King, Sergeant Kendall Kitson, Jr., Airman First Class Christopher Lester, Airman First Class Brent Marthaler, Airman First Class Brian McVeigh, Airman First Class Peter Morgera, Sergeant Thanh Nguyen, Airman First Class Joseph Rimkus, Senior Airman Jeremy Taylor, Airman First Class Justin Wood, and Airman First Class Joshua Woody;

Whereas those guilty of this attack have yet to be brought to justice;

Whereas the families of these brave servicemen still mourn their loss and await the day when those guilty of this act are brought to justice; and

Whereas terrorism remains a constant and ever-present threat around the world: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That the Congress, on the occasion of the fifth anniversary of the terrorist bombing of the Khobar Towers in Saudi Arabia, recognizes the sacrifice of the 19 servicemen who died in that attack, and calls upon every American to pause and pay tribute to these brave soldiers and to remain ever vigilant for signs which may warn of a terrorist attack.

SENATE CONCURRENT RESOLUTION 56—EXPRESSING THE SENSE OF CONGRESS THAT A COMMEMORATIVE POSTAGE STAMP SHOULD BE ISSUED BY THE UNITED STATES POSTAL SERVICE HONORING THE MEMBERS OF THE ARMED FORCES WHO HAVE BEEN AWARDED THE PURPLE HEART

Ms. SNOWE submitted the following concurrent resolution; which was referred to the Committee on Governmental Affairs:

S. CON. RES. 56

Whereas the Order of the Purple Heart for Military Merit, commonly known as the Purple Heart, is the oldest military decoration in the world in present use;

Whereas the Purple Heart is awarded in the name of the President of the United States to members of the Armed Forces who are wounded in conflict with an enemy force or while held by an enemy force as a prisoner of war, and posthumously to the next of kin of members of the Armed Forces who are killed in conflict with an enemy force or who die of a wound received in conflict with an enemy force;

Whereas the Purple Heart was established on August 7, 1782, during the Revolutionary War, when General George Washington issued an order establishing the Honorary Badge of Distinction, otherwise known as the Badge of Military Merit or the Decoration of the Purple Heart;

Whereas the award of the Purple Heart ceased with the end of the Revolutionary War, but was revived out of respect for the memory and military achievements of George Washington in 1932, the year marking the 200th anniversary of his birth; and

Whereas the issuance of a postage stamp commemorating the members of the Armed Forces who have been awarded the Purple Heart is a fitting tribute both to those members and to the memory of George Washington: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring), That it is the sense of Congress that—

(1) the United States Postal Service should issue a postage stamp commemorating the members of the Armed Forces who have been awarded the Purple Heart; and

(2) the Citizens' Stamp Advisory Committee should recommend to the Postmaster General that such a stamp be issued not later than 1 year after the adoption of this resolution.

Ms. SNOWE. Mr. President. I rise today to submit a concurrent resolution to express the sense of Congress that a commemorative postage stamp should be issued by the United States Postal Service honoring the members of the Armed Forces that have been awarded the Purple Heart.

The Purple Heart, our nation's oldest military decoration, was originated by General George Washington in 1782 to recognize ''instances of unusual gallantry.'' Referred to then as the Badge of Military Merit, the decoration was awarded only three times during the Revolutionary War.

Following the war, the general order authorizing the ''Badge'' was misfiled for over 150 years until the War Department reactivated the decoration in 1932. The Army's then Adjutant General, Douglas MacArthur, succeeded in having the medal re-instituted in its modern form—to recognize the sacrifice our service members make when they go into harm's way.

Both literally and figuratively, the Purple Heart is the world's most costly decoration. However, the 19 separate steps necessary to make the medal pale in comparison to the actions and heroics that so often lead to its award. The Department of Defense does not track the number of Purple Hearts awarded, but we do know that just over 500,000 of the veterans and military personnel that have received the medal are still living. And we also know that every single recipient served this country in one form or another; a good number of the awardees even made the ultimate sacrifice—giving their lives for the liberty and freedoms that we all enjoy and often take for granted.

I am sure you will agree that these sacrifices deserve our respect and remembrance. This resolution, to express the sense of the Congress that a postage stamp honoring Purple Heart recipients should be issued by the U.S. Postal Service, is a fitting place to start. I urge my colleagues to support this effort to recognize those brave service members.

AMENDMENTS SUBMITTED AND PROPOSED

SA 813. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table.

SA 814. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 815. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 816. Mr. BOND proposed an amendment to the bill S. 1052, supra.

SA 817. Mr. ALLARD (for himself, Mr. BOND, Mr. SANTORUM, and Mr. NICKLES) proposed an amendment to the bill S. 1052, supra.

SA 818. Mr. KYL (for himself, Mr. NELSON of Nebraska, and Mr. NICKLES) proposed an amendment to the bill S. 1052, supra.

TEXT OF AMENDMENTS

SA 813. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

At the end of the bill, add the following

TITLE ____—HUMAN GERMLINE GENE MODIFICATION

SEC. 01. SHORT TITLE.

This title may be cited as the ''Human Germline Gene Modification Prohibition Act of 2001''.

SEC. 02. FINDINGS.

Congress makes the following findings:

(1) Human Germline gene modification is not needed to save lives, or alleviate suffering, of existing people. Its target population is ''prospective people'' who have not been conceived.

(2) The cultural impact of treating humans as biologically perfectible artifacts would be entirely negative. People who fall short of some technically achievable ideal would be seen as ''damaged goods'', while the standards for what is genetically desirable will be those of the society's economically and politically dominant groups. This will only increase prejudices and discrimination in a society where too many such prejudices already exist.

(3) There is no way to be accountable to those in future generations who are harmed or stigmatized by wrongful or unsuccessful human germline modifications of themselves or their ancestors.

(4) The negative effects of human germline manipulation would not be fully known for generations, if ever, meaning that countless people will have been exposed to harm probably often fatal as the result of only a few instances of germline manipulations.

(5) All people have the right to have been conceived, gestated, and born without genetic manipulation.

SEC. 03. PROHIBITION ON HUMAN GERMLINE GENE MODIFICATION.

(a) IN GENERAL.—Title 18, United States Code, is amended by inserting after chapter 15, the following:

''CHAPTER 16—GERMLINE GENE MODIFICATION

''§ 301. Definitions

''In this chapter:

(1) HUMAN GERMLINE GENE MODIFICATION.—The term 'human germline gene modification' means the introduction of DNA into any human cell (including human eggs, sperm, fertilized eggs, (ie. embryos, or any early cells that will differentiate into gametes or can be manipulated to do so) that can result in a change which can be passed on to future individuals, including DNA from any source, and in any form, such as nuclei, chromosomes, nuclear, mitochondrial, and synthetic DNA. The term does not include any modification of cells that are not a part

of or are not used to construct human embryos.

''(2) HUMAN HAPLOID CELL.—The term 'haploid cell' means a cell that contains only a single copy of each of the human chromosomes, such as eggs, sperm, and their precursors; the haploid number in a human cell is 23.

''(3) SOMATIC CELL.—The term 'somatic cell' means a diploid cell (having two sets of the chromosomes of almost all body cells) obtained or derived from a living or deceased human body at any stage of development; its diploid number is 46. Somatic cells are diploid cells that are not precursors of either eggs or sperm. A genetic modification of somatic cells is therefore not germline genetic modification.

''§ 302. Prohibition on germline gene modification

''(a) IN GENERAL.—It shall be unlawful for any person or entity, public or private, in or affecting interstate commerce—

''(1) to perform or attempt to perform human germline gene modification;

''(2) to participate in an attempt to perform human germline gene modification; or

''(3) to ship or receive the product of human germline gene modification for any purpose.

''(b) IMPORTATION.—It shall be unlawful for any person or entity, public or private, to import the product of human germline gene modification for any purpose.

''(c) PENALTIES—

''(1) IN GENERAL.—Any person or entity that is convicted of violating any provision of this section shall be fined under this section or imprisoned not more than 10 years, or both.

''(2) CIVIL PENALTY.—Any person or entity that is convicted of violating any provision of this section shall be subject to, in the case of a violation that involves the derivation of a pecuniary gain, a civil penalty of not less than $1,000,000 and not more than an amount equal to the amount of the gross gain multiplied by 2, if that amount is greater than $1,000,000.

(b) CLERICAL AMENDMENT.—The table of chapters for part I of title 18, United States Code, is amended by inserting after the item relating to chapter 15 the following:

''16. Germline Gene Modification ..... 301''.

SA 814. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

On page 179, after line 14, add the following:

SEC. ___. DEFINITION OF BORN-ALIVE INFANT.

(a) IN GENERAL.—Chapter 1 of title 1, United States Code, is amended by adding at the end the following:

''§ 8. 'Person', 'human being', 'child', and 'individual' as including born-alive infant

''(a) In determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the words 'person', 'human being', 'child', and 'individual', shall include every infant member of the species homo sapiens who is born alive at any stage of development.

''(b) As used in this section, the term 'born alive', with respect to a member of the species homo sapiens, means the complete expulsion or extraction from his or her mother of that member, at any stage of development, who after such expulsion or extraction breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, caesarean section, or induced abortion.

''(c) Nothing in this section shall be construed to affirm, deny, expand, or contract any legal status or legal right applicable to any member of the species homo sapiens at any point prior to being born alive as defined in this section.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 1 of title 1, United States Code, is amended by adding at the end the following new item:

''8. 'Person', 'human being', 'child', and 'individual' as including born-alive infant.''.

SA 815. Mr. SANTORUM submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

At the end, add the following:

TITLE ___—FAIR CARE FOR THE UNINSURED

Subtitle A—Refundable Credit for Health Insurance Coverage

SEC. ___01. REFUNDABLE CREDIT FOR HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by redesignating section 35 as section 36 and by inserting after section 34 the following new section:

''SEC. 35. HEALTH INSURANCE COSTS.

''(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle an amount equal to the amount paid during the taxable year for qualified health insurance for the taxpayer, his spouse, and dependents.

''(b) LIMITATIONS.—

''(1) IN GENERAL.—The amount allowed as a credit under subsection (a) to the taxpayer for the taxable year shall not exceed the sum of the monthly limitations for coverage months during such taxable year for each individual referred to in subsection (a) for whom the taxpayer paid during the taxable year any amount for coverage under qualified health insurance.

''(2) MONTHLY LIMITATION.—

''(A) IN GENERAL.—The monthly limitation for an individual for each coverage month of such individual during the taxable year is the amount equal to 1/12 of—

''(i) $1,000 if such individual is the taxpayer,

''(ii) $1,000 if—

''(I) such individual is the spouse of the taxpayer,

''(II) the taxpayer and such spouse are married as of the first day of such month, and

''(III) the taxpayer files a joint return for the taxable year, and

''(iii) $500 if such individual is an individual for whom a deduction under section 151(c) is allowable to the taxpayer for such taxable year.

''(B) LIMITATION TO 2 DEPENDENTS.—Not more than 2 individuals may be taken into account by the taxpayer under subparagraph (A)(iii).

''(C) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of an individual—

''(i) who is married (within the meaning of section 7703) as of the close of the taxable year but does not file a joint return for such year, and

''(ii) who does not live apart from such individual's spouse at all times during the taxable year,

the limitation imposed by subparagraph (B) shall be divided equally between the individual and the individual's spouse unless they agree on a different division.

''(3) COVERAGE MONTH.—For purposes of this subsection—

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

''(i) as of the first day of such month such individual is covered by qualified health insurance, and

''(ii) the premium for coverage under such insurance for such month is paid by the taxpayer.

''(B) EMPLOYER-SUBSIDIZED COVERAGE.—

''(i) IN GENERAL.—Such term shall not include any month for which such individual is eligible to participate in any subsidized health plan (within the meaning of section 162(l)(2)) maintained by any employer of the taxpayer or of the spouse of the taxpayer.

''(ii) PREMIUMS TO NONSUBSIDIZED PLANS.—If an employer of the taxpayer or the spouse of the taxpayer maintains a health plan which is not a subsidized health plan (as so defined) and which constitutes qualified health insurance, employee contributions to the plan shall be treated as amounts paid for qualified health insurance.

''(C) CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNT BENEFICIARIES.—Such term shall not include any month during a taxable year if any amount is not includible in the gross income of the taxpayer for such year under section 106 with respect to—

''(i) a benefit chosen under a cafeteria plan (as defined in section 125(d)), or

''(ii) a benefit provided under a flexible spending or similar arrangement.

''(D) MEDICARE AND MEDICAID.—Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual—

''(i) is entitled to any benefits under title XVIII of the Social Security Act, or

''(ii) is a participant in the program under title XIX or XXI of such Act.

''(E) CERTAIN OTHER COVERAGE.—Such term shall not include any month during a taxable year with respect to an individual if, at any time during such year, any benefit is provided to such individual under—

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

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

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

''(iv) any medical care program under the Indian Health Care Improvement Act.

''(F) PRISONERS.—Such term shall not include any month with respect to an individual if, as of the first day of such month, such individual is imprisoned under Federal, State, or local authority.

''(G) INSUFFICIENT PRESENCE IN UNITED STATES.—Such term shall not include any month during a taxable year with respect to an individual if such individual is present in the United States on fewer than 183 days during such year (determined in accordance with section 7701(b)(7)).

''(4) COORDINATION WITH DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—In the case of a taxpayer who is eligible to deduct any amount under section 162(l) for the taxable year, this section

shall apply only if the taxpayer elects not to claim any amount as a deduction under such section for such year.

''(c) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified health insurance' means insurance which constitutes medical care as defined in section 213(d) without regard to—

''(A) paragraph (1)(C) thereof, and

''(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance contracts.

''(2) EXCLUSION OF CERTAIN OTHER CONTRACTS.—Such term shall not include insurance if a substantial portion of its benefits are excepted benefits (as defined in section 9832(c)).

''(d) ARCHER MSA CONTRIBUTIONS.—

''(1) IN GENERAL.—If a deduction would (but for paragraph (2)) be allowed under section 220 to the taxpayer for a payment for the taxable year to the Archer MSA of an individual, subsection (a) shall be applied by treating such payment as a payment for qualified health insurance for such individual.

''(2) DENIAL OF DOUBLE BENEFIT.—No deduction shall be allowed under section 220 for that portion of the payments otherwise allowable as a deduction under section 220 for the taxable year which is equal to the amount of credit allowed for such taxable year by reason of this subsection.

''(e) SPECIAL RULES.—

''(1) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—The amount which would (but for this paragraph) be taken into account by the taxpayer under section 213 for the taxable year shall be reduced by the credit (if any) allowed by this section to the taxpayer for such year.

''(2) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(3) INFLATION ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 2002, each dollar amount contained in subsection (b)(2)(A) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

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

Any increase determined under the preceding sentence shall be rounded to the nearest multiple of $50 ($25 in the case of the dollar amount in subsection (b)(2)(A)(iii)).''

(b) INFORMATION REPORTING.—

(1) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 of such Code (relating to information concerning transactions with other persons) is amended by inserting after section 6050S the following new section:

''SEC. 6050T. RETURNS RELATING TO PAYMENTS FOR QUALIFIED HEALTH INSURANCE.

''(a) IN GENERAL.—Any person who, in connection with a trade or business conducted by such person, receives payments during any calendar year from any individual for coverage of such individual or any other individual under creditable health insurance, shall make the return described in subsection (b) (at such time as the Secretary may by regulations prescribe) with respect to each individual from whom such payments were received.

''(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

''(1) is in such form as the Secretary may prescribe, and

''(2) contains—

''(A) the name, address, and TIN of the individual from whom payments described in subsection (a) were received,

''(B) the name, address, and TIN of each individual who was provided by such person with coverage under creditable health insurance by reason of such payments and the period of such coverage, and

''(C) such other information as the Secretary may reasonably prescribe.

''(c) CREDITABLE HEALTH INSURANCE.—For purposes of this section, the term 'creditable health insurance' means qualified health insurance (as defined in section 35(c)) other than—

''(1) insurance under a subsidized group health plan maintained by an employer, or

''(2) to the extent provided in regulations prescribed by the Secretary, any other insurance covering an individual if no credit is allowable under section 35 with respect to such coverage.

''(d) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required under subsection (b)(2)(A) to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person,

''(2) the aggregate amount of payments described in subsection (a) received by the person required to make such return from the individual to whom the statement is required to be furnished, and

''(3) the information required under subsection (b)(2)(B) with respect to such payments.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.

''(e) RETURNS WHICH WOULD BE REQUIRED TO BE MADE BY 2 OR MORE PERSONS.—Except to the extent provided in regulations prescribed by the Secretary, in the case of any amount received by any person on behalf of another person, only the person first receiving such amount shall be required to make the return under subsection (a).''.

(2) ASSESSABLE PENALTIES.—

(A) Subparagraph (B) of section 6724(d)(1) of such Code (relating to definitions) is amended by redesignating clauses (xi) through (xvii) as clauses (xii) through (xviii), respectively, and by inserting after clause (x) the following new clause:

''(xi) section 6050T (relating to returns relating to payments for qualified health insurance),''.

(B) Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of the next to last subparagraph, by striking the period at the end of the last subparagraph and inserting '', or'', and by adding at the end the following new subparagraph:

''(BB) section 6050T(d) (relating to returns relating to payments for qualified health insurance).''.

(3) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to section 6050S the following new item:

''Sec. 6050T. Returns relating to payments for qualified health insurance.''.

(c) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting before the period '', or from section 35 of such Code''.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of such Code is amended by striking the last item and inserting the following new items:

''Sec. 35. Health insurance costs.

''Sec. 36. Overpayments of taxes.''.

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

SEC. ___02. ADVANCE PAYMENT OF CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.

(a) IN GENERAL.—Chapter 77 of the Internal Revenue Code of 1986 (relating to miscellaneous provisions) is amended by adding at the end the following new section:

''SEC. 7527. ADVANCE PAYMENT OF HEALTH INSURANCE CREDIT FOR PURCHASERS OF QUALIFIED HEALTH INSURANCE.

''(a) GENERAL RULE.—In the case of an eligible individual, the Secretary shall make payments to the provider of such individual's qualified health insurance equal to such individual's qualified health insurance credit advance amount with respect to such provider.

''(b) ELIGIBLE INDIVIDUAL.—For purposes of this section, the term 'eligible individual' means any individual—

''(1) who purchases qualified health insurance (as defined in section 35(c)), and

''(2) for whom a qualified health insurance credit eligibility certificate is in effect.

''(c) QUALIFIED HEALTH INSURANCE CREDIT ELIGIBILITY CERTIFICATE.—For purposes of this section, a qualified health insurance credit eligibility certificate is a statement furnished by an individual to the Secretary which—

''(1) certifies that the individual will be eligible to receive the credit provided by section 35 for the taxable year,

''(2) estimates the amount of such credit for such taxable year, and

''(3) provides such other information as the Secretary may require for purposes of this section.

''(d) QUALIFIED HEALTH INSURANCE CREDIT ADVANCE AMOUNT.—For purposes of this section, the term 'qualified health insurance credit advance amount' means, with respect to any provider of qualified health insurance, the Secretary's estimate of the amount of credit allowable under section 35 to the individual for the taxable year which is attributable to the insurance provided to the individual by such provider.

''(e) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this section.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 77 of such Code is amended by adding at the end the following new item:

''Sec. 7527. Advance payment of health insurance credit for purchasers of qualified health insurance.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2002.

Subtitle B—Assuring Health Insurance Coverage for Uninsurable Individuals

SEC. ___11. ESTABLISHMENT OF HEALTH INSURANCE SAFETY NETS.

(a) IN GENERAL.—

(1) REQUIREMENT.—For years beginning with 2002, each health insurer, health maintenance organization, and health service organization shall be a participant in a health

insurance safety net (in this subtitle referred to as a ''safety net'') established by the State in which it operates.

(2) FUNCTIONS.—Any safety net shall assure, in accordance with this subtitle, the availability of qualified health insurance coverage to uninsurable individuals.

(3) FUNDING.—Any safety net shall be funded by an assessment against health insurers, health service organizations, and health maintenance organizations on a pro rata basis of premiums collected in the State in which the safety net operates. The costs of the assessment may be added by a health insurer, health service organization, or health maintenance organization to the costs of its health insurance or health coverage provided in the State.

(4) GUARANTEED RENEWABLE.—Coverage under a safety net shall be guaranteed renewable except for nonpayment of premiums, material misrepresentation, fraud, medicare eligibility under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), loss of dependent status, or eligibility for other health insurance coverage.

(5) COMPLIANCE WITH NAIC MODEL ACT.—In the case of a State that has not established, as of the date of the enactment of this Act, a high risk pool or other comprehensive health insurance program that assures the availability of qualified health insurance coverage to all eligible individuals residing in the State, a safety net shall be established in accordance with the requirements of the ''Model Health Plan For Uninsurable Individuals Act'' (or the successor model Act), as adopted by the National Association of Insurance Commissioners and as in effect on the date of the safety net's establishment.

(b) DEADLINE.—Safety nets required under subsection (a) shall be established not later than January 1, 2002.

(c) WAIVER.—This subtitle shall not apply in the case of insurers and organizations operating in a State if the State has established a similar comprehensive health insurance program that assures the availability of qualified health insurance coverage to all eligible individuals residing in the State.

(d) RECOMMENDATION FOR COMPLIANCE REQUIREMENT.—Not later than January 1, 2003, the Secretary of Health and Human Services shall submit to Congress a recommendation on appropriate sanctions for States that fail to meet the requirement of subsection (a).

SEC. ___12. UNINSURABLE INDIVIDUALS ELIGIBLE FOR COVERAGE.

(a) UNINSURABLE AND ELIGIBLE INDIVIDUAL DEFINED.—In this subtitle:

(1) UNINSURABLE INDIVIDUAL.—The term ''uninsurable individual'' means, with respect to a State, an eligible individual who presents proof of uninsurability by a private insurer in accordance with subsection (b) or proof of a condition previously recognized as uninsurable by the State.

(2) ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—The term ''eligible individual'' means, with respect to a State, a citizen or national of the United States (or an alien lawfully admitted for permanent residence) who is a resident of the State for at least 90 days and includes any dependent (as defined for purposes of the Internal Revenue Code of 1986) of such a citizen, national, or alien who also is such a resident.

(B) EXCEPTION.—An individual is not an ''eligible individual'' if the individual—

(i) is covered by or eligible for benefits under a State medicaid plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.),

(ii) has voluntarily terminated safety net coverage within the past 6 months,

(iii) has received the maximum benefit payable under the safety net,

(iv) is an inmate in a public institution, or

(v) is eligible for other public or private health care programs (including programs that pay for directly, or reimburse, otherwise eligible individuals with premiums charged for safety net coverage).

(b) PROOF OF UNINSURABILITY.—

(1) IN GENERAL.—The proof of uninsurability for an individual shall be in the form of—

(A) a notice of rejection or refusal to issue substantially similar health insurance for health reasons by one insurer; or

(B) a notice of refusal by an insurer to issue substantially similar health insurance except at a rate in excess of the rate applicable to the individual under the safety net plan.

For purposes of this paragraph, the term ''health insurance'' does not include insurance consisting only of stoploss, excess of loss, or reinsurance coverage.

(2) EXCEPTION FOR INDIVIDUALS WITH UNINSURABLE CONDITIONS.—The State shall promulgate a list of medical or health conditions for which an individual shall be eligible for safety net plan coverage without applying for health insurance or establishing proof of uninsurability under paragraph (1). Individuals who can demonstrate the existence or history of any medical or health conditions on such list shall not be required to provide the proof described in paragraph (1). The list shall be effective on the first day of the operation of the safety net plan and may be amended from time to time as may be appropriate.

SEC. ___13. QUALIFIED HEALTH INSURANCE COVERAGE UNDER SAFETY NET.

In this subtitle, the term ''qualified health insurance coverage'' means, with respect to a State, health insurance coverage that provides benefits typical of major medical insurance available in the individual health insurance market in such State.

SEC. ___14. FUNDING OF SAFETY NET.

(a) LIMITATIONS ON PREMIUMS.—

(1) IN GENERAL.—The premium established under a safety net may not exceed 125 percent of the applicable standard risk rate, except as provided in paragraph (2).

(2) SURCHARGE FOR AVOIDABLE HEALTH RISKS.—A safety net may impose a surcharge on premiums for individuals with avoidable high risks, such as smoking.

(b) ADDITIONAL FUNDING.—A safety net shall provide for additional funding through an assessment on all health insurers, health service organizations, and health maintenance organizations in the State through a nonprofit association consisting of all such insurers and organizations doing business in the State on an equitable and pro rata basis consistent with section ___11.

SEC. ___15. ADMINISTRATION.

A safety net in a State shall be administered through a contract with 1 or more insurers or third party administrators operating in the State.

SEC. ___16. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated such sums as may be necessary to reimburse States for their costs in administering this subtitle.

SA 816. Mr. BOND proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 179, after line 14, add the following:

SEC. ___. ANNUAL REVIEW.

(a) IN GENERAL.—Not later than 24 months after the general effective date referred to in section 401(a)(1), and annually thereafter for each of the succeeding 4 calendar years (or until a repeal is effective under subsection (b)), the Secretary of Health and Human Services shall request that the Institute of Medicine of the National Academy of Sciences prepare and submit to the appropriate committees of Congress a report concerning the impact of this Act, and the amendments made by this Act, on the number of individuals in the United States with health insurance coverage.

(b) LIMITATION WITH RESPECT TO CERTAIN PLANS.—If the Secretary, in any report submitted under subsection (a), determines that more than 1,000,000 individuals in the United States have lost their health insurance coverage as a result of the enactment of this Act, as compared to the number of individuals with health insurance coverage in the 12-month period preceding the date of enactment of this Act, section 302 of this Act shall be repealed effective on the date that is 12 month after the date on which the report is submitted, and the submission of any further reports under subsection (a) shall not be required.

(c) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 2003 and 2004, the Secretary of Health and Human Services shall provide for such funding as the Secretary determines necessary for the conduct of the study of the National Academy of Sciences under this section.

SA 817. Mr. ALLARD (for himself, Mr. BOND, Mr. SANTORUM, and Mr. NICKLES) proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 148, between lines 23 and 24, insert the following:

''(D) EXCLUSION OF SMALL EMPLOYERS.—

''(i) IN GENERAL.—Notwithstanding any other provision of this paragraph, in addition to excluding certain physicians, other health care professionals, and certain hospitals from liability under paragraph (1), paragraph (1)(A) does not create any liability on the part of a small employer (or on the part of an employee of such an employer acting within the scope of employment).

''(ii) DEFINITION.—In clause (i), the term 'small employer' means an employer—

''(I) that, during the calendar year preceding the calendar year for which a determination under this subparagraph is being made, employed an average of at least 2 but not more than 50 employees on business days; and

''(II) maintaining the plan involved that is acting, serving, or functioning as a fiduciary, trustee or plan administrator, including—

''(aa) a small employer described in section 3(16)(B)(i) with respect to a plan maintained by a single employer; and

''(bb) one or more small employers or employee organizations described in section 3(16)(B)(iii) in the case of a multi-employer plan.

''(iii) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subparagraph:

''(I) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

''(II) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the

preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

''(III) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

On page 165, between lines 14 and 15, insert the following:

''(D) EXCLUSION OF SMALL EMPLOYERS.—

''(i) IN GENERAL.—Notwithstanding any other provision of this paragraph, in addition to excluding certain physicians, other health care professionals, and certain hospitals from liability under paragraph (1), paragraph (1)(A) does not create any liability on the part of a small employer (or on the part of an employee of such an employer acting within the scope of employment).

''(ii) DEFINITION.—In clause (i), the term 'small employer' means an employer—

''(I) that, during the calendar year preceding the calendar year for which a determination under this subparagraph is being made, employed an average of at least 2 but not more than 50 employees on business days; and

''(II) maintaining the plan involved that is acting, serving, or functioning as a fiduciary, trustee or plan administrator, including—

''(aa) a small employer described in section 3(16)(B)(i) with respect to a plan maintained by a single employer; and

''(bb) one or more small employers or employee organizations described in section 3(16)(B)(iii) in the case of a multi-employer plan.

''(iii) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subparagraph:

''(I) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

''(II) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

''(III) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

SA 818. Mr. KYL (for himself, Mr. NELSON of Nebraska, and Mr. NICKLES) proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

Beginning on page 35, strike line 20 and all that follows through line 8 on page 36, and insert the following:

(C) NO COVERAGE FOR EXCLUDED BENEFITS.—Nothing in this subsection shall be construed to permit an independent medical reviewer to require that a group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, provide coverage for items or services that are specifically excluded or expressly limited under the plan or coverage and that are disclosed under subparagraphs (C) and (D) of section 121(b)(1) and that are not covered regardless of any determination relating to medical necessity and appropriateness, experimental or investigational nature of the treatment, or an evaluation of the medical facts in the case involved.

On page 37, line 16, strike ''and''.

On page 37, line 25, strike the period and insert ''; and''.

On page 37, after line 25, add the following:

''(iii) notwithstanding clause (ii), adhere to the definition used by the plan or issuer of 'medically necessary and appropriate', or 'experimental or investigational' if such definition is the same as either—

''(I) in the case of a plan or coverage that is offered in a State that requires the plan or coverage to use a definition of such term for purposes of health insurance coverage offered to participants, beneficiaries and enrollees in such State, the definition of such term that is required by that State;

''(II) a definition that determines whether the provision of services, drugs, supplies, or equipment—

''(aa) is appropriate to prevent, diagnose, or treat the condition, illness, or injury;

''(bb) is consistent with standards of good medical practice in the United States;

''(cc) is not primarily for the personal comfort or convenience of the patient, the family, or the provider;

''(dd) is not part of or associated with scholastic education or the vocational training of the patient; and

''(ee) in the case of inpatient care, cannot be provided safely on an outpatient basis;

except that this subclause shall not apply beginning on the date that is 1 year after the date on which a definition is promulgated based on a report that is published under subsection (i)(6)(B); or

''(III) the definition of such term that is developed through a negotiated rulemaking process pursuant to subsection (i).

On page 66, between lines 10 and 11, insert the following:

''(i) ESTABLISHMENT OF NEGOTIATED RULEMAKING SAFE HARBOR.—

''(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards described in subsection (d)(3)(E)(iii)(IV) (relating to the definition of 'medically necessary and appropriate' or 'experimental or investigational') that group health plans and health insurance issuers offering health insurance coverage in connection with group health plans may use when making a determination with respect to a claim for benefits.

''(2) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under paragraph (1), the Secretary shall, not later than November 30, 2002, publish a notice of the establishment of a negotiated rulemaking committee, as provided for under section 564(a) of title 5, United States Code, to develop the standards described in paragraph (1). Such notice shall include a solicitation for public comment on the committee and description of—

''(A) the scope of the committee;

''(B) the interests that may be impacted by the standards;

''(C) the proposed membership of the committee;

''(D) the proposed meeting schedule of the committee; and

''(E) the procedure under which an individual may apply for membership on the committee.

''(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice described in paragraph (2), and for purposes of this subsection, the term 'target date for publication' (as referred to in section 564(a)(5) of title 5, United States Code, means May 15, 2003.

''(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—Notwithstanding section 564(c) of title 5, United States Code, the Secretary shall provide for a period, beginning on the date on which the notice is published under paragraph (2) and ending on December 14, 2002, for the submission of public comments on the committee under this subsection.

''(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall carry out the following:

''(A) APPOINTMENT OF COMMITTEE.—Not later than January 10, 2003, appoint the members of the negotiated rulemaking committee under this subsection.

''(B) FACILITATOR.—Not later than January 21, 2002, provide for the nomination of a facilitator under section 566(c) of title 5, United States Code, to carry out the activities described in subsection (d) of such section.

''(C) MEMBERSHIP.—Ensure that the membership of the negotiated rulemaking committee includes at least one individual representing—

''(i) health care consumers;

''(ii) small employers;

''(iii) large employers;

''(iv) physicians;

''(v) hospitals;

''(vi) other health care providers;

''(vii) health insurance issuers;

''(viii) State insurance regulators;

''(ix) health maintenance organizations;

''(x) third-party administrators;

''(xi) the medicare program under title XVIII of the Social Security Act;

''(xii) the medicaid program under title XIX of the Social Security Act;

''(xiii) the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code;

''(xiv) the Department of Defense;

''(xv) the Department of Veterans' Affairs; and

''(xvi) the Agency for Healthcare Research and Quality.

''(6) FINAL COMMITTEE REPORT.—

''(A) IN GENERAL.—Not later than 1 year after the general effective date referred to in section 401, the committee shall submit to the Secretary a report containing a proposed rule.

''(B) PUBLICATION OF RULE.—If the Secretary receives a report under subparagraph (A), the Secretary shall provide for the publication in the Federal Register, by not later than the date that is 30 days after the date on which such report is received, of the proposed rule.

''(7) FAILURE TO REPORT.—If the committee fails to submit a report as provided for in paragraph (6)(A), the Secretary may promulgate a rule to establish the standards described in subsection (d)(3)(E)(iii)(IV) (relating to the definition of 'medically necessary and appropriate' or 'experimental or investigational') that group health plans and health insurance issuers offering health insurance coverage in connection with group health plans may use when making a determination with respect to a claim for benefits.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. KENNEDY. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on June 26, 2001, to conduct a hearing on