respect to a provider that was treating the terminal illness before the date of such notice.

(b) **TRANSITIONAL PERIODS.**—

(1) **SERIOUS AND COMPLEX CONDITIONS.**—The transitional period under this subsection with respect to a continuing care patient described in subsection (a)(4)(A) shall extend for up to 90 days (as determined by the treating health care professional) from the date of the notice described in subsection (a)(3)(A).

(2) **INSTITUTIONAL OR INPATIENT CARE.**—The transitional period under this subsection for

a continuing care patient described in subsection (a)(4)(B) shall extend until the earlier of—

(A) the expiration of the 90-day period beginning on the date on which the notice under subsection (a)(3)(A) is provided; or

(B) the date of discharge of the patient from such care or the termination of the period of institutionalization, or, if later, the date of completion of reasonable follow-up care.

(3) SCHEDULED NON-ELECTIVE SURGERY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(C) shall extend until the completion of the surgery involved and post-surgical follow-up care relating to the surgery and occurring within 90 days after the date of the surgery.

(4) PREGNANCY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(D) shall extend through the provision of post-partum care directly related to the delivery.

(5) TERMINAL ILLNESS.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(E) shall extend for the remainder of the patient's life for care that is directly related to the treatment of the terminal illness or its medical manifestations.

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer 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 or issuer and continuing care patient involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or coverage after the date of the termination of the contract with the group health plan or health insurance issuer) and not to impose cost-sharing with respect to the patient in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

(2) The treating health care provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

(3) The treating health care provider agrees otherwise to adhere to such plan's or issuer'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 or issuer.

(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 or health insurance issuer from requiring that the health care provider—

(A) notify participants, beneficiaries, or enrollees of their rights under this section; or

(B) provide the plan or issuer with the name of each participant, beneficiary, or enrollee who the provider believes is a continuing care patient.

(e) DEFINITIONS.—In this section:

(1) CONTRACT.—The term "contract" includes, with respect to a plan or issuer and a treating health care provider, a contract be-

tween such plan or issuer and an organized network of providers that includes the treating health care provider, and (in the case of such a contract) the contract between the treating health care provider and the organized network.

(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, beneficiary, or enrollee under the plan or coverage—

(A) in the case of an acute illness, a condition that is 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 ongoing special condition (as defined in section 114(b)(2)(B)).

(4) TERMINATED.—The term "terminated" includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

SEC. 118. ACCESS TO NEEDED PRESCRIPTION DRUGS.

(a) IN GENERAL.—To the extent that a group health plan, or health insurance coverage offered by a health insurance issuer, provides coverage for benefits with respect to prescription drugs, and limits such coverage to drugs included in a formulary, the plan or issuer shall—

(1) ensure the participation of physicians and pharmacists in developing and reviewing such formulary;

(2) provide for disclosure of the formulary to providers; and

(3) in accordance with the applicable quality assurance and utilization review standards of the plan or issuer, provide for exceptions from the formulary limitation when a non-formulary alternative is medically necessary and appropriate and, in the case of such an exception, apply the same cost-sharing requirements that would have applied in the case of a drug covered under the formulary.

(b) COVERAGE OF APPROVED DRUGS AND MEDICAL DEVICES.—

(1) IN GENERAL.—A group health plan (or health insurance coverage offered in connection with such a plan) that provides any coverage of prescription drugs or medical devices shall not deny coverage of such a drug or device on the basis that the use is investigational, if the use—

(A) in the case of a prescription drug—

(i) is included in the labeling authorized by the application in effect for the drug pursuant to subsection (b) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act, without regard to any postmarketing requirements that may apply under such Act; or

(ii) is included in the labeling authorized by the application in effect for the drug under section 351 of the Public Health Service Act, without regard to any postmarketing requirements that may apply pursuant to such section; or

(B) in the case of a medical device, is included in the labeling authorized by a regulation under subsection (d) or (3) of section 513 of the Federal Food, Drug, and Cosmetic Act, an order under subsection (f) of such section, or an application approved under section 515 of such Act, without regard to any postmarketing requirements that may apply under such Act.

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any coverage of prescription drugs or medical devices.

SEC. 119. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

(a) COVERAGE.—

(1) IN GENERAL.—If a group health plan, or health insurance issuer that is providing health insurance coverage, provides coverage to a qualified individual (as defined in subsection (b)), the plan or issuer—

(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

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

(C) may not discriminate against the individual on the basis of the enrollee's 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 or issuer 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, or who is an enrollee under health insurance coverage, and who meets the following conditions:

(1)(A) The individual has a life-threatening or serious illness 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, beneficiary, or enrollee 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 or health insurance issuer shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected (as determined by the appropriate Secretary) to be paid for by the sponsors of an approved clinical trial.

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

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

(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer 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 clinical research study or clinical investigation approved and 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 appropriate 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 or issuer's coverage with respect to clinical trials.

SEC. 120. 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, 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, may not modify the terms and conditions of coverage based on the determination by a participant, beneficiary, or enrollee to request less than the minimum coverage required under subsection (a).

(c) SECONDARY CONSULTATIONS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage, 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 diag-

nosis. 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 or coverage 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 or issuer.

(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.

(d) PROHIBITION ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage, 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, beneficiary, or enrollee 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, beneficiary, or enrollee for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (c).

Subtitle C—Access to Information

SEC. 121. PATIENT ACCESS TO INFORMATION.

(a) REQUIREMENT—

(1) DISCLOSURE.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer that provides coverage in connection with health insurance coverage, shall provide for the disclosure to participants, beneficiaries, and enrollees—

(i) of the information described in subsection (b) at the time of the initial enrollment of the participant, beneficiary, or enrollee under the plan or coverage;

(ii) of such information on an annual basis—

(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) of information relating to any material reduction to the benefits or information described in such subsection or subsection (c), in the form of a notice provided not later than 30 days before the date on which the reduction takes effect.

(B) PARTICIPANTS, BENEFICIARIES, AND ENROLLEES.—The disclosure required under subparagraph (A) shall be provided—

(i) jointly to each participant, beneficiary, and enrollee who reside at the same address; or

(ii) in the case of a beneficiary or enrollee who does not reside at the same address as the participant or another enrollee, separately to the participant or other enrollees and such beneficiary or enrollee.

(2) PROVISION OF INFORMATION.—Information shall be provided to participants, beneficiaries, and enrollees under this section at the last known address maintained by the plan or issuer with respect to such participants, beneficiaries, or enrollees, to the extent that such information is provided to participants, beneficiaries, or enrollees 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 preventive services covered under the plan or coverage if such services are covered;

(C) any specific exclusions or express limitations of benefits described in section 104(b)(3)(C);

(D) any other 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

(E) 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, for which the participant, beneficiary, or enrollee will be responsible under each option available under the plan;

(B) any maximum out-of-pocket expense for which the participant, beneficiary, or enrollee 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, beneficiaries, and enrollees 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 116 for a participant, beneficiary, or enrollee 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, beneficiaries, and enrollees in accessing specialty care and obtaining referrals to participating and nonparticipating specialists, including any limitations on choice of health care professionals referred to in section 112(b)(2) and the right to timely access to specialists care under section 114 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 clinical trials under section 119 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, beneficiaries, and enrollees in obtaining access to access to prescription drugs under section 118 if such section applies.

(11) EMERGENCY SERVICES.—A summary of the rules and procedures for accessing emergency services, including the right of a participant, beneficiary, or enrollee to obtain emergency services under the prudent layperson standard under section 113, 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 (including deadlines for exercising rights) of participants, beneficiaries, and enrollees under subtitle A 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 of the Employee Retirement Income Security Act of 1974 and applicable State law.

(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, beneficiaries, and enrollees seeking information about plan or coverage benefits and services, payment of a claim, or authorization for services and treatment. Notice of whether the benefits under the plan or coverage 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, beneficiaries, and enrollees 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, beneficiaries, and enrollees.

(17) NOTICE OF REQUIREMENTS.—A description of any rights of participants, beneficiaries, and enrollees that are established by the Bipartisan Patient Protection Act of 2001 (excluding those described in paragraphs (1) through (16)) if such sections apply. The description required under this paragraph may be combined with the notices of the type described in sections 711(d), 713(b), or 606(a)(1) of the Employee Retirement Income Security Act of 1974 and with any other notice provision that the appropriate Secretary determines may be combined, so long as such combination does not result in any reduction in the information that would otherwise be provided to the recipient.

(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, beneficiary, or enrollee 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 by category of the applicable methods (such as capitation, fee-for-service, salary, bundled payments, per diem, or a combination thereof) used for compensating prospective or treating health care professionals (including primary care providers and specialists) and facilities in connection with the provision of health care under the plan or coverage.

(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) under the plan or under the coverage of the issuer.

(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 an average participant or enrollee.

(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 health insurance coverage, from—

(1) distributing any other additional information determined by the plan or issuer to be important or necessary in assisting participants, beneficiaries, and enrollees in the selection of a health plan or health insurance coverage; 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—

(A) the disclosure of such information in such form is in accordance with requirements as the appropriate Secretary may impose, and

(B) in connection with any such disclosure of information through the Internet or other electronic media—

(i) the recipient has affirmatively consented to the disclosure of such information in such form,

(ii) the recipient is capable of accessing the information so disclosed on the recipient's individual workstation or at the recipient's home,

(iii) the recipient retains an ongoing right to receive paper disclosure of such information and receives, in advance of any attempt at disclosure of such information to him or her through the Internet or other electronic media, notice in printed form of such ongoing right and of the proper software required to view information so disclosed, and

(iv) the plan administrator appropriately ensures that the intended recipient is receiving the information so disclosed and provides the information in printed form if the information is not received.

Subtitle D—Protecting the Doctor-Patient Relationship

SEC. 131. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

SEC. 132. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

(a) IN GENERAL.—A group health plan, and a health insurance issuer with respect to health insurance coverage, 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 or health insurance coverage of a particular benefit or service or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer;

(2) to override any State licensure or scope-of-practice law; or

(3) as requiring a plan or issuer that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan or issuer.

SEC. 133. PROHIBITION AGAINST IMPROPER INCENTIVE ARRANGEMENTS.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in clauses (i), (ii)(I), and (iii) of subparagraph (A) of such section are met with respect to such a plan.

(b) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant, beneficiary, or enrollee with the plan or organization, respectively.

(c) CONSTRUCTION.—Nothing in this section shall be construed as prohibiting all capitation and similar arrangements or all provider discount arrangements.

SEC. 134. PAYMENT OF CLAIMS.

A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for prompt payment of claims submitted for health care services or supplies furnished to a participant, beneficiary, or enrollee with respect to benefits covered by the plan or issuer, in a manner consistent with the provisions of section 1842(c)(2) of the Social Security Act (42 U.S.C. 1395u(c)(2)).

SEC. 135. PROTECTION FOR PATIENT ADVOCACY.

(a) PROTECTION FOR USE OF UTILIZATION REVIEW AND GRIEVANCE PROCESS.—A group health plan, and a health insurance issuer with respect to the provision of health insurance coverage, may not retaliate against a participant, beneficiary, enrollee, or health care provider based on the participant's, beneficiary's, enrollee's or provider's use of, or participation in, a utilization review process or a grievance process of the plan or issuer (including an internal or external review or appeal process) under this title.

(b) PROTECTION FOR QUALITY ADVOCACY BY HEALTH CARE PROFESSIONALS.—

(1) IN GENERAL.—A group health plan or health insurance issuer may not retaliate or discriminate against a protected health care professional because the professional in good faith—

(A) discloses information relating to the care, services, or conditions affecting one or more participants, beneficiaries, or enrollees of the plan or issuer to an appropriate public regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the plan or issuer; or

(B) initiates, cooperates, or otherwise participates in an investigation or proceeding by such an agency with respect to such care, services, or conditions.

If an institutional health care provider is a participating provider with such a plan or issuer or otherwise receives payments for benefits provided by such a plan or issuer, the provisions of the previous sentence shall apply to the provider in relation to care, services, or conditions affecting one or more patients within an institutional health care provider in the same manner as they apply to the plan or issuer in relation to care, services, or conditions provided to one or more participants, beneficiaries, or enrollees; and for purposes of applying this sentence, any reference to a plan or issuer is deemed a reference to the institutional health care provider.

(2) GOOD FAITH ACTION.—For purposes of paragraph (1), a protected health care professional is considered to be acting in good faith with respect to disclosure of information or participation if, with respect to the information disclosed as part of the action—

(A) the disclosure is made on the basis of personal knowledge and is consistent with that degree of learning and skill ordinarily possessed by health care professionals with the same licensure or certification and the same experience;

(B) the professional reasonably believes the information to be true;

(C) the information evidences either a violation of a law, rule, or regulation, of an ap-

plicable accreditation standard, or of a generally recognized professional or clinical standard or that a patient is in imminent hazard of loss of life or serious injury; and

(D) subject to subparagraphs (B) and (C) of paragraph (3), the professional has followed reasonable internal procedures of the plan, issuer, or institutional health care provider established for the purpose of addressing quality concerns before making the disclosure.

(3) EXCEPTION AND SPECIAL RULE.—

(A) GENERAL EXCEPTION.—Paragraph (1) does not protect disclosures that would violate Federal or State law or diminish or impair the rights of any person to the continued protection of confidentiality of communications provided by such law.

(B) NOTICE OF INTERNAL PROCEDURES.—Subparagraph (D) of paragraph (2) shall not apply unless the internal procedures involved are reasonably expected to be known to the health care professional involved. For purposes of this subparagraph, a health care professional is reasonably expected to know of internal procedures if those procedures have been made available to the professional through distribution or posting.

(C) INTERNAL PROCEDURE EXCEPTION.—Subparagraph (D) of paragraph (2) also shall not apply if—

(i) the disclosure relates to an imminent hazard of loss of life or serious injury to a patient;

(ii) the disclosure is made to an appropriate private accreditation body pursuant to disclosure procedures established by the body; or

(iii) the disclosure is in response to an inquiry made in an investigation or proceeding of an appropriate public regulatory agency and the information disclosed is limited to the scope of the investigation or proceeding.

(4) ADDITIONAL CONSIDERATIONS.—It shall not be a violation of paragraph (1) to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved demonstrates that it would have taken the same adverse action even in the absence of the activities protected under such paragraph.

(5) NOTICE.—A group health plan, health insurance issuer, and institutional health care provider shall post a notice, to be provided or approved by the Secretary of Labor, setting forth excerpts from, or summaries of, the pertinent provisions of this subsection and information pertaining to enforcement of such provisions.

(6) CONSTRUCTIONS.—

(A) DETERMINATIONS OF COVERAGE.—Nothing in this subsection shall be construed to prohibit a plan or issuer from making a determination not to pay for a particular medical treatment or service or the services of a type of health care professional.

(B) ENFORCEMENT OF PEER REVIEW PROTOCOLS AND INTERNAL PROCEDURES.—Nothing in this subsection shall be construed to prohibit a plan, issuer, or provider from establishing and enforcing reasonable peer review or utilization review protocols or determining whether a protected health care professional has complied with those protocols or from establishing and enforcing internal procedures for the purpose of addressing quality concerns.

(C) RELATION TO OTHER RIGHTS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees, and protected health care professionals under other applicable Federal or State laws.

(7) PROTECTED HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term “protected health care professional” means an individual who is a li-

censed or certified health care professional and who—

(A) with respect to a group health plan or health insurance issuer, is an employee of the plan or issuer or has a contract with the plan or issuer for provision of services for which benefits are available under the plan or issuer; or

(B) with respect to an institutional health care provider, is an employee of the provider or has a contract or other arrangement with the provider respecting the provision of health care services.

Subtitle E—Definitions

SEC. 151. DEFINITIONS.

(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 2791 of the Public Health Service Act shall apply for purposes of this title in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, the term “Secretary” means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the term “appropriate Secretary” means the Secretary of Health and Human Services in relation to carrying out this title under sections 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this title under section 713 of the Employee Retirement Income Security Act of 1974.

(c) ADDITIONAL DEFINITIONS.—For purposes of this title:

(1) APPLICABLE AUTHORITY.—The term “applicable authority” means—

(A) in the case of a group health plan, the Secretary of Health and Human Services and the Secretary of Labor; and

(B) in the case of a health insurance issuer with respect to a specific provision of this title, the applicable State authority (as defined in section 2791(d) of the Public Health Service Act), or the Secretary of Health and Human Services, if such Secretary is enforcing such provision under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act.

(3) ENROLLEE.—The term “enrollee” means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(4) GROUP HEALTH PLAN.—The term “group health plan” has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974, except that such term includes a employee welfare benefit plan treated as a group health plan under section 732(d) of such Act or defined as such a plan under section 607(1) of such Act.

(5) HEALTH CARE PROFESSIONAL.—The term “health care professional” means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(6) HEALTH CARE PROVIDER.—The term “health care provider” includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(7) NETWORK.—The term “network” means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

(8) NONPARTICIPATING.—The term “non-participating” means, with respect to a

health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(9) **PARTICIPATING.**—The term “participating” means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(10) **PRIOR AUTHORIZATION.**—The term “prior authorization” means the process of obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

(11) **TERMS AND CONDITIONS.**—The term “terms and conditions” includes, with respect to a group health plan or health insurance coverage, requirements imposed under this title with respect to the plan or coverage.

SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) **CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.**—

(1) **IN GENERAL.**—Subject to paragraph (2), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers (in connection with group health insurance coverage or otherwise) except to the extent that such standard or requirement prevents the application of a requirement of this title.

(2) **CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.**—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(3) **CONSTRUCTION.**—In applying this section, a State law that provides for equal access to, and availability of, all categories of licensed health care providers and services shall not be treated as preventing the application of any requirement of this title.

(b) **APPLICATION OF SUBSTANTIALLY EQUIVALENT STATE LAWS.**—

(1) **IN GENERAL.**—In the case of a State law that imposes, with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan, a requirement that is substantially equivalent (within the meaning of subsection (c)) to a patient protection requirement (as defined in paragraph (3)) and does not prevent the application of other requirements under this Act (except in the case of other substantially equivalent requirements), in applying the requirements of this title under section 2707 and 2753 (as applicable) of the Public Health Service Act (as added by title II), subject to subsection (a)(2)—

(A) the State law shall not be treated as being superseded under subsection (a); and

(B) the State law shall apply instead of the patient protection requirement otherwise applicable with respect to health insurance coverage and non-Federal governmental plans.

(2) **LIMITATION.**—In the case of a group health plan covered under title I of the Employee Retirement Income Security Act of 1974, paragraph (1) shall be construed to apply only with respect to the health insurance coverage (if any) offered in connection with the plan.

(3) **PATIENT PROTECTION REQUIREMENT DEFINED.**—For purposes of this section, the term “patient protection requirement” means a requirement under this title, and includes (as a single requirement) a group or related set of requirements under a section or similar unit under this title.

(c) DETERMINATIONS OF SUBSTANTIAL EQUIVALENCE.

(1) **CERTIFICATION BY STATES.**—A State may submit to the Secretary a certification that a State law provides for patient protections that are at least substantially equivalent to one or more patient protection requirements. Such certification shall be accompanied by such information as may be required to permit the Secretary to make the determination described in paragraph (2)(A).

(2) REVIEW.

(A) **IN GENERAL.**—The Secretary shall promptly review a certification submitted under paragraph (1) with respect to a State law to determine if the State law provides for at least substantially equivalent and effective patient protections to the patient protection requirement (or requirements) to which the law relates.

(B) APPROVAL DEADLINES.

(i) **INITIAL REVIEW.**—Such a certification is considered approved unless the Secretary notifies the State in writing, within 90 days after the date of receipt of the certification, that the certification is disapproved (and the reasons for disapproval) or that specified additional information is needed to make the determination described in subparagraph (A).

(ii) **ADDITIONAL INFORMATION.**—With respect to a State that has been notified by the Secretary under clause (i) that specified additional information is needed to make the determination described in subparagraph (A), the Secretary shall make the determination within 60 days after the date on which such specified additional information is received by the Secretary.

(3) APPROVAL.

(A) **IN GENERAL.**—The Secretary shall approve a certification under paragraph (1) unless—

(i) the State fails to provide sufficient information to enable the Secretary to make a determination under paragraph (2)(A); or

(ii) the Secretary determines that the State law involved does not provide for patient protections that are at least substantially equivalent to and as effective as the patient protection requirement (or requirements) to which the law relates.

(B) **STATE CHALLENGE.**—A State that has a certification disapproved by the Secretary under subparagraph (A) may challenge such disapproval in the appropriate United States district court.

(4) **CONSTRUCTION.**—Nothing in this subsection shall be construed as preventing the certification (and approval of certification) of a State law under this subsection solely because it provides for greater protections for patients than those protections otherwise required to establish substantial equivalence.

(d) **DEFINITIONS.**—For purposes of this section:

(1) **STATE LAW.**—The term “State law” includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) **STATE.**—The term “State” includes a State, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any political subdivisions of such, or any agency or instrumentality of such.

SEC. 153. EXCLUSIONS.

(a) **NO BENEFIT REQUIREMENTS.**—Nothing in this title shall be construed to require a group health plan or a health insurance issuer offering health insurance coverage to include specific items and services under the terms of such a plan or coverage, other than those provided under the terms and conditions of such plan or coverage.

(b) **EXCLUSION FROM ACCESS TO CARE MANAGED CARE PROVISIONS FOR FEE-FOR-SERVICE COVERAGE.**—

(1) **IN GENERAL.**—The provisions of sections 111 through 117 shall not apply to a group health plan or health insurance coverage if the only coverage offered under the plan or coverage is fee-for-service coverage (as defined in paragraph (2)).

(2) FEE-FOR-SERVICE COVERAGE DEFINED.

For purposes of this subsection, the term “fee-for-service coverage” means coverage under a group health plan or health insurance coverage that—

(A) reimburses hospitals, health professionals, and other providers on a fee-for-service basis without placing the provider at financial risk;

(B) does not vary reimbursement for such a provider based on an agreement to contract terms and conditions or the utilization of health care items or services relating to such provider;

(C) allows access to any provider that is lawfully authorized to provide the covered services and that agrees to accept the terms and conditions of payment established under the plan or by the issuer; and

(D) for which the plan or issuer does not require prior authorization before providing for any health care services.

SEC. 154. COVERAGE OF LIMITED SCOPE PLANS.

Only for purposes of applying the requirements of this title under sections 2707 and 2753 of the Public Health Service Act and section 714 of the Employee Retirement Income Security Act of 1974, section 2791(c)(2)(A), and section 733(c)(2)(A) of the Employee Retirement Income Security Act of 1974 shall be deemed not to apply.

SEC. 155. REGULATIONS.

The Secretaries of Health and Human Services and Labor shall issue such regulations as may be necessary or appropriate to carry out this title. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this title.

SEC. 156. INCORPORATION INTO PLAN OR COVERAGE DOCUMENTS.

The requirements of this title with respect to a group health plan or health insurance coverage are deemed to be incorporated into, and made a part of, such plan or the policy, certificate, or contract providing such coverage and are enforceable under law as if directly included in the documentation of such plan or such policy, certificate, or contract.

TITLE II—APPLICATION OF QUALITY CARE STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT

SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) **IN GENERAL.**—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

SEC. 2707. PATIENT PROTECTION STANDARDS.

“Each group health plan shall comply with patient protection requirements under title I of the Bipartisan Patient Protection Act of

2001, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.”.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg-21(b)(2)(A)) is amended by inserting “(other than section 2707)” after “requirements of such subparts”.

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2752 the following new section:

“SEC. 2753. PATIENT PROTECTION STANDARDS.

“Each health insurance issuer shall comply with patient protection requirements under title I of the Bipartisan Patient Protection Act of 2001 with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.”.

TITLE III—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 301. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE 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 is amended by adding at the end the following new section:

“SEC. 714. PATIENT PROTECTION STANDARDS.

“(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Bipartisan Patient Protection Act of 2001 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

“(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.

“(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of title I of the Bipartisan Patient Protection Act of 2001 with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

“(A) Section 111 (relating to consumer choice option).

“(B) Section 112 (relating to choice of health care professional).

“(C) Section 113 (relating to access to emergency care).

“(D) Section 114 (relating to timely access to specialists).

“(E) Section 115 (relating to patient access to obstetrical and gynecological care).

“(F) Section 116 (relating to access to pediatric care).

“(G) Section 117 (relating to continuity of care), but only insofar as a replacement issuer assumes the obligation for continuity of care.

“(H) Section 118 (relating to access to needed prescription drugs).

“(I) Section 119 (relating to coverage for individuals participating in approved clinical trials).

“(J) Section 120 (relating to required coverage for minimum hospital stay for

mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations).

“(K) Section 134 (relating to payment of claims).

“(2) INFORMATION.—With respect to information required to be provided or made available under section 121 of the Bipartisan Patient Protection Act of 2001, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer’s failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

“(3) INTERNAL APPEALS.—With respect to the internal appeals process required to be established under section 103 of such Act, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such process and system (and is not liable for the issuer’s failure to provide for such process and system), if the issuer is obligated to provide for (and provides for) such process and system.

“(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 104 of such Act, the plan shall be treated as meeting the requirement of such section and is not liable for the entity’s failure to meet any requirements under such section.

“(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any of the following sections of the Bipartisan Patient Protection Act of 2001, the group health plan shall not be liable for such violation unless the plan caused such violation:

“(A) Section 131 (relating to prohibition of interference with certain medical communications).

“(B) Section 132 (relating to prohibition of discrimination against providers based on licensure).

“(C) Section 133 (relating to prohibition against improper incentive arrangements).

“(D) Section 135 (relating to protection for patient advocacy).

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

“(7) TREATMENT OF SUBSTANTIALLY EQUIVALENT STATE LAWS.—For purposes of applying this subsection, any reference in this subsection to a requirement in a section or other provision in the Bipartisan Patient Protection Act of 2001 with respect to a health insurance issuer is deemed to include a reference to a requirement under a State law that is substantially equivalent (as determined under section 152(c) of such Act) to the requirement in such section or other provisions.

“(8) APPLICATION TO CERTAIN PROHIBITIONS AGAINST RETALIATION.—With respect to compliance with the requirements of section 135(b)(1) of the Bipartisan Patient Protection Act of 2001, for purposes of this subtitle the term ‘group health plan’ is deemed to include a reference to an institutional health care provider.

“(C) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

“(1) COMPLAINTS.—Any protected health care professional who believes that the professional has been retaliated or discriminated against in violation of section 135(b)(1) of the Bipartisan Patient Protection Act of 2001 may file with the Secretary a complaint within 180 days of the date of the alleged retaliation or discrimination.

“(2) INVESTIGATION.—The Secretary shall investigate such complaints and shall determine if a violation of such section has occurred and, if so, shall issue an order to ensure that the protected health care professional does not suffer any loss of position, pay, or benefits in relation to the plan, issuer, or provider involved, as a result of the violation found by the Secretary.

“(d) 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 the other provisions of this title. In order to reduce duplication and clarify the rights of participants and beneficiaries with respect to information that is required to be provided, such regulations shall coordinate the information disclosure requirements under section 121 of the Bipartisan Patient Protection Act of 2001 with the reporting and disclosure requirements imposed under part 1, so long as such coordination does not result in any reduction in the information that would otherwise be provided to participants and beneficiaries.”.

(b) SATISFACTION OF ERISA CLAIMS PROCEDURE REQUIREMENT.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting “(a)” after “SEC. 503.” and by adding at the end the following new subsection:

“(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subtitle A of title I of the Bipartisan Patient Protection Act of 2001, and compliance with regulations promulgated by the Secretary, in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.”.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking “section 711” and inserting “sections 711 and 714”.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 713 the following new item:

“Sec. 714. Patient protection standards.”.

(3) Section 502(b)(3) of such Act (29 U.S.C. 1132(b)(3)) is amended by inserting “(other than section 135(b))” after “part 7”.

SEC. 302. AVAILABILITY OF CIVIL REMEDIES.

(a) AVAILABILITY OF FEDERAL CIVIL REMEDIES IN CASES NOT INVOLVING MEDICALLY REVIEWABLE DECISIONS.

(1) 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 new subsection:

“(n) CAUSE OF ACTION RELATING TO PROVISION OF HEALTH BENEFITS.—

“(1) IN GENERAL.—In any case in which—

“(A) a person who is a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with the plan, or an agent of the plan, issuer, or plan sponsor—

“(i) upon consideration of a claim for benefits of a participant or beneficiary under section 102 of the Bipartisan Patient Protection Act of 2001 (relating to procedures for initial claims for benefits and prior authorization determinations) or upon review of a denial of such a claim under section 103 of such Act (relating to internal appeal of a denial of a claim for benefits), fails to exercise ordinary care in making a decision—

“(I) regarding whether an item or service is covered under the terms and conditions of the plan or coverage,

“(II) regarding whether an individual is a participant or beneficiary who is enrolled under the terms and conditions of the plan or coverage (including the applicability of any waiting period under the plan or coverage), or

“(III) 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, or

“(ii) otherwise fails to exercise ordinary care in the performance of a duty under the terms and conditions of the plan with respect to a participant or beneficiary, and

“(B) such failure is a proximate cause of personal injury to, or the death of, the participant or beneficiary,

such person shall be liable to the participant or beneficiary (or the estate of such participant or beneficiary) for economic and non-economic damages (but not exemplary or punitive damages) in connection with such personal injury or death.

“(2) CAUSE OF ACTION MUST NOT INVOLVE MEDICALLY REVIEWABLE DECISION.—

“(A) IN GENERAL.—A cause of action is established under paragraph (1)(A) only if the decision referred to in clause (i) or the failure described in clause (ii) does not include a medically reviewable decision.

“(B) MEDICALLY REVIEWABLE DECISION.—For purposes of subparagraph (A), the term ‘medically reviewable decision’ means a denial of a claim for benefits under the plan which is described in section 104(d)(2) of the Bipartisan Patient Protection Act of 2001 (relating to medically reviewable decisions).

“(3) DEFINITIONS.—For purposes of this subsection—

“(A) ORDINARY CARE.—The term ‘ordinary care’ means—

“(i) with respect to a determination on a claim for benefits, that degree of care, skill, and diligence that a reasonable and prudent individual would exercise in making a fair determination on a claim for benefits of like kind to the claim involved; and

“(ii) with respect to the performance of a duty, that degree of care, skill, and diligence that a reasonable and prudent individual would exercise in performing the duty or a duty of like character.

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

“(C) CLAIM FOR BENEFITS; DENIAL.—The terms ‘claim for benefits’ and ‘denial of a claim for benefits’ have the meanings provided such terms in section 102(e) of the Bipartisan Patient Protection Act of 2001.

“(D) TERMS AND CONDITIONS.—The term ‘terms and conditions’ includes, with respect to a group health plan or health insurance coverage, requirements imposed under title I of the Bipartisan Patient Protection Act of 2001 or under part 6 or 7.

“(E) GROUP HEALTH PLAN AND OTHER RELATED TERMS.—The provisions of sections 732(d) and 733 apply for purposes of this subsection in the same manner as they apply for purposes of part 7, except that the term ‘group health plan’ includes a group health plan (as defined in section 607(1)).

“(4) EXCLUSION OF EMPLOYERS AND OTHER PLAN SPONSORS.—

“(A) CAUSES OF ACTION AGAINST EMPLOYERS AND PLAN SPONSORS PRECLUDED.—Subject to subparagraph (B), paragraph (1)(A) does not authorize a cause of action against an employer or other plan sponsor maintaining the plan (or against an employee of such an em-

ployer or sponsor acting within the scope of employment).

“(B) CERTAIN CAUSES OF ACTION PERMITTED.—Notwithstanding subparagraph (A), a cause of action may arise against an employer or other plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment)—

“(i) under clause (i) of paragraph (1)(A), to the extent there was direct participation by the employer or other plan sponsor (or employee) in the decision of the plan under section 102 of the Bipartisan Patient Protection Act of 2001 upon consideration of a claim for benefits or under section 103 of such Act upon review of a denial of a claim for benefits, or

“(ii) under clause (ii) of paragraph (1)(A), to the extent there was direct participation by the employer or other plan sponsor (or employee) in the failure described in such clause.

“(C) DIRECT PARTICIPATION.—

“(i) DIRECT PARTICIPATION IN DECISIONS.—For purposes of subparagraph (B), the term ‘direct participation’ means, in connection with a decision described in clause (i) of paragraph (1)(A) or a failure described in clause (ii) of such paragraph, the actual making of such decision or the actual exercise of control in making such decision or in the conduct constituting the failure.

“(ii) RULES OF CONSTRUCTION.—For purposes of clause (i), the employer or plan sponsor (or employee) shall not be construed to be engaged in direct participation because of any form of decisionmaking or other conduct that is merely collateral or precedent to the decision described in clause (i) of paragraph (1)(A) on a particular claim for benefits of a participant or beneficiary or that is merely collateral or precedent to the conduct constituting a failure described in clause (ii) of paragraph (1)(A) with respect to a particular participant or beneficiary, including (but not limited to)—

“(I) any participation by the employer or other plan sponsor (or employee) in the selection of the group health plan or health insurance coverage involved or the third party administrator or other agent;

“(II) any engagement by the employer or other plan sponsor (or employee) in any cost-benefit analysis undertaken in connection with the selection of, or continued maintenance of, the plan or coverage involved;

“(III) any participation by the employer or other plan sponsor (or employee) in the process of creating, continuing, modifying, or terminating the plan or any benefit under the plan, if such process was not substantially focused solely on the particular situation of the participant or beneficiary referred to in paragraph (1)(A); and

“(IV) any participation by the employer or other plan sponsor (or employee) in the design of any benefit under the plan, including the amount of copayment and limits connected with such benefit.

“(iv) IRRELEVANCE OF CERTAIN COLLATERAL EFFORTS MADE BY EMPLOYER OR PLAN SPONSOR.—For purposes of this subparagraph, an employer or plan sponsor shall not be treated as engaged in direct participation in a decision with respect to any claim for benefits or denial thereof in the case of any particular participant or beneficiary solely by reason of—

“(I) any efforts that may have been made by the employer or plan sponsor to advocate for authorization of coverage for that or any other participant or beneficiary (or any group of participants or beneficiaries), or

“(II) any provision that may have been made by the employer or plan sponsor for benefits which are not covered under the terms and conditions of the plan for that or

any other participant or beneficiary (or any group of participants or beneficiaries).

“(5) REQUIREMENT OF EXHAUSTION.—

“(A) IN GENERAL.—Except as provided in this paragraph, a cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102 and 103 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

“(B) LATE MANIFESTATION OF INJURY.—The requirements under subparagraph (A) for a cause of action in connection with any denial of a claim for benefits shall be deemed satisfied, notwithstanding any failure to timely commence review under section 103 with respect to the denial, if the personal injury is first known (or first reasonably should have been known) to the individual (or the death occurs) after the latest date by which the applicable requirements of subparagraph (A) can be met in connection with such denial.

“(C) OCCURRENCE OF IMMEDIATE AND IRREPARABLE HARM OR DEATH PRIOR TO COMPLETION OF PROCESS.—

“(i) IN GENERAL.—The requirements of subparagraph (A) shall not apply if the action involves an allegation that immediate and irreparable harm or death was, or would be, caused by the denial of a claim for benefits prior to the completion of the administrative processes referred to in subparagraph (A) with respect to such denial.

“(ii) CONSTRUCTION.—Nothing in clause (i) shall be construed to preclude—

“(I) continuation of such processes to their conclusion if so moved by any party, and

“(II) consideration in such action of the final decisions issued in such processes.

“(iii) DEFINITION.—In clause (i), the term ‘irreparable harm’, with respect to an individual, means an injury or condition that, regardless of whether the individual receives the treatment that is the subject of the denial, cannot be repaired in a manner that would restore the individual to the individual’s pre-injured condition.

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

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

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

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

“(6) STATUTORY DAMAGES.—

“(A) IN GENERAL.—The remedies set forth in this subsection (n) shall be the exclusive remedies for causes of action brought under this subsection.

“(B) ASSESSMENT OF CIVIL PENALTIES.—In addition to the remedies provided for in paragraph (1) (relating to the failure to provide contract benefits in accordance with the plan), a civil assessment, in an amount not to exceed \$5,000,000, payable to the claimant may be awarded in any action under such paragraph if the claimant establishes by clear and convincing evidence that the alleged conduct carried out by the defendant demonstrated bad faith and flagrant disregard for the rights of the participant or beneficiary under the plan and was a proximate cause of the personal injury or death that is the subject of the claim.

“(7) LIMITATION OF ACTION.—Paragraph (1) shall not apply in connection with any action commenced after 3 years after the later of—

“(A) the date on which the plaintiff first knew, or reasonably should have known, of the personal injury or death resulting from the failure described in paragraph (1), or

“(B) the date as of which the requirements of paragraph (5) are first met.

“(8) TOLLING PROVISION.—The statute of limitations for any cause of action arising under State law relating to a denial of a claim for benefits that is the subject of an action brought in Federal court under this subsection shall be tolled until such time as the Federal court makes a final disposition, including all appeals, of whether such claim should properly be within the jurisdiction of the Federal court. The tolling period shall be determined by the applicable Federal or State law, whichever period is greater.

“(10) PURCHASE OF INSURANCE TO COVER LIABILITY.—Nothing in section 410 shall be construed to preclude the purchase by a group health plan of insurance to cover any liability or losses arising under a cause of action under subsection (a)(1)(C) and this subsection.

“(11) EXCLUSION OF DIRECTED RECORDKEEPERS.—

“(A) IN GENERAL.—Subject to subparagraph (C), paragraph (1) shall not apply with respect to a directed recordkeeper in connection with a group health plan.

“(B) DIRECTED RECORDKEEPER.—For purposes of this paragraph, the term ‘directed recordkeeper’ means, in connection with a group health plan, a person engaged in directed recordkeeping activities pursuant to the specific instructions of the plan or the employer or other plan sponsor, including the distribution of enrollment information and distribution of disclosure materials under this Act or title I of the Bipartisan Patient Protection Act of 2001 and whose duties do not include making decisions on claims for benefits.

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

“(12) NO EFFECT ON STATE LAW.—No provision of State law (as defined in section 514(c)(1)) shall be treated as superseded or otherwise altered, amended, modified, invalidated, or impaired by reason of the provisions of subsection (a)(1)(C) and this subsection.”

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

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

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

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

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

(b) RULES RELATING TO ERISA PREEMPTION.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended—

(1) by redesignating subsection (d) as subsection (f); and

(2) by inserting after subsection (c) the following new subsections:

“(d) PREEMPTION NOT TO APPLY TO CAUSES OF ACTION UNDER STATE LAW INVOLVING MEDICALLY REVIEWABLE DECISION.—

“(1) NON-PREEMPTION OF CERTAIN CAUSES OF ACTION.—

“(A) IN GENERAL.—Except as provided in this subsection, nothing in this title (including section 502) shall be construed to super-

cede or otherwise alter, amend, modify, invalidate, or impair any cause of action under State law of a participant or beneficiary under a group health plan (or the estate of such a participant or beneficiary) to recover damages resulting from personal injury or for wrongful death against any person if such cause of action arises by reason of a medically reviewable decision.

“(B) MEDICALLY REVIEWABLE DECISION.—For purposes of subparagraph (A), the term ‘medically reviewable decision’ means a denial of a claim for benefits under the plan which is described in section 104(d)(2) of the Bipartisan Patient Protection Act of 2001 (relating to medically reviewable decisions).

“(C) LIMITATION ON PUNITIVE DAMAGES.—

“(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), with respect to a cause of action described in subparagraph (A) brought with respect to a participant or beneficiary, State law is superseded insofar as it provides any punitive, exemplary, or similar damages if, as of the time of the personal injury or death, all the requirements of the following sections of the Bipartisan Patient Protection Act of 2001 were satisfied with respect to the participant or beneficiary:

“(II) Section 102 (relating to procedures for initial claims for benefits and prior authorization determinations).

“(III) Section 103 of such Act (relating to internal appeals of claims denials).

“(ii) EXCEPTION FOR CERTAIN ACTIONS FOR WRONGFUL DEATH.—Clause (i) shall not apply with respect to an action for wrongful death if the applicable State law provides (or has been construed to provide) for damages in such an action which are only punitive or exemplary in nature.

“(iii) EXCEPTION FOR WILLFUL OR WANTON DISREGARD FOR THE RIGHTS OR SAFETY OF OTHERS.—Clause (i) shall not apply with respect to any cause of action described in subparagraph (A) if, in such action, the plaintiff establishes by clear and convincing evidence that conduct carried out by the defendant with willful or wanton disregard for the rights or safety of others was a proximate cause of the personal injury or wrongful death that is the subject of the action.

“(3) DEFINITIONS.—For purposes of this subsection and subsection (e)—

“(A) GROUP HEALTH PLAN AND OTHER RELATED TERMS.—The provisions of sections 732(d) and 733 apply for purposes of this subsection in the same manner as they apply for purposes of part 7, except that the term ‘group health plan’ includes a group health plan (as defined in section 607(1)).

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

“(C) CLAIM FOR BENEFIT; DENIAL.—The terms ‘claim for benefits’ and ‘denial of a claim for benefits’ shall have the meaning provided such terms under section 102(e) of the Bipartisan Patient Protection Act of 2001.

“(4) EXCLUSION OF EMPLOYERS AND OTHER PLAN SPONSORS.—

“(A) CAUSES OF ACTION AGAINST EMPLOYERS AND PLAN SPONSORS PRECLUDED.—Subject to subparagraph (B), paragraph (1) does not apply with respect to—

“(i) any cause of action against an employer or other plan sponsor maintaining the plan (or against an employee of such an employer or sponsor acting within the scope of employment), or

“(ii) a right of recovery, indemnity, or contribution by a person against an employer or other plan sponsor (or such an employee) for damages assessed against the person pursuant to a cause of action to which paragraph (1) applies.

“(B) CERTAIN CAUSES OF ACTION PERMITTED.—Notwithstanding subparagraph (A), paragraph (1) applies with respect to any cause of action described in paragraph (1) maintained by a participant or beneficiary against an employer or other plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment)—

“(i) in the case of any cause of action based on a decision of the plan under section 102 of the Bipartisan Patient Protection Act of 2001 upon consideration of a claim for benefits or under section 103 of such Act upon review of a denial of a claim for benefits, to the extent there was direct participation by the employer or other plan sponsor (or employee) in the decision, or

“(ii) in the case of any cause of action based on a failure to otherwise perform a duty under the terms and conditions of the plan with respect to a claim for benefits of a participant or beneficiary, to the extent there was direct participation by the employer or other plan sponsor (or employee) in the failure.

“(C) DIRECT PARTICIPATION.—

“(i) DIRECT PARTICIPATION IN DECISIONS.—For purposes of subparagraph (B), the term ‘direct participation’ means, in connection with a decision described in subparagraph (B)(i) or a failure described in subparagraph (B)(ii), the actual making of such decision or the actual exercise of control in making such decision or in the conduct constituting the failure.

“(ii) RULES OF CONSTRUCTION.—For purposes of clause (i), the employer or plan sponsor (or employee) shall not be construed to be engaged in direct participation because of any form of decisionmaking or other conduct that is merely collateral or precedent to the decision described in subparagraph (B)(i) on a particular claim for benefits of a particular participant or beneficiary or that is merely collateral or precedent to the conduct constituting a failure described in subparagraph (B)(ii) with respect to a particular participant or beneficiary, including (but not limited to)—

“(I) any participation by the employer or other plan sponsor (or employee) in the selection of the group health plan or health insurance coverage involved or the third party administrator or other agent;

“(II) any engagement by the employer or other plan sponsor (or employee) in any cost-benefit analysis undertaken in connection with the selection of, or continued maintenance of, the plan or coverage involved;

“(III) any participation by the employer or other plan sponsor (or employee) in the process of creating, continuing, modifying, or terminating the plan or any benefit under the plan, if such process was not substantially focused on the particular situation of the participant or beneficiary referred to in paragraph (1)(A); and

“(IV) any participation by the employer or other plan sponsor (or employee) in the design of any benefit under the plan, including the amount of copayment and limits connected with such benefit.

“(iv) IRRELEVANCE OF CERTAIN COLLATERAL EFFORTS MADE BY EMPLOYER OR PLAN SPONSOR.—For purposes of this subparagraph, an employer or plan sponsor shall not be treated as engaged in direct participation in a decision with respect to any claim for benefits or denial thereof in the case of any particular participant or beneficiary solely by reason of—

“(I) any efforts that may have been made by the employer or plan sponsor to advocate for authorization of coverage for that or any

other participant or beneficiary (or any group of participants or beneficiaries), or

“(II) any provision that may have been made by the employer or plan sponsor for benefits which are not covered under the terms and conditions of the plan for that or any other participant or beneficiary (or any group of participants or beneficiaries).

“(5) REQUIREMENT OF EXHAUSTION.—

“(A) IN GENERAL.—Except as provided in this paragraph, paragraph (1) shall not apply with respect to a cause of action described in such paragraph in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102, 103, and 104 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

“(B) LATE MANIFESTATION OF INJURY.—The requirements under subparagraph (A) for a cause of action in connection with any denial of a claim for benefits shall be deemed satisfied, notwithstanding any failure to timely commence review under section 103 or 104 with respect to the denial, if the personal injury is first known (or first should have been known) to the individual (or the death occurs) after the latest date by which the applicable requirements of subparagraph (A) can be met in connection with such denial.

“(C) OCCURRENCE OF IMMEDIATE AN IRREPARABLE HARM OR DEATH PRIOR TO COMPLETION OF PROCESS.—

“(i) IN GENERAL.—The requirements of subparagraph (A) shall not apply if the action involves an allegation that immediate and irreparable harm or death was, or would be, caused by the denial of a claim for benefits prior to the completion of the administrative processes referred to in subparagraph (A) with respect to such denial.

“(ii) CONSTRUCTION.—Nothing in clause (i) shall be construed to preclude—

“(I) continuation of such processes to their conclusion if so moved by any party, and

“(II) consideration in such action of the final decisions issued in such processes.

“(iii) DEFINITION.—In clause (i), the term ‘irreparable harm’, with respect to an individual, means an injury or condition that, regardless of whether the individual receives the treatment that is the subject of the denial, cannot be repaired in a manner that would restore the individual to the individual’s pre-injured condition.

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

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

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

“(6) TOLLING PROVISION.—The statute of limitations for any cause of action arising under section 502(n) relating to a denial of a claim for benefits that is the subject of an action brought in State court shall be tolled until such time as the State court makes a final disposition, including all appeals, of whether such claim should properly be within the jurisdiction of the State court. The tolling period shall be determined by the applicable Federal or State law, whichever period is greater.

“(7) EXCLUSION OF DIRECTED RECORDKEEPERS.—

“(A) IN GENERAL.—Subject to subparagraph (C), paragraph (1) shall not apply with respect to a directed recordkeeper in connection with a group health plan.

“(B) DIRECTED RECORDKEEPER.—For purposes of this paragraph, the term ‘directed

recordkeeper’ means, in connection with a group health plan, a person engaged in directed recordkeeping activities pursuant to the specific instructions of the plan or the employer or other plan sponsor, including the distribution of enrollment information and distribution of disclosure materials under this Act or title I of the Bipartisan Patient Protection Act of 2001 and whose duties do not include making decisions on claims for benefits.

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

“(8) CONSTRUCTION.—Nothing in this subsection shall be construed as—

“(A) saving from preemption a cause of action under State law for the failure to provide a benefit for an item or service which is specifically excluded under the group health plan involved, except to the extent that—

“(i) the application or interpretation of the exclusion involves a determination described in section 104(d)(2) of the Bipartisan Patient Protection Act of 2001, or

“(ii) the provision of the benefit for the item or service is required under Federal law or under applicable State law consistent with subsection (b)(2)(B);

“(B) preempting a State law which requires an affidavit or certificate of merit in a civil action;

“(C) affecting a cause of action or remedy under State law in connection with the provision or arrangement of excepted benefits (as defined in section 733(c)), other than those described in section 733(c)(2)(A); or

“(D) affecting a cause of action under State law other than a cause of action described in paragraph (1)(A).

“(9) PURCHASE OF INSURANCE TO COVER LIABILITY.—Nothing in section 410 shall be construed to preclude the purchase by a group health plan of insurance to cover any liability or losses arising under a cause of action described in paragraph (1)(A).

“(e) RULES OF CONSTRUCTION RELATING TO HEALTH CARE.—Nothing in this title shall be construed as—

“(1) affecting any State law relating to the practice of medicine or the provision of medical care, or affecting any action based upon such a State law,

“(2) superseding any State law permitted under section 152(b)(1)(A) of the Bipartisan Patient Protection Act of 2001, or

“(3) affecting any applicable State law with respect to limitations on monetary damages.”.

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

SEC. 303. LIMITATIONS ON ACTIONS.

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) (as amended by section 302(a)) is amended further by adding at the end the following new subsection:

“(o) LIMITATIONS ON ACTIONS RELATING TO GROUP HEALTH PLANS.—

“(1) IN GENERAL.—Except as provided in paragraph (2), no action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the application of any provision in section 101, subtitle B, or subtitle D of title I of the Bipartisan Patient Protection Act of 2001 (as incorporated under section 714).

“(2) CERTAIN ACTIONS ALLOWABLE.—An action may be brought under subsection (a)(1)(B), (a)(2), or (a)(3) by a participant or beneficiary seeking relief based on the appli-

cation of section 101, 113, 114, 115, 116, 117, 118(a)(3), 119, or 120 of the Bipartisan Patient Protection Act of 2001 (as incorporated under section 714) to the individual circumstances of that participant or beneficiary, except that—

“(A) such an action may not be brought or maintained as a class action; and

“(B) in such an action, relief may only provide for the provision of (or payment of) benefits, items, or services denied to the individual participant or beneficiary involved (and for attorney’s fees and the costs of the action, at the discretion of the court) and shall not provide for any other relief to the participant or beneficiary or for any relief to any other person.

“(3) OTHER PROVISIONS UNAFFECTED.—Nothing in this subsection shall be construed as affecting subsections (a)(1)(C) and (n) or section 514(d).

“(4) ENFORCEMENT BY SECRETARY UNAFFECTED.—Nothing in this subsection shall be construed as affecting any action brought by the Secretary.

TITLE IV—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

SEC. 401. APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986.

Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended—

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

“Sec. 9813. Standard relating to patients’ bill of rights.”;

and

(2) by inserting after section 9812 the following:

“SEC. 9813. STANDARD RELATING TO PATIENTS’ BILL OF RIGHTS.

“A group health plan shall comply with the requirements of title I of the Bipartisan Patient Protection Act of 2001 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section.”.

SEC. 402. CONFORMING ENFORCEMENT FOR WOMEN’S HEALTH AND CANCER RIGHTS.

Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 401, is further amended—

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

“Sec. 9814. Standard relating to women’s health and cancer rights.”;

and

(2) by inserting after section 9813 the following:

“SEC. 9814. STANDARD RELATING TO WOMEN’S HEALTH AND CANCER RIGHTS.

“The provisions of section 713 of the Employee Retirement Income Security Act of 1974 (as in effect as of the date of the enactment of this section) shall apply to group health plans as if included in this chapter.”.

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 501. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2) and subsection (d), the amendments made by sections 201(a), 301, 303, and 401 and 402 (and title I insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 2002 (in this section referred to as the “general effective date”).

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health

plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by sections 201(a), 301, 303, and 401 and 402 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

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

(B) the general effective date.

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

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—Subject to subsection (d), the amendments made by section 202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

(c) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

(1) IN GENERAL.—Nothing in this Act (or the amendments made thereby) shall be construed to—

(A) restrict or limit the right of group health plans, and of health insurance issuers offering health insurance coverage, to include as providers religious nonmedical providers;

(B) require such plans or issuers to—

(i) utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers;

(ii) use medical professionals or criteria to decide patient access to religious nonmedical providers;

(iii) utilize medical professionals or criteria in making decisions in internal or external appeals regarding coverage for care by religious nonmedical providers; or

(iv) compel a participant or beneficiary to undergo a medical examination or test as a condition of receiving health insurance coverage for treatment by a religious nonmedical provider; or

(C) require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other required data, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider.

(2) RELIGIOUS NONMEDICAL PROVIDER.—For purposes of this subsection, the term “religious nonmedical provider” means a provider who provides no medical care but who provides only religious nonmedical treatment or religious nonmedical nursing care.

(d) TRANSITION FOR NOTICE REQUIREMENT.—The disclosure of information required under section 121 of this Act shall first be provided pursuant to—

(1) subsection (a) with respect to a group health plan that is maintained as of the general effective date, not later than 30 days before the beginning of the first plan year to which title I applies in connection with the plan under such subsection; or

(2) subsection (b) with respect to an individual health insurance coverage that is in effect as of the general effective date, not later than 30 days before the first date as of which title I applies to the coverage under such subsection.

SEC. 502. COORDINATION IN IMPLEMENTATION.

The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury shall ensure, through

the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which such Secretaries have responsibility under the provisions of this division (and the amendments made thereby) are administered so as to have the same effect at all times; and

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

SEC. 503. SEVERABILITY.

If any provision of this Act, an amendment made by this Act, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this Act, the amendments made by this Act, and the application of the provisions of such to any person or circumstance shall not be affected thereby.

S. 284

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

SECTION 1. SHORT TITLE.

This Act may be cited as the “Bipartisan Patient Protection Act of 2001—Part II”.

SEC. 2. EXPANDED AVAILABILITY OF ARCHER MSAS.

(a) EXTENSION OF PROGRAM.—Paragraphs (2) and (3)(B) of section 220(i) of the Internal Revenue Code of 1986 (defining cut-off year) are each amended by striking “2002” each place it appears and inserting “2004”.

(b) INCREASE IN NUMBER OF PERMITTED ACCOUNT PARTICIPANTS.—

(1) IN GENERAL.—Subsection (j) of section 220 of such Code is amended by redesignating paragraphs (3), (4), and (5) as paragraphs (4), (5), and (6) and by inserting after paragraph (2) the following new paragraph:

“(3) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR YEARS AFTER 2001.—

“(A) IN GENERAL.—The numerical limitation for any year after 2001 is exceeded if the sum of—

“(i) the number of Archer MSA returns filed on or before April 15 of such calendar year for taxable years ending with or within the preceding calendar year, plus

“(ii) the Secretary’s estimate (determined on the basis of the returns described in clause (i)) of the number of Archer MSA returns for such taxable years which will be filed after such date, exceeds 1,000,000. For purposes of the preceding sentence, the term ‘Archer MSA return’ means any return on which any exclusion is claimed under section 106(b) or any deduction is claimed under this section.

“(B) ALTERNATIVE COMPUTATION OF LIMITATION.—The numerical limitation for any year after 2001 is also exceeded if the sum of—

“(i) 90 percent of the sum determined under subparagraph (A) for such calendar year, plus

“(ii) the product of 2.5 and the number of medical savings accounts established during the portion of such year preceding July 1 (based on the reports required under paragraph (5)) for taxable years beginning in such year, exceeds 1,000,000.”

(2) CONFORMING AMENDMENTS.—

(A) Clause (ii) of section 220(j)(2)(B) of such Code is amended by striking “paragraph (4)” and inserting “paragraph (5)”.

(B) Subparagraph (A) of section 220(j)(4) of such Code is amended by striking “and 2001” and inserting “2001, 2002, and 2003”.

(C) INCREASE IN SIZE OF ELIGIBLE EMPLOYERS.—Subparagraph (A) of section 220(c)(4) of

such Code is amended by striking “50 or fewer employees” and inserting “100 or fewer employees”.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

(e) GAO STUDY.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit a report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the impact of Archer MSAs on the cost of conventional insurance (especially in those areas where there are higher numbers of such accounts) and on adverse selection and health care costs.

SEC. 3. 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) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 4. CREDIT FOR HEALTH INSURANCE EXPENSES OF SMALL BUSINESSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by adding at the end the following:

SEC. 45E. SMALL BUSINESS HEALTH INSURANCE EXPENSES.

“(a) GENERAL RULE.—For purposes of section 38, in the case of a small employer, the health insurance credit determined under this section for the taxable year is an amount equal to the applicable percentage of the expenses paid by the taxpayer during the taxable year for health insurance coverage for such year provided under a new health plan for employees of such employer.

“(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the applicable percentage is—

“(1) in the case of insurance purchased as a member of a qualified health benefit purchasing coalition (as defined in section 9841), 30 percent, and

“(2) in the case of insurance not described in paragraph (1), 20 percent.

“(C) LIMITATIONS.

“(1) PER EMPLOYEE DOLLAR LIMITATION.—The amount of expenses taken into account under subsection (a) with respect to any employee for any taxable year shall not exceed—

“(A) \$2,000 in the case of self-only coverage, and

“(B) \$5,000 in the case of family coverage. In the case of an employee who is covered by a new health plan of the employer for only a portion of such taxable year, the limitation under the preceding sentence shall be an amount which bears the same ratio to such limitation (determined without regard to this sentence) as such portion bears to the entire taxable year.

“(2) PERIOD OF COVERAGE.—Expenses may be taken into account under subsection (a) only with respect to coverage for the 4-year period beginning on the date the employer establishes a new health plan.

“(d) DEFINITIONS.—For purposes of this section—

“(1) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ has the

meaning given such term by section 9832(b)(1).

“(2) NEW HEALTH PLAN.—

“(A) IN GENERAL.—The term ‘new health plan’ means any arrangement of the employer which provides health insurance coverage to employees if—

“(i) such employer (and any predecessor employer) did not establish or maintain such arrangement (or any similar arrangement) at any time during the 2 taxable years ending prior to the taxable year in which the credit under this section is first allowed, and

“(ii) such arrangement provides health insurance coverage to at least 70 percent of the qualified employees of such employer.

“(B) QUALIFIED EMPLOYEE.—

“(i) IN GENERAL.—The term ‘qualified employee’ means any employee of an employer if the annual rate of such employee’s compensation (as defined in section 414(s)) exceeds \$10,000.

“(ii) TREATMENT OF CERTAIN EMPLOYEES.—The term ‘employee’ shall include a leased employee within the meaning of section 414(n).

“(3) SMALL EMPLOYER.—The term ‘small employer’ has the meaning given to such term by section 4980D(d)(2); except that only qualified employees shall be taken into account.

“(e) SPECIAL RULES.—

“(1) CERTAIN RULES MADE APPLICABLE.—For purposes of this section, rules similar to the rules of section 52 shall apply.

“(2) AMOUNTS PAID UNDER SALARY REDUCTION ARRANGEMENTS.—No amount paid or incurred pursuant to a salary reduction arrangement shall be taken into account under subsection (a).

“(f) TERMINATION.—This section shall not apply to expenses paid or incurred by an employer with respect to any arrangement established on or after January 1, 2010.”.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Section 38(b) of such Code (relating to current year business credit) is amended by striking “plus” at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting “, plus”, and by adding at the end the following:

“(14) in the case of a small employer (as defined in section 45E(d)(3)), the health insurance credit determined under section 45E(a).”

(c) NO CARRYBACKS.—Subsection (d) of section 39 of such Code (relating to carryback and carryforward of unused credits) is amended by adding at the end the following:

“(10) NO CARRYBACK OF SECTION 45E CREDIT BEFORE EFFECTIVE DATE.—No portion of the unused business credit for any taxable year which is attributable to the employee health insurance expenses credit determined under section 45E may be carried back to a taxable year ending before the date of the enactment of section 45E.”

(d) DENIAL OF DOUBLE BENEFIT.—Section 280C of such Code is amended by adding at the end the following new subsection:

“(d) CREDIT FOR SMALL BUSINESS HEALTH INSURANCE EXPENSES.—

“(1) IN GENERAL.—No deduction shall be allowed for that portion of the expenses (otherwise allowable as a deduction) taken into account in determining the credit under section 45E for the taxable year which is equal to the amount of the credit determined for such taxable year under section 45E(a).

“(2) CONTROLLED GROUPS.—Persons treated as a single employer under subsection (a) or (b) of section 52 shall be treated as 1 person for purposes of this section.”

(e) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of such Code is amended by adding at the end the following:

“Sec. 45E. Small business health insurance expenses.”

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2001, for arrangements established after the date of the enactment of this Act.

SEC. 5. CERTAIN GRANTS BY PRIVATE FOUNDATIONS TO QUALIFIED HEALTH BENEFIT PURCHASING COALITIONS.

(a) IN GENERAL.—Section 4942 of the Internal Revenue Code of 1986 (relating to taxes on failure to distribute income) is amended by adding at the end the following:

“(k) CERTAIN QUALIFIED HEALTH BENEFIT PURCHASING COALITION DISTRIBUTIONS.—

“(1) IN GENERAL.—For purposes of subsection (g), sections 170, 501, 507, 509, and 2522, and this chapter, a qualified health benefit purchasing coalition distribution by a private foundation shall be considered to be a distribution for a charitable purpose.

“(2) QUALIFIED HEALTH BENEFIT PURCHASING COALITION DISTRIBUTION.—For purposes of paragraph (1)—

“(A) IN GENERAL.—The term ‘qualified health benefit purchasing coalition distribution’ means any amount paid or incurred by a private foundation to or on behalf of a qualified health benefit purchasing coalition (as defined in section 9841) for purposes of payment or reimbursement of amounts paid or incurred in connection with the establishment and maintenance of such coalition.

“(B) EXCLUSIONS.—Such term shall not include any amount used by a qualified health benefit purchasing coalition (as so defined)—

“(i) for the purchase of real property,

“(ii) as payment to, or for the benefit of, members (or employees or affiliates of such members) of such coalition, or

“(iii) for any expense paid or incurred more than 48 months after the date of establishment of such coalition.

“(3) TERMINATION.—This subsection shall not apply—

“(A) to qualified health benefit purchasing coalition distributions paid or incurred after December 31, 2009, and

“(B) with respect to start-up costs of a coalition which are paid or incurred after December 31, 2010.”.

(b) QUALIFIED HEALTH BENEFIT PURCHASING COALITION.—

(1) IN GENERAL.—Chapter 100 of such Code (relating to group health plan requirements) is amended by adding at the end the following new subchapter:

Subchapter D—Qualified Health Benefit Purchasing Coalition

“Sec. 9841. Qualified health benefit purchasing coalition.

SEC. 9841. QUALIFIED HEALTH BENEFIT PURCHASING COALITION.

“(a) IN GENERAL.—A qualified health benefit purchasing coalition is a private not-for-profit corporation which—

“(1) sells health insurance through State licensed health insurance issuers in the State in which the employers to which such coalition is providing insurance are located, and

“(2) establishes to the Secretary, under State certification procedures or other procedures as the Secretary may provide by regulation, that such coalition meets the requirements of this section.

“(b) BOARD OF DIRECTORS.—

“(1) IN GENERAL.—Each purchasing coalition under this section shall be governed by a Board of Directors.

“(2) ELECTION.—The Secretary shall establish procedures governing election of such Board.

“(3) MEMBERSHIP.—The Board of Directors shall—

“(A) be composed of representatives of the members of the coalition, in equal number, including small employers and employee representatives of such employers, but

“(B) not include other interested parties, such as service providers, health insurers, or insurance agents or brokers which may have a conflict of interest with the purposes of the coalition.

“(C) MEMBERSHIP OF COALITION.—

“(1) IN GENERAL.—A purchasing coalition shall accept all small employers residing within the area served by the coalition as members if such employers request such membership.

“(2) OTHER MEMBERS.—The coalition, at the discretion of its Board of Directors, may be open to individuals and large employers.

“(3) VOTING.—Members of a purchasing coalition shall have voting rights consistent with the rules established by the State.

“(d) DUTIES OF PURCHASING COALITIONS.—Each purchasing coalition shall—

“(1) enter into agreements with small employers (and, at the discretion of its Board, with individuals and other employers) to provide health insurance benefits to employees and retirees of such employers,

“(2) where feasible, enter into agreements with 3 or more unaffiliated, qualified licensed health plans, to offer benefits to members,

“(3) offer to members at least 1 open enrollment period of at least 30 days per calendar year,

“(4) serve a significant geographical area and market to all eligible members in that area, and

“(5) carry out other functions provided for under this section.

“(e) LIMITATION ON ACTIVITIES.—A purchasing coalition shall not—

“(1) perform any activity (including certification or enforcement) relating to compliance or licensing of health plans,

“(2) assume insurance or financial risk in relation to any health plan, or

“(3) perform other activities identified by the State as being inconsistent with the performance of its duties under this section.

“(f) ADDITIONAL REQUIREMENTS FOR PURCHASING COALITIONS.—As provided by the Secretary in regulations, a purchasing coalition shall be subject to requirements similar to the requirements of a group health plan under this chapter.

“(g) RELATION TO OTHER LAWS.—

“(1) PREEMPTION OF STATE FICTITIOUS GROUP LAWS.—Requirements (commonly referred to as fictitious group laws) relating to grouping and similar requirements for health insurance coverage are preempted to the extent such requirements impede the establishment and operation of qualified health benefit purchasing coalitions.

“(2) ALLOWING SAVINGS TO BE PASSED THROUGH.—Any State law that prohibits health insurance issuers from reducing premiums on health insurance coverage sold through a qualified health benefit purchasing coalition to reflect administrative savings is preempted. This paragraph shall not be construed to preempt State laws that impose restrictions on premiums based on health status, claims history, industry, age, gender, or other underwriting factors.

“(3) NO WAIVER OF HIPAA REQUIREMENTS.—Nothing in this section shall be construed to change the obligation of health insurance issuers to comply with the requirements of title XXVII of the Public Health Service Act with respect to health insurance coverage offered to small employers in the small group market through a qualified health benefit purchasing coalition.

“(h) DEFINITION OF SMALL EMPLOYER.—For purposes of this section—

“(1) IN GENERAL.—The term ‘small employer’ means, with respect to any calendar year, any employer if such employer employed an average of at least 2 and not more than 50 qualified employees on business days during either of the 2 preceding calendar years. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer was in existence throughout such year.

“(2) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the 1st preceding calendar year, the determination under paragraph (1) shall be based on the average number of qualified employees that it is reasonably expected such employer will employ on business days in the current calendar year.”.

(2) CONFORMING AMENDMENT.—The table of subchapters for chapter 100 of such Code is amended by adding at the end the following item:

“Subchapter D. Qualified health benefit purchasing coalition.”.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2001.

SEC. 6. STATE GRANT PROGRAM FOR MARKET INNOVATION.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish a program (in this section referred to as the “program”) to award demonstration grants under this section to States to allow States to demonstrate the effectiveness of innovative ways to increase access to health insurance through market reforms and other innovative means. Such innovative means may include (and are not limited to) any of the following:

(1) Alternative group purchasing or pooling arrangements, such as a purchasing cooperatives for small businesses, reinsurance pools, or high risk pools.

(2) Individual or small group market reforms.

(3) Consumer education and outreach.

(4) Subsidies to individuals, employers, or both, in obtaining health insurance.

(b) SCOPE; DURATION.—The program shall be limited to not more than 10 States and to a total period of 5 years, beginning on the date the first demonstration grant is made.

(c) CONDITIONS FOR DEMONSTRATION GRANTS.—

(1) IN GENERAL.—The Secretary may not provide for a demonstration grant to a State under the program unless the Secretary finds that under the proposed demonstration grant—

(A) the State will provide for demonstrated increase of access for some portion of the existing uninsured population through a market innovation (other than merely through a financial expansion of a program initiated before the date of the enactment of this Act);

(B) the State will comply with applicable Federal laws;

(C) the State will not discriminate among participants on the basis of any health status-related factor (as defined in section 2791(d)(9) of the Public Health Service Act), except to the extent a State wishes to focus on populations that otherwise would not obtain health insurance because of such factors; and

(D) the State will provide for such evaluation, in coordination with the evaluation required under subsection (d), as the Secretary may specify.

(2) APPLICATION.—The Secretary shall not provide a demonstration grant under the program to a State unless—

(A) the State submits to the Secretary such an application, in such a form and manner, as the Secretary specifies;

(B) the application includes information regarding how the demonstration grant will address issues such as governance, targeted population, expected cost, and the continuation after the completion of the demonstration grant period; and

(B) the Secretary determines that the demonstration grant will be used consistent with this section.

(3) FOCUS.—A demonstration grant proposal under section need not cover all uninsured individuals in a State or all health care benefits with respect to such individuals.

(d) EVALUATION.—The Secretary shall enter into a contract with an appropriate entity outside the Department of Health and Human Services to conduct an overall evaluation of the program at the end of the program period. Such evaluation shall include an analysis of improvements in access, costs, quality of care, or choice of coverage, under different demonstration grants.

(e) OPTION TO PROVIDE FOR INITIAL PLANNING GRANTS.—Notwithstanding the previous provisions of this section, under the program the Secretary may provide for a portion of the amounts appropriated under subsection (f) (not to exceed \$5,000,000) to be made available to any State for initial planning grants to permit States to develop demonstration grant proposals under the previous provisions of this section.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated \$100,000,000 for each fiscal year to carry out this section. Amounts appropriated under this subsection shall remain available until expended.

(g) STATE DEFINED.—For purposes of this section, the term “State” has the meaning given such term for purposes of title XIX of the Social Security Act.

Mr. KENNEDY. Mr. President, I’m honored to join my colleagues in introducing the Bipartisan Patient Protection Act. This bill is a true bipartisan compromise, and I am confident it will receive the support of the majority of the Senate.

We believe that our proposal is just what the doctor ordered to end abuses by HMOs and managed care health plans. Doctors and patients should be making medical decisions, not insurance company accountants. It is long past time for Congress to start protecting patients, instead of HMO profits.

Prompt passage of this legislation is vital for the 161 million Americans with private health insurance coverage. This is the fifth year that Congress has considered patient protection—and too many patients have been subject to unacceptable abuses as the result of our inaction. Every day that Congress fails to act, more patients suffer.

A survey by the School of Public Health at the University of California found that every day—each and every day—50,000 patients experience added pain and suffering because of actions by their health plan. Thirty-five thousand patients have needed care delayed—or denied all together. Thirty-five thousand other patients have a referral to a specialist delayed or denied. Thirty-one thousand patients are forced to change their doctors. Eighteen thousand patients are forced to change their medications.

A survey of physicians by the Kaiser Family Foundation and the Harvard School of Public Health found similar results. Every day, tens of thousands of patients across the country suffer serious declines in their health as the result of the action—or inaction—of their health plan.

Whether the issue is diagnostic tests, specialty care, emergency care, access to clinical trials, availability of needed drugs, protection of doctors who give patients their best possible advice, or women’s ability to obtain gynecological services—too often, in all of these cases. HMOs and managed care plans treat the company’s bottom line as more important than the patient’s vital signs. These abuses have no place in American medicine. Every doctor knows it. Every patient knows it. And in their hearts, every member of Congress knows it.

Every American also knows that it is wrong for the current legal system to give immunity to health insurance companies and HMOs that kill or injure patients. No other industry in America has immunity from liability when it acts irresponsibly, and HMOs and health insurance companies shouldn’t have it either.

The legislation we are offering today is bipartisan. Whether the issue is liability, the appeals process, or state flexibility, we have made significant modifications to respond to legitimate concerns, but we have preserved the basic principle that when serious illness strikes, every American deserves the protection they were promised.

President Bush campaigned on a pledge to pass an effective patients’ bill of rights. We are ready to work with him to bring the American people the protection they deserve. Ending the current abuses should be a priority for the new Congress and the new Administration, and I am hopeful that we can work together to pass this legislation as soon as possible this year.

ADDITIONAL COSPONSORS

S. 29

At the request of Mr. BOND, the names of the Senator from Pennsylvania (Mr. SANTORUM) and the Senator from Connecticut (Mr. DODD) were added as cosponsors of S. 29, a bill to amend the Internal Revenue Code of 1986 to allow a deduction for 100 percent of the health insurance costs of self-employed individuals.

S. 31

At the request of Mr. CAMPBELL, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 31, a bill to amend the Internal Revenue Code of 1986 to phase out the estate and gift taxes over a 10-year period.

S. 41

At the request of Mr. HAGEL, the names of the Senator from California (Mrs. FEINSTEIN) and the Senator from North Dakota (Mr. DORGAN) were added