national parks, monuments, and recreational areas, and our association has members actively involved in providing transportation services at several national parks.

All of us know the danger that congestion and increases in traffic pose for the future of these sites and locations. Your continued sponsorship of the Transit in Parks Act is an important step in helping ensure that America's natural beauty and historic treasures remain a continuous part of our nation's future. We have members throughout the country whose experiences support the principle that public transit investments in and near national parks and public lands can improve mobility, support the economic vitality of these parks' ''gateway communities,'' and make dramatic improvements in the experiences of park visitors, employees, and community residents alike.

As an illustration of this point, enclosed is an article recently published in our Community Transportation magazine that discusses public transportation as part of the solution to traffic congestion and mobility issues in Acadia, Yosemite and Zion National Parks. These success stories could be replicated in many other communities under your Transit in Parks proposal.

We appreciate your dedicated efforts and initiative in this regard, and look forward to helping you advance this important piece of legislation.

Sincerely,

DALE J. MARSICO,
Executive Director.

AMENDMENTS SUBMITTED AND PROPOSED

SA 831. Mr. BOND (for himself, Mr. ROBERTS, and Mr. HELMS) 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.

SA 832. Mr. FRIST (for himself, Mr. BREAUX, and Mr. JEFFORDS) submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 833. Mr. WARNER proposed an amendment to the bill S. 1052, supra.

SA 834. Ms. SNOWE (for herself, Mrs. LINCOLN, Mr. DEWINE, Mr. NELSON, of Nebraska, Mr. SPECTER, Mr. MCCAIN, Mr. BAUCUS, Ms. STABENOW, and Mr. CHAFEE) proposed an amendment to the bill S. 1052, supra.

SA 835. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 836. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 837. Mr. BROWNBACK submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 838. Mrs. HUTCHISON submitted an amendment intended to be proposed by her to the bill S. 1052, supra; which was ordered to lie on the table.

SA 839. Mrs. HUTCHISON (for herself and Mrs. CLINTON) submitted an amendment intended to be proposed by her to the bill S. 1052, supra.

SA 840. Mr. ENZI proposed an amendment to the bill S. 1052, supra.

SA 841. 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 842. Mr. DEWINE submitted an amendment intended to be proposed by him to the bill S. 1052, supra.

SA 843. Mr. GRAMM (for himself and Mr. MCCAIN) proposed an amendment to the bill S. 1052, supra.

SA 844. Mr. SPECTER proposed an amendment to the bill S. 1052, supra.

SA 845. Mr. GRASSLEY proposed an amendment to the bill S. 1052, supra.

SA 846. Mr. NICKLES (for himself and Mr. ENSIGN) proposed an amendment to the bill S. 1052, supra.

SA 847. Mr. BROWNBACK proposed an amendment to the bill S. 1052, supra.

SA 848. Mr. ENSIGN proposed an amendment to the bill S. 1052, supra.

SA 849. Mr. ENSIGN proposed an amendment to the bill S. 1052, supra.

TEXT OF AMENDMENTS

SA 831. Mr. BOND (for himself, Mr. ROBERTS, and Mr. HELMS) 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 154, between lines 2 and 3, insert the following:

''(11) MINIMUM SHARE OF SETTLEMENT OF AWARD.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a participant or beneficiary (or the estate of such participant or beneficiary) shall receive not less than 85 percent of any award made as a result of a cause of action brought by the participant or beneficiary (or estate) under this subsection, after subtracting the amount of any attorneys' fees from the total amount of such award.

''(B) EXCEPTION.—This paragraph shall not apply where the amount awarded as a result of a cause of action brought by a participant or beneficiary (or estate) under this subsection is less than $100,000.

''(C) DEFINITIONS.—In this paragraph:

''(i) ATTORNEYS' FEES.—The term 'attorneys' fees' means any compensation for the direct or indirect representation or other legal work performed in connection with a cause of action brought under this subsection. Such term shall not include reimbursements for any expenses incurred in connection with such representation or work.

''(ii) AWARD.—The term 'award' means the sum of—

''(I) any monetary consideration provided to a participant or beneficiary (or the estate of such participant or beneficiary) by a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with a group health plan, or an agent of the plan, issuer, or plan sponsor in connection with a cause of action brought under this subsection, including any monetary consideration provided for in any—

''(aa) final court decision;

''(bb) court order;

''(cc) settlement agreement;

''(dd) arbitration procedure; or

''(ee) alternative dispute resolution procedure (including mediation); plus

''(II) any attorney's fees awarded under subsection (g)(1) with respect to the participant or beneficiary (or estate); less

''(III) any reimbursement for any expenses incurred in connection with direct or indirect representation or other legal work performed in connection with a cause of action under this subsection.

On page 169, between lines 12 and 13, insert the following:

''(11) MINIMUM SHARE OF SETTLEMENT OF AWARD.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a participant or beneficiary (or the estate of such participant or beneficiary) shall receive not less than 85 percent of any award made as a result of a cause of action brought by the participant or beneficiary (or estate) under this subsection, after subtracting the amount of any attorneys' fees from the total amount of such award.

''(B) EXCEPTION.—This paragraph shall not apply where the amount awarded as a result of a cause of action brought by a participant or beneficiary (or estate) under this subsection is less than $100,000.

''(C) DEFINITIONS.—In this paragraph:

''(i) ATTORNEYS' FEES.—The term 'attorneys' fees' means any compensation for the direct or indirect representation or other legal work performed in connection with a cause of action brought under this subsection. Such term shall not include reimbursements for any expenses incurred in connection with such representation or work.

''(ii) AWARD.—The term 'award' means the sum of—

''(I) any monetary consideration provided to a participant or beneficiary (or the estate of such participant or beneficiary) by a fiduciary of a group health plan, a health insurance issuer offering health insurance coverage in connection with a group health plan, or an agent of the plan, issuer, or plan sponsor in connection with a cause of action brought under this subsection, including any monetary consideration provided for in any—

''(aa) final court decision;

''(bb) court order;

''(cc) settlement agreement;

''(dd) arbitration procedure; or

''(ee) alternative dispute resolution procedure (including mediation); less

''(II) any reimbursement for any expenses incurred in connection with direct or indirect representation or other legal work performed in connection with a cause of action under this subsection.''

SA 832. Mr. FRIST (for himself, Mr. BREAUX, and Mr. JEFFORDS) 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 105, line 2, after ''treatment'' insert the following: ''The name of the designated decision-maker (or decision-makers) appointed under section 502(n)(2) of the Employee Retirement Income Security Act of 1974 for purposes of making final determinations under section 103 and approving coverage pursuant to the written determination of an independent medical reviewer under section 104.''.

Beginning on page 139, strike line 21 and all that follows through line 14 on page 171, and insert the following:

SEC. 302. AVAILABILITY OF COURT REMEDIES.

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following:

''(n) CAUSE OF ACTION RELATING TO DENIAL OF A CLAIM FOR HEALTH BENEFITS.—

''(1) IN GENERAL.—

''(A) FAILURE TO COMPLY WITH EXTERNAL MEDICAL REVIEW.—With respect to an action commenced by a participant or beneficiary (or the estate of the participant or beneficiary) in connection with a claim for benefits under a group health plan, if—

''(i) a designated decision-maker described in paragraph (2) fails to exercise ordinary care in approving coverage pursuant to the written determination of an independent medical reviewer under section 104(d)(3)(F) of the Bipartisan Patient Protection Act that reverses a denial of the claim for benefits; and

''(ii) the failure described in clause (i) is the proximate cause of substantial harm (as defined in paragraph (10)(G)) to the participant or beneficiary;

such designated decision-maker shall be liable to the participant or beneficiary (or the estate) for economic and noneconomic damages in connection with such failure and such injury or death (subject to paragraph (4)).

''(B) WRONGFUL DETERMINATION RESULTING IN DELAY IN PROVIDING BENEFITS.—With respect to an action commenced by a participant or beneficiary (or the estate of the participant or beneficiary) in connection with a claim for benefits under a group health plan, if—

''(i) a designated decision-maker described in paragraph (2)—

''(I) fails to exercise ordinary care in making a determination denying the claim for benefits under section 102 of the Bipartisan Patient Protection Act (relating to an initial claim for benefits); or

''(II) fails to exercise ordinary care in making a determination denying the claim for benefits under section 103 of such Act (relating to an internal appeal);

''(ii) the denial described in clause (i) is reversed by an independent medical reviewer under section 104(d) of such Act, or the coverage for the benefit involved is approved after the denial is referred to the independent medical reviewer but prior to the determination of the reviewer under such section; and

''(iii) the delay attributable to the failure described in clause (i) is the proximate cause of substantial harm to, or the wrongful death of, the participant or beneficiary;

such designated decision-maker shall be liable to the participant or beneficiary (or the estate) for economic and noneconomic damages in connection with such failure and such injury or death (subject to paragraph (4)).

''(C) LIMITATION ON LIABILITY BASED ON APPOINTMENT OF DESIGNATED DECISION-MAKER.—If a plan sponsor or named fiduciary appoints a designated decision-maker in accordance with paragraph (2), the plan sponsor or named fiduciary, or any other person or group health plan (or their employees) associated with the plan sponsor or named fiduciary, shall not be liable under this paragraph. The appointment of a designated decision-maker in accordance with paragraph (2) shall not affect the liability of the appointing plan sponsor or named fiduciary for the failure of the plan sponsor or named fiduciary to comply with any other requirement of this title.

''(D) PREVENTION OF DUPLICATION OF ACTION WITH ACTION UNDER STATE LAW.—No action may be brought under this subsection based upon facts and circumstances if a cause of action under State law is brought based upon the same facts and circumstances.

''(2) DESIGNATED DECISION-MAKER.—

''(A) APPOINTMENT.—

''(i) IN GENERAL.—The plan sponsor or named fiduciary of a group health plan shall, in accordance with this paragraph, designate one or more persons to serve as a designated decision-maker with respect to causes of action described in subparagraphs (A) and (B) of paragraph (1), except that—

''(I) with respect to health insurance coverage offered in connection with a group health plan, the health insurance issuer shall be the designated decision-maker unless the plan sponsor and the issuer specifically agree in writing (on a form to be prescribed by the Secretary) to substitute another person as the designated decision-maker; or

''(II) with respect to the designation of a person other than a plan sponsor or health insurance issuer, such person shall satisfy the requirements of subparagraph (D).

''(ii) PLAN DOCUMENTS.—The designated decision-maker shall be specifically designated as such in the written instruments of the plan (under section 402(a)) and be identified as required under section 121(b)(14) of the Bipartisan Patient Protection Act.

''(B) AUTHORITY.—A designated decision-maker appointed under subparagraph (A) shall have the exclusive authority under the group health plan—

''(i) to make determinations with respect to a claim for benefits under section 102 of the Bipartisan Patient Protection Act (relating to an initial claim for benefits);

''(ii) to make final determinations under section 103 of such Act (relating to an internal appeal); or

''(iii) to approve coverage pursuant to the written determination of independent medical reviewers under section 104 of such Act.

''(C) ALLOCATION OF RESPONSIBILITY.—Responsibility may be allocated among different designated decision-makers with respect to—

''(i) for purposes of paragraph (1)(A), the approval of coverage under section 104 of the Bipartisan Patient Protection Act;

''(ii) for purposes of paragraph (1)(B), making determinations on a claim for benefits under section 102 of such Act (relating to an initial claim for benefits); and

''(iii) for purposes of paragraph (1)(B), making final determinations on claims for benefits under section 103 of such Act (relating to internal appeals),

except that not more than one designated decision-maker may be appointed with respect to each level of review under clauses (i), (ii), and (iii). Where such an allocation is made, liability under a cause of action under paragraph (1) shall be assessed against the appropriate designated decision-maker.

''(D) QUALIFICATIONS.—

''(i) CERTIFICATION OF ABILITY.—To be appointed as a designated decision-maker under this paragraph, a person shall provide to the plan sponsor or named fiduciary a certification of such person's ability to meet the requirements of clause (ii) relating to financial obligation for liability under this subsection. Such certification shall be provided upon appointment and not less frequently than annually thereafter, or if the designation is pursuant to a multi-year contract, in conjunction with the renewal of the contract, but in no case less than once every 3 years.

''(ii) OTHER REQUIREMENTS RELATING TO FINANCIAL OBLIGATIONS.—For purposes of clause (i), requirements relating to financial obligation for liability shall include evidence of—

''(I) coverage of the person under insurance policies or other arrangements, secured and maintained by the person, to insure the person against losses arising from professional liability claims, including those arising from being designated as a designated decision-maker under this paragraph; or

''(II) minimum capital and surplus levels that are maintained by the person to cover any losses as a result of liability arising from being designated as a designated decision-maker under this paragraph.

The appropriate amounts of liability insurance and minimum capital and surplus levels for purposes of subclauses (I) and (II) shall be determined by an actuary using sound actuarial principles and accounting practices pursuant to established guidelines of the American Academy of Actuaries and shall be maintained throughout the course of the contract in which such person is designated as a designated decision-maker.

''(E) FLEXIBILITY IN ADMINISTRATION.—A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, may provide—

''(i) that any person or group of persons may serve in more than one capacity with respect to the plan or coverage (including service as a designated decision-maker, administrator, and named fiduciary); or

''(ii) that a designated decision-maker may employ one or more persons to provide advice with respect to any responsibility of such decision-maker under the plan or coverage.

''(F) FAILURE TO APPOINT.—

''(i) IN GENERAL.—With respect to any cause of action under paragraph (1) relating to a denial of a claim for benefits where a designated decision-maker has not been appointed in accordance with this paragraph, the plan sponsor or named fiduciary responsible for determinations under section 503 shall be deemed to be the designated decision-maker.

''(ii) LIMITATION ON APPOINTMENT.—A treating health care professional who directly delivered the care, treatment, or provided the patient service that is the subject of an action under this subsection may not be designated as a designated decision-maker under this paragraph unless the professional—

''(I) is a person or entity that may be appointed in accordance with subparagraph (A); and

''(II) specifically agrees to accept such appointment in accordance with the requirements under such subparagraph.

''(3) REQUIREMENT OF EXHAUSTION OF INDEPENDENT MEDICAL REVIEW.—

''(A) IN GENERAL.—Paragraph (1) shall apply only if a final determination denying a claim for benefits under section 103 of the Bipartisan Patient Protection Act has been referred for independent medical review under section 104(d) of such Act and a written determination by an independent medical reviewer to reverse such final determination has been issued with respect to such review or where the coverage for the benefit involved is approved after the denial is referred to the independent medical reviewer but prior to the determination of the reviewer under such section.

''(B) EXCEPTION TO EXHAUSTION FOR NEEDED CARE.—A participant or beneficiary may seek relief under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under section 103 or 104 of the Bipartisan Patient Protection Act (as required under subparagraph (A)) if it is demonstrated to the court, by a preponderance of the evidence, that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Any determinations that already have been made under section 102, 103, or 104 of such Act in such case, or that are made in such case while an action under this subparagraph is pending, shall be given due consideration by the court in any action under this subsection in such case. Notwithstanding the awarding of relief under subsection 502(a)(1)(B) pursuant to this subparagraph, no relief shall be available under—

''(i) paragraph (1), with respect to a participant or beneficiary, unless the requirements of subparagraph (A) are met; or

''(ii) subsection (q) unless the requirements of such subsection are met.

''(4) LIMITATIONS ON RECOVERY OF DAMAGES.—

''(A) MAXIMUM AWARD OF NONECONOMIC DAMAGES.—The aggregate amount of liability for noneconomic loss in an action under paragraph (1) may not exceed the greater of—

''(i) $750,000; or

''(ii) an amount equal to 3 times the amount awarded for economic loss.

''(B) INCREASE IN AMOUNT.—The amount referred to in subparagraph (A)(i) shall be increased or decreased, for each calendar year that ends after December 31, 2002, by the same percentage as the percentage by which the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, for September of the preceding calendar year has increased or decreased from the such Index for September of 2002.

''(C) SEVERAL LIABILITY.—In the case of any action commenced pursuant to paragraph (1), the designated decision-maker shall be liable only for the amount of noneconomic damages attributable to such designated decision-maker in direct proportion to such decision-maker's share of fault or responsibility for the injury suffered by the participant or beneficiary. In all such cases, the liability of a designated decision-maker for noneconomic damages shall be several and not joint.

''(D) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

''(i) IN GENERAL.—In the case of any action commenced pursuant to paragraph (1), the total amount of damages received by a participant or beneficiary under such action shall be reduced, in accordance with clause (ii), by any other payment that has been, or will be, made to such participant or beneficiary, pursuant to an order or judgment of another court, to compensate such participant or beneficiary for the injury that was the subject of such action.

''(ii) AMOUNT OF REDUCTION.—The amount by which an award of damages to a participant or beneficiary for an injury shall be reduced under clause (i) shall be—

''(I) the total amount of any payments (other than such award) that have been made or that will be made to such participant or beneficiary to pay costs of or compensate such participant or beneficiary for the injury that was the subject of the action; less

''(II) the amount paid by such participant or beneficiary (or by the spouse, parent, or legal guardian of such participant or beneficiary) to secure the payments described in subclause (I).

''(iii) DETERMINATION OF AMOUNTS FROM COLLATERAL SOURCES.—The reduction required under clause (ii) shall be determined by the court in a pretrial proceeding. At the subsequent trial no evidence shall be admitted as to the amount of any charge, payments, or damage for which a participant or beneficiary—

''(I) has received payment from a collateral source or the obligation for which has been assured by a third party; or

''(II) is, or with reasonable certainty, will be eligible to receive from a collateral source which will, with reasonable certainty, be assumed by a third party.

''(E) PROHIBITION OF AWARD OF PUNITIVE DAMAGES.—Notwithstanding any other provision of law, in the case of any action commenced pursuant to paragraph (1), the court may not award any punitive, exemplary, or similar damages against a defendant.

''(5) AFFIRMATIVE DEFENSES.—In the case of any cause of action under paragraph (1), it shall be an affirmative defense that—

''(A) the designated decision-maker of a group health plan, or health insurance issuer that offers health insurance coverage in connection with a group health plan, involved did not receive from the participant or beneficiary (or authorized representative) or the treating health care professional (if any), the information requested by the plan or issuer regarding the medical condition of the participant or beneficiary that was necessary to make a determination on a claim for benefits under section 102 of the Bipartisan Patient Protection Act or a final determination on a claim for benefits under section 103 of such Act;

''(B) the participant or beneficiary (or authorized representative)—

''(i) was in possession of facts that were sufficient to enable the participant or beneficiary (or authorized representative) to know that an expedited review under section 102, 103, or 104 of such Act would have prevented the harm that is the subject of the action; and

''(ii) failed to notify the plan or issuer of the need for such an expedited review; or

''(C) the qualified external review entity or an independent medical reviewer failed to meet the timelines applicable under section 104 of such Act, or a period of time elapsing after coverage has been authorized.

Nothing in this paragraph shall be construed to limit the application of any other affirmative defense that may be applicable to the cause of action involved.

''(6) WAIVER OF INTERNAL REVIEW.—In the case of any cause of action under paragraph (1), the waiver or nonwaiver of internal review under section 103(a)(4) of the Bipartisan Patient Protection Act by the group health plan, or health insurance issuer that offers health insurance coverage in connection with a group health plan, shall not be used in determining liability.

''(7) LIMITATIONS ON ACTIONS.—Paragraph (1) shall not apply in connection with any action that is commenced more than 3 years after the date on which the failure described in paragraph (1) occurred.

''(8) PROTECTION OF THE REGULATION OF QUALITY OF MEDICAL CARE UNDER STATE LAW.—Nothing in this subsection shall be construed to preclude any action under State law against a person or entity for liability or vicarious liability with respect to the delivery of medical care. A claim that is based on or otherwise relates to a group health plan's administration or determination of a claim for benefits (as such term is defined in section 102(e)(2) of the Bipartisan Patient Protection Act and notwithstanding the definition contained in paragraph (10)(B)) shall not be deemed to be the delivery of medical care under any State law for purposes of this section. Any such claim shall be maintained exclusively under section 502.

''(9) CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing a cause of action under paragraph (1) for the failure of a group health plan or health insurance issuer to provide an item or service that is specifically excluded under the plan or coverage.

''(10) DEFINITIONS.—In this subsection:

''(A) AUTHORIZED REPRESENTATIVE.—The term 'authorized representative' has the meaning given such term in section 102(e)(1) of the Bipartisan Patient Protection Act.

''(B) CLAIM FOR BENEFITS.—Except as provided for in paragraph (8), the term 'claim for benefits' shall have the meaning given such term in section 103(e)(2) of the Bipartisan Patient Protection Act, except that such term shall only include claims for which prior authorization is required (as such term is defined in section 151(c)(9) of such Act)).

''(C) GROUP HEALTH PLAN.—The term 'group health plan' shall have the meaning given such term in section 733(a). In applying this paragraph, excepted benefits described in section 733(c) shall not be treated as benefits consisting of medical care.

''(D) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 733(b)(1). In applying this paragraph, excepted benefits described in section 733(c) shall not be treated as benefits consisting of medical care.

''(E) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 733(b)(2).

''(F) ORDINARY CARE.—The term 'ordinary care' means the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent individual acting in a like capacity and familiar with such matters would use in making a determination on a claim for benefits of a similar character.

''(G) SUBSTANTIAL HARM.—The term 'substantial harm' means the loss of life, loss or significant impairment of limb or bodily function, significant mental illness or disease, significant disfigurement, or severe and chronic physical pain.''.

(b) AUTHORITY TO IMPOSE CIVIL PENALTIES FOR FAILURE TO PROVIDE A PLAN BENEFIT NOT ELIGIBLE FOR MEDICAL REVIEW.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by subsection (a), is further amended by adding at the end the following:

''(o) AUTHORITY TO IMPOSE CIVIL PENALTIES FOR FAILURE TO PROVIDE A PLAN BENEFIT NOT ELIGIBLE FOR MEDICAL REVIEW.—In connection with any action maintained under subsection (a)(1)(B), the court, in its discretion, may assess a civil penalty against the designated decision-maker (as designated pursuant to section 502(n)(2)) of a group health plan or a health insurance issuer (that offers health insurance coverage in connection with a group health plan) of not to exceed $100,000 where—

''(1) in its final determination under section 103(d)(2) of the Bipartisan Patient Protection Act, the designated decision-maker fails to provide, or authorize coverage of, a benefit to which a participant or beneficiary is entitled under the terms and conditions of the plan;

''(2) the participant or beneficiary has appealed such determination under section 104 of such Act and such determination is not subject to independent medical review as determined by a qualified external review entity under section 104(c)(3)(A) of such Act;

''(3) the plan has failed to exercise ordinary care in making a final determination under section 103(d)(2) of such Act denying a claim for benefits under the plan; and

''(4) that denial is the proximate cause of substantial harm (as defined in subsection (n)(10)(G)) the participant or beneficiary.''.

(c) LIMITATION ON CERTAIN CLASS ACTION LITIGATION.—

(1) ERISA.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by subsections (a) and (b), is further amended by adding at the end the following:

''(p) 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 Patient Protection Act. This subsection shall apply to civil actions that are pending and have not been finally determined by judgment or settlement prior to such date of enactment.''.

(2) RICO.—Section 1964(c) of title 18, United States Code, is amended—

(1) by inserting ''(1)'' after the subsection designation; and

(2) by adding at the end the following:

''(2)(A) No action may be brought under this subsection, or alleging any violation of section 1962, where the action seeks relief concerning the manner in which any person has marketed, provided information concerning, established, administered, or otherwise operated a group health plan, or health insurance coverage in connection with a group health plan. Any such action shall only be brought under the Employee Retirement Income Security Act of 1974. In this paragraph, the terms 'group health plan' and 'health insurance issuer' shall have the meanings given such terms in section 733 of the Employee Retirement Income Security Act of 1974.

''(B) Subparagraph (A) shall apply to civil actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of the Bipartisan Patient Protection Act and all actions commenced on or after such date.''.

(d) CONFORMING AMENDMENT.—Section 502(a)(1)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(a)(1)(A)) is amended by inserting ''or (n)'' after ''subsection (c)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to acts and omissions (from which a cause of action arises) occurring on or after October 1, 2002.

SA 833. Mr. WARNER 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 154, between lines 2 and 3, insert the following:

''(11) LIMITATION ON AWARD OF ATTORNEYS' FEES.—

''(A) IN GENERAL.—Subject to subparagraph (C), with respect to a participant or beneficiary (or the estate of such participant or beneficiary) who brings a cause of action under this subsection and prevails in that action, the amount of attorneys' fees that a court may award to such participant, beneficiary, or estate under subsection (g)(1) (not including the reimbursement of actual out-of-pocket expenses of an attorney as approved by the court in such action) may not exceed the sum of the amounts described in subparagraph (B).

''(B) AMOUNTS DESCRIBED.—For purposes of subparagraph (A), the amounts described in this subparagraph are as follows:

''(i) With respect to a recovery in a cause of action described in subparagraph (A) that does not exceed $100,000, the amount of attorneys' fees awarded may not exceed an amount equal to ⅓ of the amount of the recovery.

''(ii) With respect to a recovery in such a cause of action that exceeds $100,000 but does not exceed $500,000, the amount of the attorneys' fees awarded may not exceed an amount equal to 25 percent of such excess recovery above $100,000.

''(iii) With respect to a recovery in such a cause of action that exceeds $500,000, the amount of the attorneys' fees awarded may not exceed an amount equal to 15 percent of such excess recovery above $500,000.

''(C) EQUITABLE DISCRETION.—A court in its discretion may adjust the amount of an award of attorneys' fees required under subparagraph (A) as equity and the interests of justice may require.

On page 170, between lines 21 and 22, insert the following:

''(9) LIMITATION ON ATTORNEYS' FEES.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, or any arrangement, agreement, or contract regarding attorneys' fees, subject to subparagraph (B), a court shall limit the amount of attorneys' fees that may be incurred for the representation of a participant or beneficiary (or the estate of such participant or beneficiary) who brings a cause of action under paragraph (1) to the amount of attorneys' fees that may be awarded under section 502(n)(11).

''(B) EQUITABLE DISCRETION.—A court in its discretion may adjust the amount of attorneys' fees allowed under subparagraph (A) as equity and the interests of justice may require.''

SA 834. Ms. SNOWE (for herself, Mrs. LINCOLN, Mr. DEWINE, Mr. NELSON of Nebraska, Mr. SPECTER, Mr. MCCAIN, Mr. BAUCUS, Ms. STABENOW, and Mr. CHAFEE) 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 106, between lines 16 and 17, insert the following:

(19) DESIGNATED DECISIONMAKERS.—A description of the participants and beneficiaries with respect to whom each designated decisionmaker under the plan has assumed liability under section 502(o) of the Employee Retirement Income Security Act of 1974 and the name and address of each such decisionmaker.

On page 141, strike lines 16 through 21, and insert the following: ''tions of the plan or coverage, and''.

On page 142, lines 10 and 11, strike ''or the failure described in clause (ii)''.

On page 143, strike lines 12 through 18, and insert the following: ''benefits of like kind to the claims involved.''.

On page 145, strike lines 15 through 20, and insert the following: ''of a denial of a claim for benefits.''.

Beginning on page 145, strike line 22 and all that follows through line 6 on page 146, and insert the following:

''(i) IN GENERAL.—For purposes of subparagraph (B), the term 'direct participation' means, in connection with a decision described in paragraph (1)(A), the actual making of such decision or the actual exercise of control in making such decision.

On page 146, line 14, strike ''clause (i) of''.

On page 146, strike lines 16 through 20, and insert the following: ''or beneficiary, including (but not lim-''.

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

''(D) APPLICATION TO CERTAIN PLANS.—

''(i) IN GENERAL.—Notwithstanding any other provision of this subsection, no group health plan described in clause (ii) shall be liable under paragraph (1) for the performance of, or the failure to perform, any nonmedically reviewable duty under the plan.

''(ii) DEFINITION.—A group health plan described in this clause is—

''(I) a group health plan that is self-insured and self administered; or

''(II) a group health plan that is maintained by one or more employers or employee organizations described in section 3(16)(B)(iii).

On page 156, between lines 15 and 16, insert the following:

''(17) RELIEF FROM LIABILITY FOR EMPLOYER OR OTHER PLAN SPONSOR BY MEANS OF DESIGNATED DECISIONMAKER.—

''(A) IN GENERAL.—Notwithstanding the direct participation (as defined in paragraph (5)(C)(i)) of an employer or plan sponsor, in any case in which there is deemed to be a designated decisionmaker under subparagraph (B) that meets the requirements of subsection (o)(1) for an employer or other plan sponsor—

''(i) all liability of such employer or plan sponsor (and any employee thereof acting within the scope of employment) under this subsection in connection with any participant or beneficiary shall be transferred to, and assumed by, the designated decisionmaker, and

''(ii) with respect to such liability, the designated decisionmaker shall be substituted for the employer or plan sponsor (or employee) in the action and may not raise any defense that the employer or plan sponsor (or employee) could not raise if such a decisionmaker were not so deemed.

''(B) AUTOMATIC DESIGNATION.—A health insurance issuer shall be deemed to be a designated decisionmaker for purposes of subparagraph (A) with respect to the participants and beneficiaries of an employer or plan sponsor, whether or not the employer or plan sponsor makes such a designation, and shall be deemed to have assumed unconditionally all liability of the employer or plan sponsor under such designation in accordance with subsection (o), unless the employer or plan sponsor affirmatively enters into a contract to prevent the service of the designated decisionmaker.

''(18) PREVIOUSLY PROVIDED SERVICES.—

''(A) IN GENERAL.—Except as provided in this paragraph, a cause of action shall not arise under paragraph (1) where the denial involved relates to an item or service that has already been fully provided to the participant or beneficiary under the plan or coverage and the claim relates solely to the subsequent denial of payment for the provision of such item or service.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit a cause of action under paragraph (1) where the nonpayment involved results in the participant or beneficiary being unable to receive further items or services that are directly related to the item or service involved in the denial referred to in subparagraph (A) or that are part of a continuing treatment or series of procedures;

''(ii) prohibit a cause of action under paragraph (1) relating to quality of care; or

''(iii) limit liability that otherwise would arise from the provision of the item or services or the performance of a medical procedure.

''(19) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

''(A) a member of a board of directors of an employer or plan sponsor; or

''(B) a member of an association, committee, employee organization, joint board of trustees, or other similar group of representatives of the entities that are the plan sponsor of plan maintained by two or more employers and one or more employee organizations;

shall not be personally liable under this subsection for conduct that is within the scope of employment of the individuals unless the individual acts in a fraudulent manner for personal enrichment.

''(o) REQUIREMENTS FOR DESIGNATED DECISIONMAKERS OF GROUP HEALTH PLANS.—

''(1) IN GENERAL.—For purposes of subsection (n)(17) and section 514(d)(9), a designated decisionmaker meets the requirements of this paragraph with respect to any participant or beneficiary if—

''(A) such designation is in such form as may be prescribed in regulations of the Secretary,

''(B) the designated decisionmaker—

''(i) meets the requirements of paragraph (2),

''(ii) assumes unconditionally all liability of the employer or plan sponsor involved (and any employee thereof acting within the scope of employment) either arising under subsection (n) or arising in a cause of action permitted under section 514(d) in connection with actions (and failures to act) of the employer or plan sponsor (or employee) occurring during the period in which the designation under subsection (n)(17) or section 514(d)(9) is in effect relating to such participant and beneficiary,

''(iii) agrees to be substituted for the employer or plan sponsor (or employee) in the action and not to raise any defense with respect to such liability that the employer or plan sponsor (or employee) may not raise, and

''(iv) where paragraph (2)(B) applies, assumes unconditionally the exclusive authority under the group health plan to make medically reviewable decisions under the plan with respect to such participant or beneficiary, and

''(C) the designated decisionmaker and the participants and beneficiaries for whom the decisionmaker has assumed liability are identified in the written instrument required under section 402(a) and as required under section 121(b)(19) of the Bipartisan Patient Protection Act.

Any liability assumed by a designated decisionmaker pursuant to this subsection shall be in addition to any liability that it may otherwise have under applicable law.

''(2) QUALIFICATIONS FOR DESIGNATED DECISIONMAKERS.—

''(A) IN GENERAL.—Subject to subparagraph (B), an entity is qualified under this paragraph to serve as a designated decisionmaker with respect to a group health plan if the entity has the ability to assume the liability described in paragraph (1) with respect to participants and beneficiaries under such plan, including requirements relating to the financial obligation for timely satisfying the assumed liability, and maintains with the plan sponsor and the Secretary certification of such ability. Such certification shall be provided to the plan sponsor or named fiduciary and to the Secretary upon designation under subsection (n)(17)(B) or section 517(d)(9)(B) and not less frequently than annually thereafter, or if such designation constitutes a multiyear arrangement, in conjunction with the renewal of the arrangement.

''(B) SPECIAL QUALIFICATION IN THE CASE OF CERTAIN REVIEWABLE DECISIONS.—In the case of a group health plan that provides benefits consisting of medical care to a participant or beneficiary only through health insurance coverage offered by a single health insurance issue, such issuer is the only entity that may be qualified under this paragraph to serve as a designated decisionmaker with respect to such participant or beneficiary, and shall serve as the designated decisionmaker unless the employer or other plan sponsor acts affirmatively to prevent such service.

''(3) REQUIREMENTS RELATING TO FINANCIAL OBLIGATIONS.—For purposes of paragraph (2)(A), the requirements relating to the financial obligation of an entity for liability shall include—

''(A) coverage of such entity under an insurance policy or other arrangement, secured and maintained by such entity, to effectively insure such entity against losses arising from professional liability claims, including those arising from its service as a designated decisionmaker under this part; or

''(B) evidence of minimum capital and surplus levels that are maintained by such entity to cover any losses as a result of liability arising from its service as a designated decisionmaker under this part.

The appropriate amounts of liability insurance and minimum capital and surplus levels for purposes of subparagraphs (A) and (B) shall be determined by an actuary using sound actuarial principles and accounting practices pursuant to established guidelines of the American Academy of Actuaries and in accordance with such regulations as the Secretary may prescribe and shall be maintained throughout the term for which the designation is in effect.

''(4) LIMITATION ON APPOINTMENT OF TREATING PHYSICIANS.—A treating physician who directly delivered the care, treatment, or provided the patient service that is the subject of a cause of action by a participant or beneficiary under subsection (n) or section 514(d) may not be designated as a designated decisionmaker under this subsection with respect to such participant or beneficiary.

Beginning on page 161, strike line 14, and all that follows through line 13 on page 162, and insert the following:

''(B) CERTAIN CAUSES OF ACTION PERMITTED.—Notwithstanding subparagraph (A), paragraph (1) applies with respect to any cause of action that is brought by a participant or beneficiary under a group health plan (or the estate of such a participant or beneficiary) to recover damages resulting from personal injury or for wrongful death against any employer or other plan sponsor maintaining the plan (or against an employee of such an employer or sponsor acting within the scope of employment) if such cause of action arises by reason of a medically reviewable decision, to the extent that there was direct participation by the employer or other plan sponsor (or employee) in the decision.

On page 162, lines 19 and 20, strike ''(i) or a failure described in subparagraph (B)(ii)''.

On page 163, line 6, strike ''paragraph (B)(i)'' and insert ''paragraph (B)''.

On page 163, line 8, strike ''or that'' and all that follows through ''ficiary'' on line 11.

On page 170, between lines 21 and 22, insert the following:

''(9) RELIEF FROM LIABILITY FOR EMPLOYER OR OTHER PLAN SPONSOR BY MEANS OF DESIGNATED DECISIONMAKER.—

''(A) IN GENERAL.—Paragraph (1) shall not apply with respect to any cause of action described in paragraph (1)(A) under State law insofar as such cause of action provides for liability of an employer or plan sponsor (or an employee thereof acting within the scope of employment) with respect to a participant or beneficiary, if with respect to the employer or plan sponsor there is deemed to be a designated decisionmaker that meets the requirements of section 502(o)(1) with respect to such participant or beneficiary. Such paragraph (1) shall apply with respect to any cause of action described in paragraph (1)(A) under State law against the designated decisionmaker of such employer or other plan sponsor with respect to the participant or beneficiary.

''(B) AUTOMATIC DESIGNATION.—A health insurance issuer shall be deemed to be a designated decisionmaker for purposes of subparagraph (A) with respect to the participants and beneficiaries of an employer or plan sponsor, whether or not the employer or plan sponsor makes such a designation, and shall be deemed to have assumed unconditionally all liability of the employer or plan sponsor under such designation in accordance with subsection (o), unless the employer or plan sponsor affirmatively enters into a contract to prevent the service of the designated decisionmaker.

''(10) PREVIOUSLY PROVIDED SERVICES.—

''(A) IN GENERAL.—Except as provided in this paragraph, a cause of action shall not arise under paragraph (1) where the denial involved relates to an item or service that has already been fully provided to the participant or beneficiary under the plan or coverage and the claim relates solely to the subsequent denial of payment for the provision of such item or service.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit a cause of action under paragraph (1) where the nonpayment involved results in the participant or beneficiary being unable to receive further items or services that are directly related to the item or service involved in the denial referred to in subparagraph (A) or that are part of a continuing treatment or series of procedures;

''(ii) prohibit a cause of action under paragraph (1) relating to quality of care; or

''(iii) limit liability that otherwise would arise from the provision of the item or services or the performance of a medical procedure.

''(11) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

''(A) a member of a board of directors of an employer or plan sponsor; or

''(B) a member of an association, committee, employee organization, joint board of trustees, or other similar group of representatives of the entities that are the plan sponsor of plan maintained by two or more employers and one or more employee organizations;

shall not be personally liable under this subsection for conduct that is within the scope of employment of the individuals unless the individual acts in a fraudulent manner for personal enrichment.

SA 835. 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:

On page 119, between lines 5 and 6, insert the following:

SEC. 136. PRESERVATION OF THE HIPPOCRATIC OATH.

(a) IN GENERAL.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a physician (or group of physicians) shall require that such physician—

(1) provide notice to each participant, beneficiary, or enrollee that the physician treats of whether or not the physician has taken and upholds the Hippocratic Oath; and

(2) in the case of a physician who notifies such participant, beneficiary, or enrollee

that the physician does not uphold any part of the Oath, disclose the part of the Oath to which he or she does not subscribe.

(b) SPECIFIC AREAS OF DISCLOSURE.—A physician making a disclosure under subsection (a)(2) shall, in particular, disclose the following:

(1) That the physician does not hold the patient's health above all other consideration as in accordance with the Hippocratic Oath.

(2) That in violation of the Hippocratic oath the physician engages in physical relationships with his or her patients.

(3) That the physician does not preserve the confidentiality of his or her patients, as is required by the Hippocratic Oath.

(4) That in direct violation of the Hippocratic Oath the physician engages in euthanasia, or suggests council to assist in suicide.

(5) That the physician, in violation of the Hippocratic Oath, performs abortions.

(c) COVERAGE OF OTHER PHYSICIANS.—If a participant, beneficiary or enrollee receives a notice under subsection (a) that a physician has not taken or does not uphold the Hippocratic Oath, the group health plan or health insurance issuer involved shall permit such participant, beneficiary or enrollee to select another physician who has taken or does uphold the Oath. The plan or issuer shall provide coverage for the treatment of services provided by a physician selected under the previous sentence regardless of whether such physician is in the plan or coverage network.

(d) LIMITATION.—Nothing in this section shall be construed to preempt or supersede any State licensure or scope-of-practice law.

SA 836. 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:

On page 171, between lines 14 and 15, insert the following:

SEC. 303. DEDICATION OF PUNITIVE DAMAGES FOR THE PURCHASE OF HEALTH INSURANCE COVERAGE.

(a) AWARD OF PORTION OF DAMAGES.—

(1) IN GENERAL.—If any penalty is assessed, or non-economic or punitive damages are awarded with respect to a cause of action under section 502(n) or 514(d) of the Employee Retirement Income Security Act of 1974 (as added by section 302), the court shall award the amount described in paragraph (2) to the State health insurance trust fund established under subsection (b) for the State in which the claim was filed to enable the State to provide refundable tax credits to enable individuals in the State to purchase health insurance coverage.

(2) AMOUNT.—The amount awarded to a State under paragraph (1) shall consist of—

(A) any penalty assessed that is not awarded to the aggrieved participant or beneficiary; and

(B) any non-economic or punitive damages awarded in excess of $2,000,000.

(b) STATE REQUIREMENTS.—

(1) STATE HEALTH INSURANCE TRUST FUND.—A State that desires to receive payments under subsection (a) shall establish a State health insurance trust fund.

(2) REFUNDABLE TAX CREDIT.—

(A) IN GENERAL.—The refundable tax credit described in subsection (a)(1) shall—

(i) be available to any resident of a State who—

(I) is without access to adequate health insurance through the resident's employer; or

(II) is from a family with an income that is less that 220 percent of the poverty line, is not eligible for benefits under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), is not eligible for veteran's health benefits, and is younger than 65 years of age; and

(ii) be used to provide a benefit for private insurance that includes, at a minimum, catastrophic coverage.

(B) TIME PERIOD.—

(i) IN GENERAL.—A State shall have in place a refundable tax credit, as described in subsection (a)(1), not later than 2 years after the date of enactment of the Bipartisan Patient Protection Act.

(ii) TRANSFER OF FUNDS.—A State that fails to have a refundable tax credit in place as required by clause (i) shall transfer any funds described in subsection (a)(2) to the National Institutes of Health.

SA 837. 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 appropriate place in title I, insert the following:

SEC. ___. IMPROVED FLEXIBILITY FOR EMPLOYERS IN OBTAINING HEALTH INSURANCE COVERAGE FOR EMPLOYEES.

(a) FREEDOM FROM EMPLOYER LIABILITY.—In the case of a group health plan, or health insurance coverage provided by a health insurance issuer, that meets the requirements of subsection (b)—

(1) an employer maintaining the plan or entering into an arrangement for the coverage provided by the issuer shall not be liable pursuant to any cause of action relating to the provision of (or failure to provide, or manner of provision of) benefits under any health insurance coverage that may be secured by participants, beneficiaries, or enrollees in connection with the plan, or under the coverage provided by the issuer for participants, beneficiaries, or enrollees; and

(2) there shall be no right of recovery, indemnity, or contribution by a person against such an employer (or an employee of such an employer acting within the scope of employment) for damages assessed against the person pursuant to any such cause of action.

(b) REQUIREMENTS.—A group health plan or health insurance coverage provided by a health insurance issuer meets the requirements of this subsection if—

(1) such plan or coverage provides compensation to employees for personal injuries or sickness, within the meaning of section 106(a) of the Internal Revenue Code of 1986;

(2) under such plan or the arrangement for such coverage, all employer contributions are in the form of payments on behalf of participants, beneficiaries, or enrollees and are placed into a separate trust that forms a part of such plan or the arrangement for such coverage and that meets the additional requirements of subsection (d);

(3) the assets of such trust consist solely of such employer contributions and any income earned from investment of the contributions;

(4) the assets of such trust (other than assets used for payment of necessary and reasonable administrative expenses of the trust) are held in such trust for the sole purpose of, and are available for, payment by participants, beneficiaries, or enrollees of premiums for, or otherwise providing for the cost to participants, beneficiaries, or enrollees of—

(A) health insurance coverage for the participants, beneficiaries, or enrollees that is made available under the plan for acquisition by the participants, beneficiaries, or enrollees and that meets the applicable requirements of law; or

(B) coverage provided by the issuer for participants, beneficiaries, or enrollees that meets the applicable requirements of law;

(5) under such plan or arrangement for such coverage, at least 2 alternative and substantially different forms of health insurance coverage are available for acquisition by each participant, beneficiary, or enrollee with assets of the trust attributable to contributions to the trust on behalf of such participant, beneficiary, or enrollee; and

(6) the participant, beneficiary, or enrollee (and not the employer, plan, or issuer) has a right to the health insurance coverage provided to the participant, beneficiary, or enrollee under the plan or the coverage provided by the issuer.

(c) FIDUCIARY LIABILITY.—In the case of any group health plan or health insurance coverage provided by a health insurance issuer that meets the requirements of subsection (b)—

(1) the trustee of the separate trust referred to in subsection (b)(2) shall be the named fiduciary of the plan or the issuer, with respect to such coverage; and

(2) such trustee shall be treated, for purposes of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) and any other applicable provision of law, as the sole and exclusive fiduciary of the plan or the issuer with respect to assets held in such trust.

(d) SEPARATE TRUST REQUIREMENTS.—

(1) IN GENERAL.—A separate trust referred to in subsection (b)(2) meets the requirements of this subsection if each trustee of the trust—

(A) is not a related party;

(B) does not have a material familial, financial, or professional relationship with such a party; and

(C) does not otherwise have a conflict of interest with such a party (as determined under regulations).

(2) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in paragraph (1) shall be construed to prohibit receipt by a trustee of the separate trust of compensation from the plan or issuer for the conduct of the trustee's duties as trustee, except that any such compensation—

(A) may not exceed a reasonable level; and

(B) may not be contingent on any decision rendered by the trustee in the exercise of the trustee's duties.

(3) RELATED PARTY.—For purposes of this subsection, the term ''related party'' means, in connection with a separate trust forming a part of the plan or the arrangement for such coverage, the plan, the plan sponsor, any health insurance issuer offering the coverage involved, or any fiduciary (except as provided in subsection (c)(2)), officer, director, or employee of such plan, plan sponsor, or issuer.

(e) RULES OF CONSTRUCTION.—

(1) ADDITIONAL EMPLOYEE CONTRIBUTIONS PERMITTED.—The requirements of this section shall not be treated as not met solely because a participant, beneficiary, or enrollee may need to supplement employer contributions provided under the plan or arrangement for coverage for purposes of acquiring health insurance coverage, in order to acquire such coverage.

(2) LIABILITY OF OTHER PARTIES UNAFFECTED.—Nothing in this section shall be construed to affect any cause of action in

connection with the health insurance coverage referred to in subsection (a)(1) against the plan sponsor or health insurance issuer providing such coverage or any other party (other than the employer).

(f) DEFINITIONS.—The definitions contained in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91) shall apply for purposes of this section.

(g) REGULATIONS.—The Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury may issue such regulations as are necessary to carry out the provisions of this section. Such regulations shall be issued consistent with section 104 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 300gg–92 note).

SA 838. 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 paragraph (1), (2), or (3) of subsection (b), in the form of a notice provided not later than 30 days before the date on which the reduction takes effect; and

(iv) of the additional information described in subsection (c).

(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) DISENROLLMENT.—Information relating to the disenrollment of a participant, beneficiary, or enrollee.

(2) 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.

(3) 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.

(4) 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), and through other, easily accessible means, including electronically via the Internet, 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) 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.

SA 839. Mrs. HUTCHISON (for herself and Mrs. CLINTON) 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; as follows:

On page 101, between lines 14 and 15, insert the following:

(3) DISENROLLMENT.—Information relating to the disenrollment of a participant, beneficiary, or enrollee.

SA 840. Mr. ENZI 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 172, between lines 15 and 16, insert the following:

SEC. 304. IMMUNITY FROM LIABILITY FOR PROVISION OF INSURANCE OPTIONS.

(a) IN GENERAL.—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:

''(p) IMMUNITY FROM LIABILITY FOR PROVISION OF INSURANCE OPTIONS.—

''(1) IN GENERAL.—No liability shall arise under subsection (n) with respect to a participant or beneficiary against a group health plan described in paragraph (4) if such plan offers the participant or beneficiary the coverage option described in paragraph (2).

''(2) COVERAGE OPTION.—The coverage option described in this paragraph is one under which the group health plan, at the time of enrollment or as provided for in paragraph (3), provides the participant or beneficiary with the option to—

''(A) enroll for coverage under a fully insured health plan; or

''(B) receive an individual benefit payment, in an amount equal to the amount that would be contributed on behalf of the participant or beneficiary by the plan sponsor for enrollment in the group health plan (as determined by the plan actuary, including factors relating to participant or beneficiary's age and health status), for use by the participant or beneficiary in obtaining health insurance coverage in the individual market.

''(3) TIME OF OFFERING OF OPTION.—The coverage option described in paragraph (2) shall be offered to a participant or beneficiary—

''(A) during the first period in which the individual is eligible to enroll under the group health plan; or

''(B) during any special enrollment period provided by the group health plan after the date of enactment of the Patients' Bill of Rights Plus Act for purposes of offering such coverage option.

''(4) GROUP HEALTH PLAN DESCRIBED.—A group health plan described in this paragraph is a group health plan that is self-insured and self-administered prior to the general effective date described in section 401(a)(1) of the Bipartisan Patient Protection Act.''.

(b) AMENDMENTS TO INTERNAL REVENUE CODE.—

(1) EXCLUSION FROM INCOME.—Section 106 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following:

''(d) TREATMENT OF CERTAIN COVERAGE OPTION UNDER SELF-INSURED PLANS.—No amount shall be included in the gross income of an individual by reason of—

''(1) the individual's right to elect a coverage option described in section 502(o)(2) of the Employee Retirement Income Security Act of 1974, or

''(2) the receipt by the individual of an individual benefit payment described in section 502(o)(2)(A) of such Act.''

(2) NONDISCRIMINATION RULES.—Section 105(h) of such Code (relating to self-insured medical expense reimbursement plans) is amended by adding at the end the following:

''(11) TREATMENT OF CERTAIN COVERAGE OPTIONS.—If a self-insured medical reimbursement plan offers the coverage option described in section 502(o)(2) of the Employee Retirement Income Security Act of 1974, employees who elect such option shall be treated as eligible to benefit under the plan and the plan shall be treated as benefiting such employees.''

SA 841. 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:

SEC. ___. REFUNDABLE TAX CREDITS FOR THE UNINSURED FINANCED WITH CERTAIN CIVIL MONETARY PENALTIES.

(a) PAYMENT OF CERTAIN PENALTIES TO SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Notwithstanding any other provision of law, 75 percent of any civil monetary penalty in any proceeding allowed under any provision of, or amendment made by, this Act may only be awarded to the Secretary of the Treasury.

(2) CIVIL MONETARY PENALTY.—For purposes of this section, the term ''civil monetary penalty'' means damages awarded for the purpose of punishment or deterrence, and not solely for compensatory purposes. Such term includes exemplary and punitive damages or any similar damages which function as civil monetary penalties. Such term does not include either economic or non-economic losses. Such term does not include the portion of any award of damages that is not payable to a party or the attorney for a party pursuant to applicable State law.

(b) ESTABLISHMENT OF TRUST FUND.—

(1) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following new section:

''SEC. 9511. HEALTH INSURANCE REFUNDABLE CREDITS TRUST FUND.

''(a) CREATION OF TRUST FUND.—There is hereby established in the Treasury of the United States a trust fund to be known as the 'Health Insurance Refundable Credits Trust Fund', consisting of such amounts as may be—

''(1) appropriated to such Trust Fund as provided in this section, or

''(2) credited to such Trust Fund as provided in section 9602(b).

''(b) TRANSFER TO TRUST FUND OF AMOUNTS EQUIVALENT TO CERTAIN AWARDS.—There are hereby appropriated to the Health Insurance Refundable Credits Trust Fund amounts equivalent to the awards received by the Secretary of the Treasury under section ____(a) of the Bipartisan Patient Protection Act.

''(c) EXPENDITURES FROM TRUST FUND.—Amounts in the Health Insurance Refundable Credits Trust Fund shall be available to fund the appropriations under paragraph (2) of section 1324(b) of title 31, United States Code, with respect to any refundable tax credit to assist uninsured individuals and families with the purchase of health insurance under this title.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of the

Internal Revenue Code of 1986 is amended by adding at the end the following new item:

''9511. Health Insurance Refundable Credits Trust Fund.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

SA 842. 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; as follows:

On page 171, between lines 14 and 15, insert the following:

SEC. 303. LIMITATION ON CERTAIN CLASS ACTION LITIGATION.

(a) ERISA.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 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 January 1, 2002.''.

(b) RICO.—Section 1964(c) of title 18, United States Code, is amended—

(1) by inserting ''(1)'' after the subsection designation; and

(2) by adding at the end the following:

''(2)(A) No private action may be brought under this subsection, or alleging any violation of section 1962, where the action seeks relief concerning the manner in which any person has marketed, provided information concerning, established, administered, or otherwise operated a group health plan, or health insurance coverage in connection with a group health plan. Any such action shall only be brought under the Employee Retirement Income Security Act of 1974. In this paragraph, the terms 'group health plan' and 'health insurance issuer' shall have the meanings given such terms in section 733 of the Employee Retirement Income Security Act of 1974.

''(B) Subparagraph (A) shall apply to private civil actions that are filed on or after January 1, 2002.''.

SA 843. Mr. GRAMM (for himself and Mr. MCCAIN) 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:

Insert at the appropriate place:

Notwithstanding any other provision of this act, any exclusion of an exact medical procedure, any exact time limit on the duration or frequency of coverage, and any exact dollar limit on the amount of coverage that is specifically enumerated and defined in the plain language of the plan or coverage documents under the plan or coverage offered by a group health plan or health insurance issuer offering health insurance coverage and that is disclosed under section 121(b)(1) shall be considered to govern the scope of the benefits that may be required, provided that the terms and conditions of the plan or coverage relating to such an exclusion or limit are in compliance with the requirements of law.

SA 844. Mr. SPECTER 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 153, strike line 9 and all that follows through page 154, line 2, and insert the following:

''(10) STATUTORY DAMAGES.—The remedies set forth in this subsection (n) shall be the exclusive remedies for causes of action brought under this subsection. In such actions, the court shall apply the tort laws of the State in determining damages. If such damages are not limited under State law in actions brought under this subsection against a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan), then State law limiting such damages in actions brought against health care entities shall apply until such State enacts legislation imposing such limits against group health plans (and issuers). Nothing in this section shall be construed to require a State to enact legislation imposing limits on damages in actions against group health plans and issuers.

On page 160, between lines 2 and 3, insert the following:

''(D) ACTIONS IN FEDERAL COURT.—A cause of action described in subparagraph (A) shall be brought and maintained only in the Federal district court for the district in the State in which the alleged injury or death that is the subject of such action occurred. In any such action, the court shall apply the laws of such State in determining liability and damages. If such State limits the amount of damages that a plaintiff may receive, such limits shall apply in such actions.

On page 156, strike lines 15 and 16 and insert the following:

subsection.

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

''(1) LIMITATION.—

''(A) 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 action claimant, or the group of claimants is limited to the participants, beneficiaries, or enrollees with respect to a group health plan established by only 1 plan sponsor or with respect to coverage provided by only 1 issuer. No action maintained by such class, such derivative action claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative action claimant, or group of claimants or consolidated for any purpose with any other proceeding.

''(B) DEFINITIONS.—In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.

''(2) EFFECTIVE DATE.—Paragraph (1) shall apply to all actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of the Bipartisan Patient Protection Act, and all actions that are filed not earlier than that date.''.

(2) RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT.—Section 1964(c) of title 18, United States Code, is amended—

(A) by inserting ''(1)'' after the subsection designation; and

(B) by adding at the end the following:

''(2)(A)(i) No action may be brought under this subsection, or alleging any violation of section 1962, if the action seeks relief concerning the manner in which any person has marketed, provided information concerning, established, administered, or otherwise operated or provided a group health plan, or health insurance coverage issued in connection with a group health plan. Any such action shall only be brought under the Employee Retirement Income Security Act of 1974.

''(ii) In this subparagraph, the terms 'group health plan' and 'health insurance issuer' have the meanings given such terms in section 733 of the Employee Retirement Income Security Act of 1974.

''(B) Subparagraph (A) shall apply to actions that are pending and have not been finally determined by judgment or settlement prior to the date of enactment of the Bipartisan Patient Protection Act, and all actions that are filed not earlier than that date.''.

(3) CONFORMING AMENDMENT.—Section

SA 845. Mr. GRASSLEY 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, strike lines 1 through 14.

SA 846. Mr. NICKLES (for himself and Mr. ENSIGN) 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 173, strike line 19 and all that follows through line 14 on page 174, and insert the following:

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—The amendments made by sections 201(a), 301, 302, and 303 (and title I insofar as it relates to such sections) shall apply to group health plans maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers beginning on the general effective date.

SA 847. Mr. BROWNBACK 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:

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

''Sec.
''301. Definitions
''302. Prohibition on germline gene modification.

''§ 301. Definitions

''In this chapter:

(1) HUMAN GERMLINE GENE MODIFICATION.—The term 'human germline modification' means the intentional modification of DNA in any human cell (including human eggs, sperm, fertilized eggs, zygotes, blastocysts, embryos, or any precursor cells that will differentiate into gametes or can be manipulated to do so) for the purpose of producing a genetic change which can be passed on to future individuals, including inserting, deleting or altering 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 and will not be used to create human embryos. Nor does it include the change of DNA involved in the normal process of sexual reproduction.

''(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.

''(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. 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.

Rule of construction: Nothing in this Act is intended to limit somatic cell gene therapy, or to effect research involving human pluripotent stem cells.

''§ 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 intentionally 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 848. Mr. ENSIGN 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:

At the end, add the following:

SEC. ___. IMMUNITY.

(a) IN GENERAL.—Notwithstanding any other provision of law, no health care professional shall be liable for the performance of, or the failure to perform, any duty in providing pro bono medical services to a medically underserved or indigent individual.

(b) DEFINITIONS.—In this section:

(1) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' has the meaning given the term in section 151.

(2) MEDICALLY UNDERSERVED OR INDIGENT INDIVIDUAL.—The term ''medically underserved or indigent individual'' means an individual that does not have health care coverage under a group health plan, health insurance coverage, or any other health care coverage program, or who is unable to pay for the health care services that are provided to the individual.

SA 849. Mr. ENSIGN 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:

Subtitle C of title I is amended by adding at the end the following:

SEC. 122. GENETIC INFORMATION.

(a) DEFINITIONS.—In this section:

(1) CONTROLLED GROUP.—The term ''controlled group'' means any group treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986.

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

(A) the spouse of the individual;

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

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

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

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

(5) GENETIC TEST.—The term ''genetic test'' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites in order to detect genotypes, mutations, or chromosomal changes.

(6) GROUP HEALTH PLAN, HEALTH INSURANCE ISSUER.—The terms ''group health plan'' and ''health insurance issuer'' include a third party administrator or other person acting for or on behalf of such plan or issuer.

(7) PREDICTIVE GENETIC INFORMATION.—

(A) IN GENERAL.—The term ''predictive genetic information'' means—

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

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

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

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

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

(ii) information about chemical, blood, or urine analyses of the individual, unless these analyses are genetic tests; or

(iii) information about physical exams of the individual, and other information relevant to determining the current health status of the individual.

(b) NONDISCRIMINATION.—

(1) NO ENROLLMENT RESTRICTION FOR GENETIC SERVICES.—A group health plan, and a health insurance issuer offering health insurance coverage, shall not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on genetic information (or information about a request for or the receipt of genetic services by such individual or a family member of such individual) in relation to the individual or a dependent of the individual.

(2) NO DISCRIMINATION IN GROUP RATE BASED ON PREDICTIVE GENETIC INFORMATION.—A group health plan, and a health insurance issuer offering health insurance coverage, shall not deny eligibility to a group or adjust premium or contribution rates for a group on the basis of predictive genetic information concerning an individual in the group (or information about a request for or the receipt of genetic services by such individual or a family member of such individual).

(3) LIMITATION ON GENETIC TESTING.—

(A) LIMITATION ON REQUESTING OR REQUIRING GENETIC TESTING.—A group health plan, or a health insurance issuer offering health insurance coverage, shall not request or require an individual or a family member of such individual to undergo a genetic test.

(B) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit the authority of a health care professional, who is providing treatment with respect to an individual and who is employed by a group health plan or a health insurance issuer, to request that such individual or family member of such individual undergo a genetic test. Such a health care professional shall not require that such individual or family member undergo a genetic test.

(4) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—Except as provided in subsections (c) and (d), a group health plan, or a health insurance issuer offering health insurance coverage, shall not request, require, collect, or purchase predictive genetic information concerning an individual (or information about a request for or the receipt of genetic services by such individual or a family member of such individual).

(5) DISCLOSURE OF PREDICTIVE GENETIC INFORMATION.—A group health plan, or a health insurance issuer offering health insurance coverage, shall not disclose predictive genetic information about an individual (or information about a request for or the receipt of genetic services by such individual or a family member of such individual) to—

(A) any entity that is a member of the same controlled group as such issuer or plan sponsor of such group health plan;

(B) any other group health plan or health insurance issuer or any insurance agent, third party administrator, or other person subject to regulation under State insurance laws;

(C) the Medical Information Bureau or any other person that collects, compiles, publishes, or otherwise disseminates insurance information;

(D) the individual's employer or any plan sponsor; or

(E) any other person the Secretary may specify in regulations.

(c) INFORMATION FOR PAYMENT FOR GENETIC SERVICES.—

(1) IN GENERAL.—With respect to payment for genetic services conducted concerning an individual or the coordination of benefits, a group health plan, or a health insurance issuer offering health insurance coverage, may request that the individual provide the plan or issuer with evidence that such services were performed.

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

(A) permit a group health plan or health insurance issuer to request (or require) the results of the services referred to in such paragraph; or

(B) require that a group health plan or health insurance issuer make payment for services described in such paragraph where the individual involved has refused to provide evidence of the performance of such services pursuant to a request by the plan or issuer in accordance with such paragraph.

(d) INFORMATION FOR PAYMENT OF OTHER CLAIMS.—With respect to the payment of claims for benefits other than genetic services, a group health plan, or a health insurance issuer offering health insurance coverage, may request that an individual provide predictive genetic information so long as such information—

(1) is used solely for the payment of a claim;

(2) is limited to information that is directly related to and necessary for the payment of such claim and the claim would otherwise be denied but for the predictive genetic information; and

(3) is used only by an individual (or individuals) within such plan or issuer who needs access to such information for purposes of payment of a claim.

(e) RULES OF CONSTRUCTION.—

(1) COLLECTION OR DISCLOSURE AUTHORIZED BY INDIVIDUAL.—The provisions of paragraphs (4) (regarding collection) and (5) of subsection (b) shall not apply to an individual if the individual (or legal representative of the individual) provides prior, knowing, voluntary, and written authorization for the collection or disclosure of predictive genetic information.

(2) DISCLOSURE FOR HEALTH CARE TREATMENT.—Nothing in this section shall be construed to limit or restrict the disclosure of predictive genetic information from a health care provider to another health care provider for the purpose of providing health care treatment to the individual involved.

(f) VIOLATION OF GENETIC DISCRIMINATION OR GENETIC DISCLOSURE PROVISIONS.—

(1) IN GENERAL.—In any action under a covered provision against any administrator of a group health plan, or health insurance issuer offering health insurance coverage (including any third party administrator or other person acting for or on behalf of such plan or issuer) alleging a violation of subsection (b), (c), or (d), the court may award any appropriate legal or equitable relief. Such relief may include a requirement for the payment of attorney's fees and costs, including the costs of expert witnesses.

(2) DEFINITION.—In this subsection, the term ''covered provision'' means section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) or section 2722 or 2761 of the Public Health Service Act (42 U.S.C. 300gg–2, 300gg–61).

(g) CIVIL PENALTY.—The monetary provisions of section 308(b)(2)(C) of Public Law 101–336 (42 U.S.C. 12188(b)(2)(C)) shall apply for purposes of the Secretary enforcing the provisions referred to in subsection (f), except that any such relief awarded shall be paid only into the general fund of the Treasury.

(h) SPECIAL RULE IN CASE OF GENETIC INFORMATION.—With respect to health insurance coverage offered by a health insurance issuer, the provisions of this section relating to genetic information (including information about a request for or the receipt of genetic services by an individual or a family member of such individual) shall not be construed to supersede any provision of State law that establishes, implements, or continues in effect a standard, requirement, or remedy that more completely—

(1) protects the confidentiality of genetic information (including information about a request for or the receipt of genetic services by an individual or a family member of such individual) or the privacy of an individual or a family member of the individual with respect to genetic information (including information about a request for or the receipt of genetic services by the individual or a family member of such individual); or

(2) prohibits discrimination on the basis of genetic information than does this section.

At the end of title II, insert the following:

SEC. 203. ELIMINATION OF OPTION OF NON-FEDERAL GOVERNMENTAL PLANS TO BE EXCEPTED FROM REQUIREMENTS CONCERNING GENETIC INFORMATION.

Section 2721(b)(2) of the Public Health Service Act (42 U.S. C. 300gg–21(b)(2)) is amended—

(1) in subparagraph (A), by striking ''If the plan sponsor'' and inserting ''Except as provided in subparagraph (D), if the plan sponsor''; and

(2) by adding at the end the following:

''(D) ELECTION NOT APPLICABLE TO REQUIREMENTS CONCERNING GENETIC INFORMATION.—The election described in subparagraph (A) shall not be available with respect to the provisions of subsections (b), (c), and (d) of section 122 of the Bipartisan Patient Protection Act and the provisions of section 2702(b) to the extent that the subsections and section apply to genetic information (or information about a request for or the receipt of genetic services by an individual or a family member of such individual).''.

SEC. 204. APPLICATION OF GENETIC NONDISCRIMINATION REQUIREMENTS TO MEDIGAP PLANS.

(a) NONDISCRIMINATION.—Section 1882(s)(2) of the Social Security Act (42 U.S.C. 1395ss(s)(2)) is amended by adding at the end the following:

''(E) Each issuer of a medicare supplemental policy, and each such policy offered by such an issuer, shall comply with the requirements under section 122 of the Bipartisan Patient Protection Act.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to each issuer of a medicare supplemental policy and each such policy for policy years beginning after October 1, 2002.

(c) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the amendment made by subsection (a), the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act (42 U.S.C. 1395ss) due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, not later than June 30, 2002, the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as subsequently modified) to conform to the amendment made by subsection (a), such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall, not later than October 1, 2002, make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section; or

(ii) October 1, 2002.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the amendment made by subsection (a); but

(ii) having a legislature which is not scheduled to meet in 2002 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 2002. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 205. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE INTERNAL REVENUE CODE OF 1986.

(a) IN GENERAL.—Chapter 100 of the Internal Revenue Code of 1986 is amended—

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

(2) by inserting after subchapter B the following:

''SUBCHAPTER C—PATIENT PROTECTION STANDARDS

''SEC. 9821. PATIENT PROTECTION STANDARDS.

''Each group health plan shall comply with patient protection requirements under title I of the Bipartisan Patient Protection Act, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this section.''.

(b) APPLICATION TO EMPLOYERS WITH FEWER THAN 2 EMPLOYEES.—Section 9831(a) of the Internal Revenue Code of 1986 is amended by striking ''this chapter'' and inserting ''this chapter (other than section 9821, with respect to the application of section 122 of the Bipartisan Patient Protection Act)''.

After section 301, insert the following:

SEC. 301A. APPLICATION TO EMPLOYERS WITH FEWER THAN 2 EMPLOYEES.

Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714(a) (with respect to the application of section 122 of the Bipartisan Patient Protection Act)''.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURAL, NUTRITION, AND FORESTRY

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to meet during the session of the Senate on Thursday, June 28, 2001. The purpose of this hearing will be to discuss the next Federal farm bill.

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

COMMITTEE ON ARMED SERVICES

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Thursday, June 28, 2001, at 2:30 p.m., in open session to receive testimony on the fiscal year 2002 budget amendment, in review of the Defense authorization request for fiscal year 2002 and the Future Years Defense Program.

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

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during these session of the Senate on June 28, 2001, to conduct a hearing on ''The Reauthorization of the Iran and Libya Sanctions Act.''

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. REID. 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 Thursday, June 28 at 9:30 a.m. to conduct an oversight hearing. The committee will receive testimony on science and technology studies on climate change.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Thursday, June 28, 2001, at 2 p.m. to hold a hearing titled, ''Zimbabwe's Political and Economic Crisis'' as follows:

WITNESSES

Panel 1: Walter H. Kansteiner, Assistant Secretary of State for African Affairs, Department of State, Washington, DC.

Panel 2: Professor Robert Rotberg, President, World Peace Foundation, Cambridge, MA.

Yves Sorokobi, Africa Director, Committee to Protect Journalists, New York, NY.

Mr. John Prendergast, International Crisis Group, Washington, DC.

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

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet Thursday, June 28, 2001, at 9:30 am for a hearing regarding ''The Impact of Electric Industry Restructuring on System Reliability.''

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

COMMITTEE ON RULES AND ADMINISTRATION

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Rules and Administration be authorized to meet during the session of the Senate on Thursday, June 28, 2001, at 10 a.m., to receive testimony from Members of the House of Representatives on election reform.

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

COMMITTEE ON VETERANS' AFFAIRS

Mr. REID. Mr. President, I ask unanimous consent that the Committee on Veterans' Affairs be authorized to meet during the session of the Senate on Thursday, June 28, 2001, at 10 a.m., in room 418 of the Russell Senate Office Building, for a hearing on pending veterans' benefits legislation as follows:

S. 1090: Cost-of-living adjustment for veterans' benefits. Sponsor: Senator ROCKEFELLER.

S. 1089: U.S. Court of Appeals for Veterans Claims (CAVC) succession plan to address judges retiring in 2004/2005. Repeals the NOD as a jurisdictional threshold for appearing before the CAVC. Sponsor: Senator ROCKEFELLER.

S. 1091: (1) Eliminates the 30-year limit on manifestation from time of exposure for the presumption of service connection for Agent Orange-related respiratory cancer; (2) Restores a VA presumption, eliminated by a Court decision, that in-country Vietnam veterans were exposed to Agent Orange; (3) tasks the National Academy of Sciences to continue reporting on Agent Orange and its association with disease for 10 more years (5 reports). Sponsor: Senator ROCKEFELLER.

S. 1063: CAVC-requested bill pertaining to administrative matters. Sponsor: Senator ROCKEFELLER.

S. 1088. Creates flexibility for MGIB to pay for high tech/short-term courses. Sponsor: Senator ROCKEFELLER.

S. 1093: Miscellaneous veterans' benefits provisions (based on informal input from VA):

COMPENSATION

a. Eliminate compensation for incarcerated persons—We previously enacted legislation to reduce compensation to incarcerated veterans to the equivalent of 10 percent, disability compensation (or, if they only received 10 percent, to the equivalent of 5 percent). Veterans that were already incarcerated were grandfathered out of the reduction. This change would stop only future payments to these veterans.

b. Reduce benefits for fugitive felons—Currently, veterans who are fugitive from justice are eligible to receive VA benefits. This would bar them from receiving benefits while a fugitive (fleeing prosecution, confinement for a felony, or in violation of a condition of probation or parole).

c. Duty to assist (technical corrections).

VOCATIONAL REHABILITATION

Eliminate the cap of 500 veteran participants in Voc Rehab's ''Independent Living'' program. The cap was set when the program was initially piloted. While the time limit on the program was repealed, the cap on participants was not. VA has not turned any one away from the program, but has been exceeding 500 veterans in the last couple of years. The goal of the program is to assist a veteran who is too disabled to retrain for employment to achieve and maintain a stated independent living outcome.

LOAN GUARANTY

Increase the home loan guaranty amount to $63,175 from the current $50,750, to keep pace with FHA (and the even higher Fannie Mae or Freddie Mac). The VA amount has not been increased since 1994.

EDUCATION

Overturn court decision eliminating the delimiting date for use of chapter 35 educational benefits by surviving spouses. The spouse would be allowed to choose the beginning date of the eligibility period. It could be any date between the effective date of the rating of the veteran's service-connected disability as permanently and totally disabling, and the date VA notified the veteran of this fact. A 10-year period would run from the date the spouse chose.

PENSION

a. Excludes life insurance proceeds from countable income for determination of nonservice-connected death pension eligibility for poor surviving spouses of wartime veterans. Currently, counting life insurance could make the spouse ineligible for a year. Modifies effective date of beginning benefits.

b. Modifies the requirement for pensioners to report changes in income at the end of the month, to the end of the year.

S. 131: To increase the rate of the basic benefit of MGIB to the average cost of tuition next fiscal year, and then modify the annual COLA to be pegged to educational inflation. Sponsor: Senator JOHNSON.

S. 228: To make permanent the Native American veterans housing loan