TEXT OF AMENDMENTS

**SA 819.** Mr. THOMPSON 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 150, strike line 17 and all that follows through page 153, line 8, and insert the following:

''(9) REQUIREMENT OF EXHAUSTION.—

''(A) IN GENERAL.—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) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) or paragraph (10)(B), with respect to a participant or beneficiary, unless the requirements of subparagraph (A) are met.

''(C) 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.

''(D) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 103 of the Bipartisan Patient Protection Act of 2001 shall be admissible in any Federal court proceeding and shall be presented to the trier of fact.

On page 165, strike line 15 and all that follows through page 168, line 3, and insert the following:

''(4) REQUIREMENT OF EXHAUSTION.—

''(A) IN GENERAL.—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, 103, and 104 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

''(B) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available as a result of, or arising under, paragraph (1)(A) unless the requirements of subparagraph (A) are met.

''(C) 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.

''(D) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 104 of the Bipartisan Patient Protection Act of 2001 shall be admissible in any Federal or State court proceeding and shall be presented to the trier of fact.

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**SA 820.** Mr. MCCAIN (for himself, Mr. BAYH, Mr. CARPER, and Mr. EDWARDS) 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 36 line 5, strike ''except'' and all that follows through ''(2)'' on line 8.

On page 62, between lines 10 and 11, insert the following:

(V) Compliance with the requirement of subsection (d)(1) that only medically reviewable decisions shall be the subject of independent medical review and with the requirement of subsection (d)(3) that independent medical reviewers may not require coverage for specifically excluded benefits.

On page 62, line 20, after the period insert the following: ''The Secretary, or organization, shall revoke a certification or deny a recertification with respect to an entity if there is a showing that the entity has a pattern or practice of ordering coverage for benefits that are specifically excluded under the plan or coverage.''.

On page 62, between lines 20 and 21, insert the following:

(vii) PETITION FOR DENIAL OR WITHDRAWAL.—An individual may petition the Secretary, or an organization providing the certification involves, for a denial of recertification or a withdrawal of a certification with respect to an entity under this subparagraph if there is a pattern or practice of such entity failing to meet a requirement of this section.

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

(5) REPORT.—Not later than 12 months after the general effective date referred to in section 401, the General Accounting Office shall prepare and submit to the appropriate committees of Congress a report concerning—

(A) the information that is provided under paragraph (3)(D);

(B) the number of denials that have been upheld by independent medical reviewers and the number of denials that have been reversed by such reviewers; and

(C) the extent to which independent medical reviewers are requiring coverage for benefits that are specifically excluded under the plan or coverage.

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**SA 821.** Mr. ALLARD 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 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 15 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 15 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.''

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**SA 822.** Mr. ALLARD 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:

**SEC. . TEN-YEAR EXTENSION OF MEDICARE COST CONTRACTS.**

Section 1876(h)(5)(C) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)), as redesignated by section 634(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–568), as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by striking ''2004'' and inserting ''2014''.

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**SA 823.** Mr. ALLARD 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:

**SEC. . NINE-YEAR EXTENSION OF MEDICARE COST CONTRACTS**

Section 1876(h)(5)(C) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)), as redesignated by section 634(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–568), as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by striking ''2004'' and inserting ''2013''.

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**SA 824.** Mr. ALLARD 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:

**SEC. . NINE-YEAR EXTENSION OF MEDICARE COST CONTRACTS**

Section 1876(h)(5)(C) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)), as redesignated by section 634(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–568), as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by striking ''2004'' and inserting ''2012''.

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**SA 825.** Mr. ALLARD 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:

**SEC. . SEVEN-YEAR EXTENSION OF MEDICARE COST CONTRACTS.**

Section 1876(h)(5)(C) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)), as redesignated by section 634(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–568), as enacted into law by section 1(a)(6) of Public Law 106–554), is amended by striking ''2004'' and inserting ''2011''.

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**SA 826.** Ms. COLLINS (for herself, Mr. NELSON of Nebraska, Mr. ENZI, Mr. VOINOVICH, Mr. HUTCHINSON, and Mr. ROBERTS) 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 122, strike line 19 and all that follows through line 16 on page 129, and insert the following:

**SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.**

(a) GENERAL RULE.—

(1) NO PREEMPTION.—

(A) IN GENERAL.—Subject to paragraph (2), nothing in subtitles B, C or D shall be construed to preempt or supersede any provision of State law that is enacted prior to the effective date that establishes, implements, or continues in effect any standard or requirement relating to health insurance issuers (in connection with group health insurance coverage or otherwise) and non-Federal governmental plans with respect to a patient protection requirement.

(B) NOTIFICATION.—Subparagraph (A) shall apply to a State that has, by not later than the effective date, submitted a notice to the Secretary of the existence of a State law described in such subparagraph.

(2) APPEALS.—Subtitle A 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 individual health insurance coverage and to non-Federal governmental plans except to the extent that such standard or requirement prevents the application of a requirement of such subtitle.

(3) 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 (29 U.S.C. 1144) with respect to group health plans.

(b) STATE CERTIFICATION.—

(1) IN GENERAL.—Effective beginning on the effective date, a State shall submit to the Secretary a certification that—

(A) the State has enacted one or more State laws or regulations that are consistent with the purposes of the patient protection requirements of this title, with respect to health insurance coverage that is issued in the State, including group coverage, individual coverage, and coverage under non-Federal governmental plans;

(B) the State has not enacted a law described in subparagraph (A) because of the adverse impact that such a law would have on premiums paid for health care coverage in the State and the adverse impact that such increases in premiums would have on the number of individuals in the State with health insurance coverage; or

(C) the State has not enacted a law described in subparagraph (A) because the existence of a managed care market in the State is negligible.

(2) RECEIPT AND REVIEW BY SECRETARY.—

(A) IN GENERAL.—The Secretary shall—

(i) promptly review a certification submitted under paragraph (1); and

(ii) approve the certification unless the Secretary finds that there is no rational basis for such approval.

(B) APPROVAL DEADLINES.—

(i) INITIAL REVIEW.—A certification under paragraph (1) is considered approved unless the Secretary notifies the State in writing, within 90 days after the date of receipt of the certification—

(I) that the certification is disapproved because there is no rational basis for the certification;

(II) with respect to a certification described in paragraph (1)(A), that the Secretary determined that the State law does not provide for patient protections that are consistent with the purposes of the patient protection requirement to which the law relates; or

(III) that specified additional information is needed.

A notice under this clause shall include an explanation of the basis for the determination of the Secretary and shall identify specific deficiencies in the State certification.

(ii) ADDITIONAL INFORMATION.—With respect to a State that has been notified by the Secretary under clause (i)(III) that specified additional information is needed, the Secretary shall make a determination with respect to such certification within 60 days after the date on which such specified additional information is received by the Secretary.

(C) APPROVAL FOR FAILURE TO MEET DEADLINE.—If the Secretary fails to meet the deadline applicable under subparagraph (B) with respect to a State certification, the certification shall be deemed to be approved.

(D) 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.

(3) CERTIFICATION OF ALL OR SELECTIVE PROTECTIONS.—A certification under this subsection may be submitted with respect to all patient protection requirements or selective requirements.

(4) TERMINATION OF CERTIFICATION.—

(A) IN GENERAL.—The Secretary, not more frequently than once every 5 years, may request that a State with respect to which a certification has been approved under this subsection, submit an assurance to the Secretary that with respect to a certification, the assurances contained in the certification are still applicable with respect to the State.

(B) TERMINATION.—If a State fails to submit an assurance to the Secretary under subparagraph (A) within the 60-day period beginning on the date on which the Secretary makes a request for such an assurance, the certification applicable to the State under this section shall terminate.

(5) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a State from submitting more than one certification under paragraph (1).

(c) EFFECT OF CERTIFICATION.—

(1) IN GENERAL.—A State that has submitted—

(A) a notice under subsection (a)(1)(B); or

(B) a certification that has been approved by the Secretary under subsection (b);

with respect to all of the patient protection requirements shall be eligible to receive a grant under subsection (d).

(2) EFFECT OF TERMINATION.—A State that has a certification terminated under subsection (b)(4) shall not be eligible to receive grant funds under subsection (d) until such time as the State has a new certification in effect.

(3) RULE OF CONSTRUCTION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), nothing in this Act shall be construed to apply any patient protection requirement in a State unless the State enacts a State law with respect to such application.

(B) SELF-INSURED PLANS.—Notwithstanding this section, the patient protection requirements of this Act shall apply to self-insured group health plans as provided for under section 714 of the Employee Retirement Income Security Act.

(d) PATIENT QUALITY ENHANCEMENT GRANTS.—

(1) IN GENERAL.—Beginning on the effective date, the Secretary shall award grants to eligible States to enable such States to carry out activities to promote high quality health care.

(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, a State shall—

(A) be a State described in subsection (c)(1); and

(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(3) USE OF FUNDS.—A State may use amounts awarded under a grant under this subsection to carry out activities to promote increased health care quality, educate consumers on health care products, provide health care coverage, improve patient safety, carry out enforcement activities with respect to compliance with State patient protection laws, and carry out other activities determined appropriate by the Secretary.

(4) FORMULA.—The Secretary shall determine the amount of each grant based on the population of the State relative to other eligible States.

(5) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $500,000,000 for fiscal year 2002, and such sums as may be necessary for each subsequent fiscal year.

(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a State with a certification that has been approved under subsection (b) from amending or otherwise modifying State laws or regulations that the approval was based upon.

(f) LIMITATION ON DELEGATION OF FUNCTIONS.—The Secretary may not delegate the duties and authority provided to the Secretary under this section to the Center for Medicare and Medicaid Services.

(g) NONAPPLICABILITY OF PROVISIONS.—Nothing in this section shall be construed to apply the patient protection requirements to States except as specifically provided for in this section.

(h) DEFINITIONS.—In this section:

(1) EFFECTIVE DATE.—The term ''effective date'' means October 1, 2002.

(2) PATIENT PROTECTION REQUIREMENT.—The term ''patient protection requirement'' means any one or more of the following requirements:

(A) Section 111 (relating to consumer choice option) with respect to non-Federal governmental plans only.

(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 obstetric 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 stays).

(K) Section 121 (relating to access to information).

(L) A prohibition under—

(i) section 131 (relating to prohibition of interference with certain medical communications);

(ii) section 132 (relating to prohibition of discrimination against providers based on licensure); and

(iii) section 133 (relating to prohibition against improper incentive arrangements.)

(M) Section 134 (relating to the payment of claims).

(N) Section 135 (relating to protection for patient advocacy).

(3) STATE, STATE LAW.—The terms ''State'' and ''State law'' shall have the meanings given such terms in section 2723(d) of the Public Health Service Act (42 U.S.C. 300gg-23(d)).

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**SA 827.** Mr. DOMENICI 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 appropriate place in title V, insert the following:

**SEC. . RADIATION EXPOSURE COMPENSATION ACT.**

(a) IN GENERAL.—Section 3(e) of the Radiation Exposure Compensation Act (42 U.S.C. 2210 note) is amended—

(1) in the subsection heading by striking the first 2 words and inserting ''INDEFINITE''; and

(2) by striking ''authorized to be''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on October 1, 2001.

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**SA 828.** Mrs. HUTCHISON submitted an amendment intended to be proposed by her 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:

Beginning on page 98, strike line 2 and all that follows through line 21 on page 109, and insert the following:

**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;

(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; and

(iv) of information relating to the disenrollment of a participant, beneficiary, or enrollee or relating to the plan or issuer otherwise reducing coverage or benefits as described in clause (iii), in the form of a notice provided not later than 30 days before the date on which the disenrollment or 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) 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.

(c) ADDITIONAL INFORMATION.—The informational materials to be provided upon the request of a participant, beneficiary, or enrollee, as provided for under subsection (d), shall include for each option available under a group health plan or health insurance coverage the following:

(1) SERVICE AREA.—A description of the plan or issuer's service area, including the provision of any out-of-area coverage.

(2) 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, and the State licensure status of the providers and participating health care facilities, and, if available, the education, training, specialty qualifications or certifications of such professionals.

(3) 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.

(4) PREAUTHORIZATION REQUIREMENTS.—A description of the requirements and procedures to be used to obtain preauthorization for health services, if such preauthorization is required.

(5) 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.

(6) 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.

(7) CLINICAL TRIALS.—A description of 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.

(8) 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.

(9) 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.

(10) 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.

(11) ADVANCE DIRECTIVES AND ORGAN DONATION.—A description of procedures for advance directives and organ donation decisions if the plan or issuer maintains such procedures.

(12) 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.

(13) 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.

(14) 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.

(15) NOTICE OF REQUIREMENTS.—A description of any rights of participants, beneficiaries, and enrollees that are established by the Bipartisan Patient Protection Act (excluding those described in paragraphs (1) through (14)) 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.

(16) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, timeframes, and appeals rights) under any utilization review program under sections 101 and 102, including any drug formulary program under section 118.

(17) 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.—

(1) IN GENERAL.—The information described in this section shall be disclosed in an accessible medium and format that is calculated to be understood by a participant or enrollee.

(2) ADDITIONAL INFORMATION.—The information described in subsection (c) shall be made available and easily accessible, without cost, to participants, beneficiaries, or enrollees upon request. Such information shall be made available in writing and by electronic means (including the Internet) and in any other manner determined appropriate by the Secretary.

(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.

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**SA 829.** Mr. DEWINE 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 171, between lines 14 and 15, insert the following:

**SEC. 303. LIMITATION ON CERTAIN CLASS ACTION LITIGATION.**

Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 302, is further amended by adding at the end the following:

''(o) LIMITATION ON CLASS ACTION LITIGATION.—

''(1) IN GENERAL.—Any claim or cause of action that is maintained under this section in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative claimant, or the group of claimants is limited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such

class, such derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.''.

''(2) EFFECTIVE DATE.—This subsection shall apply to all civil actions that are filed on or after the date of enactment of the Bipartisan Patients' Bill of Rights Act of 2001.''.

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**SA 830.** Mr. BREAUX (for himself, Mr. JEFFORDS, Mr. KENNEDY, Mr. MCCAIN, and Mr. EDWARDS) 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 122, strike line 19 and all that follows through line 5 on page 128, and insert the following:

**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 COMPLIANT 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 substantially complies (within the meaning of subsection (c)) with 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 compliant 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) DEFINITIONS.—In this section:

(A) PATIENT PROTECTION REQUIREMENT.—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.

(B) SUBSTANTIALLY COMPLIANT.—The terms ''substantially compliant'', substantially complies'', or ''substantial compliance'' with respect to a State law, mean that the State law has the same or similar features as the patient protection requirements and has a similar effect.

(c) DETERMINATIONS OF SUBSTANTIAL COMPLIANCE.—

(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 compliant with 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 substantially complies with 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 substantially comply with 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.

(C) DEFERENCE TO STATES.—With respect to a certification submitted under paragraph (1), the Secretary shall give deference to the State's interpretation of the State law involved and the compliance of the law with a patient protection requirement.

(D) PUBLIC NOTIFICATION.—The Secretary shall—

(i) provide a State with a notice of the determination to approve or disapprove a certification under this paragraph;

(ii) promptly publish in the Federal Register a notice that a State has submitted a certification under paragraph (1);

(iii) promptly publish in the Federal Register the notice described in clause (i) with respect to the State; and

(iv) annually publish the status of all States with respect to certifications.

(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 compliance.

(5) PETITIONS.—

(A) PETITION PROCESS.—Effective on the date on which the provisions of this Act become effective, as provided for in section 401, a group health plan, health insurance issuer, participant, beneficiary, or enrollee may submit a petition to the Secretary for an advisory opinion as to whether or not a standard or requirement under a State law applicable to the plan, issuer, participant, beneficiary, or enrollee that is not the subject of a certification under this subsection, is superseded under subsection (a)(1) because such standard or requirement prevents the application of a requirement of this title.

(B) OPINION.—The Secretary shall issue an advisory opinion with respect to a petition submitted under subparagraph (A) within the 60-day period beginning on the date on which such petition is submitted.

(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.

On page 132, between lines 11 and 12, insert the following:

**SEC. 203. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.**

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.) is amended by adding at the end the following:

**''SEC. 2793. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.**

''(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of some or all of the Secretary's authority under this title to enforce the requirements applicable under title I of the Bipartisan Patient Protection Act 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.

''(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.''.

On page 137, lines 3 and 4, strike ''EQUIVALENT'' and insert ''COMPLIANT''.

On page 137, lines 9 and 10, strike ''is substantially equivalent'' and insert ''substantially complies''.

On page 137, line 11, strike ''to'' and insert ''with''.

On page 173, between lines 4 and 5, insert the following:

**SEC. 304. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.**

Subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191 et seq.) is amended by adding at the end the following new section:

**''SEC. 735. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.**

''(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of some or all of the Secretary's authority under this title to enforce the requirements applicable under title I of the Bipartisan Patient Protection Act 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.

''(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.''.

## AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Wednesday, June 27, 2001 at 10 a.m., in open session to consider the nominations of Dionel M. Aviles to be Assistant Secretary of the Navy (Financial Management and Comptroller); Reginald Jude Brown to be Assistant Secretary of the Army (Manpower and Reserve Affairs); Steven A. Cambone to be Deputy under Secretary of Defense for Policy; Michael Montelongo to be Assistant Secretary of the Air Force (Financial Management and Comptroller); and John J. Young, Jr. to be Assistant Secretary of the Navy (Research, Development and Acquisition).

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Wednesday, June 27 at 9:30 a.m. to conduct a hearing. The committee will consider the nominations of Vicky A. Bailey to be an Assistant Secretary of Energy (International Affairs and Domestic Policy), Frances P. Mainella to be Director of the National Park Service, and John Walton Keys, III, to be Commissioner of the Bureau of Reclamation.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FINANCE

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session of the Senate on Wednesday, June 27, 2001 to hear testimony on ''Prescription for Fraud: Consultants Selling Doctors Bad Billing Advice.''

The PRESIDING OFFICER. Without objection, it is ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Wednesday, June 27, 2001 at 9:45 a.m. to hold a nomination hearing as follows:

Nominees: Mr. Clark T. Randt, Jr., of Connecticut, to be Ambassador to the People's Republic of China.

Mr. Douglas Allan Hartwick, of Washington, to be Ambassador to the Lao People's Democratic Republic.

Charles J. Swindells, of Oregon, to be Ambassador to New Zealand, and to serve concurrently and without additional compensation as Ambassador to Samoa to be introduced by Hon. GORDON SMITH.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Wednesday, June 27, 2001 at approximately 11:15 a.m. to hold a nomination hearing as follows:

Nominees: Mr. Pierre-Richard Prosper, of California, to be Ambassador at Large for War Crimes Issues.

Mr. William A. Eaton, of Virginia, to be Assistant Secretary of State (Administration).

General Francis Xavier Taylor, of Maryland, to be Coordinator for Counterterrorism, with the rank of Ambassador at Large to be introduced by Hon. PAUL S. SARBANES.

Mr. Clark Kent Ervin, of Texas, to be Inspector General, Department of State to be introduced by Hon. PHIL GRAMM.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a markup on ''Protecting the Innocent: Ensuring Competent Counsel in Death Penalty Cases'' on Wednesday, June 27, 2001 at 10:00 a.m., in SD226. No witness list is available yet.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON RULES AND ADMINISTRATION

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Rules and Administration be authorized to meet during the session of the Senate on Wednesday, June 27, 2001, at 10:30 a.m., to receive testimony from the U.S. Commission on Civil Rights regarding its latest report on the November 2000 election and from other witnesses on election reform in general.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. DORGAN. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on Wednesday, June 27, 2001 at 2:30 p.m., to hold a hearing on intelligence matters.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON ECONOMIC POLICY

Mr. DORGAN. Mr. President, I ask unanimous consent that the Subcommittee on Economic Policy of the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on June 27, 2001 to conduct a hearing on ''The Reauthorization of the Defense Production Act.''

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT, RESTRUCTURING AND THE DISTRICT OF COLUMBIA

Mr. DORGAN. Mr. President, I ask unanimous consent that the Subcommittee on Oversight of Government Management, Restructuring and the District of Columbia of the Committee on Governmental Affairs be authorized to meet on Wednesday, June 27, 2001 at 10:00 a.m., for a hearing to examine ''Finding a Cure to Keep Nurses on the Job: The Federal Government's Role in Retaining Nurses for Delivery of Federally Funded Health Care Services.''

The PRESIDING OFFICER. Without objection, it is so ordered.

## ORDERS FOR THURSDAY, JUNE 28, 2001

Mr. REID. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until the hour of 9:15 a.m. on Thursday, June 28. I further ask consent that on Thursday, immediately following the prayer and the pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of the Patients' Bill of Rights.

The PRESIDING OFFICER. Without objection, it is so ordered.

## PROGRAM

Mr. REID. Mr. President, tomorrow the Senate will convene at 9:15 a.m. and resume consideration of the Patients' Bill of Rights. There will be 30 minutes of debate on the Collins and Breaux amendments regarding scope, with two rollcall votes beginning at approximately 9:45 a.m. Additional rollcall votes will occur throughout the day and into the evening.

The majority leader has told me it is his hope that we will complete this bill tomorrow rather than on Friday or Saturday. We have made great progress today. The minority manager, Senator GREGG, has done very good work. We have our managers—Senator MCCAIN, Senator KENNEDY, and Senator EDWARDS—who have done outstanding work. We have really made great headway. So the light at the end of the tunnel is there. It is up to us whether we take that opportunity to finish this.

Then there is the supplemental appropriations bill which needs to be