Indians of Western Oklahoma, a group which has had no nexus with the State of New Jersey for over a century, to gain control over, and operate a casino on, a site in Wildwood, New Jersey; and

Whereas, this proposed casino would not be subject to regulation or taxation by this State and would directly compete with Atlantic City's casinos and other forms of legalized gambling; and

Whereas, H.R. 334 of 1997, the ''Fair Indian Gaming Act,'' would close many of the loopholes in the existing federal law and address the risk of corruption by enhancing federal and State regulation of gambling conducted by Indian tribes; now, therefore, be it

Resolved by the General Assembly of the State of New Jersey:

1. The Congress of the United States is respectfully memorialized to enact H.R. 334 of 1997, the ''Fair Indian Gaming Act,'' into law.

2. A copy of this resolution, signed by the Speaker of the General Assembly and attested by the Clerk thereof, shall be transmitted to the Vice-President of the United States, the Speaker of the House of Representatives, and every member of Congress elected from this State.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mrs. HUTCHISON (for herself and Mr. GRAMM):

S. 2325. A bill to provide an opportunity for States to modify agreements under title II of the Social Security Act with respect to student wages; to the Committee on Finance.

By Mr. BRYAN (for himself and Mr. MCCAIN):

S. 2326. A bill to require the Federal Trade Commission to prescribe regulations to protect the privacy of personal information collected from and about children on the Internet, to provide greater parental control over the collection and use of that information, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. COATS (for himself and Mr. LIEBERMAN):

S. 2327. A bill to provide grants to grassroots organizations in certain cities to develop youth intervention models; to the Committee on the Judiciary.

By Mr. BROWNBACK (for himself and Mr. GRASSLEY):

S. 2328. A bill to establish the negotiating objectives of the United States with respect to the WTO Agreement on Agriculture, to establish criteria for the accession of state trading regimes to the WTO, and for other purposes; to the Committee on Finance.

By Mr. JEFFORDS (for himself, Mr. BINGAMAN, and Mr. GRAHAM):

S. 2329. A bill to amend the Internal Revenue Code of 1986 to enhance the portability of retirement benefits, and for other purposes; to the Committee on Finance.

By Mr. LOTT (for Mr. NICKLES (for himself, Mr. FRIST, Ms. COLLINS, Mr. JEFFORDS, Mr. ROTH, Mr. SANTORUM, Mr. HAGEL, Mr. GRAMM, Mr. COATS, Mr. LOTT, Mr. MACK, Mr. CRAIG, Mr. COVERDELL, Mr. ABRAHAM, Mr. ALLARD, Mr. ASHCROFT, Mr. BENNETT, Mr. BOND, Mr. BROWNBACK, Mr. BURNS, Mr. COCHRAN, Mr. DOMENICI, Mr. ENZI, Mr. FAIRCLOTH, Mr. GORTON, Mr. GRAMS, Mr. GRASSLEY, Mr. HATCH, Mr. HELMS, Mr. HUTCHINSON, Mrs. HUTCHISON, Mr. INHOFE, Mr. KEMPTHORNE, Mr. LUGAR, Mr. MCCAIN, Mr. MURKOWSKI, Mr. ROBERTS, Mr. SESSIONS, Mr. SHELBY, Mr. SMITH of New Hampshire, Mr. SMITH of Oregon, Ms. SNOWE, Mr. THOMAS, Mr. THOMPSON, Mr. THURMOND, and Mr. WARNER)):

S. 2330. A bill to improve the access and choice of patients to quality, affordable health care; read the first time.

By Mr. LUGAR:

S. 2331. A bill to provide a limited waiver for certain foreign students of the requirement to reimburse local educational agencies for the costs of the students' education; to the Committee on the Judiciary.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

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

By Mr. DORGAN (for himself and Mr. FRIST):

S. Con. Res. 108. A concurrent resolution recognizing the 50th anniversary of the National Heart, Lung, and Blood Institute, and for other purposes; to the Committee on the Judiciary.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BRYAN (for himself and Mr. MCCAIN):

S. 2326. A bill to require the Federal Trade Commission to prescribe regulations to protect the privacy of personal information collected from and about children on the Internet, to provide greater parental control over the collection and use of that information, and for other purposes; to the Committee on Commerce, Science, and Transportation.

THE CHILDREN'S ONLINE PRIVACY PROTECTION ACT OF 1998

Mr. BRYAN. Mr. President, today the chairman of the Senate Commerce Committee and I are introducing ''the Children's Online Privacy Protection Act of 1998.'' Commercial Web sites are currently collecting and disseminating personal information collected from children that may compromise their safety and most certainly invades their privacy. This legislation will ensure that commercial Web sites that collect and use personal information from children will have safeguards in place to protect you and your family.

The Internet is quickly becoming an significant force in the lives of our children as it moves swiftly into homes and classrooms around the country. Currently more than 3 million children under the age of 18 are online and the number is expected to grow to 15 million by the turn of the century.

I think all would agree that proficiency with the Internet is a critical and vital skill that will be necessary for academic achievement in the next century. The benefits of the Internet are extraordinary. Reference information such as news, weather, sports, stock quotes, movie reviews, encyclopedia and online airline fares are readily available. Users can conduct transactions such as stock trading, make travel arrangements, bank, and shop online.

Millions of people communicate through electronic mail to family and friends around the world, and others use the public message boards to make new friends and share common interests. As an educational and entertainment tool, users can learn about virtually any topic or take a college course.

Unfortunately, the same marvelous advances in computer and telecommunication technology that allow our children to reach out to new resources of knowledge and cultural experiences are also leaving them unwittingly vulnerable to exploitation and harm by deceptive marketers and criminals.

Earlier this spring, I held several meetings in Nevada with educators and parents' representatives to alert them of some of the deceptive practices found on the Internet. Representatives of the FBI and Federal Trade Commission informed Nevadans about some of the Internet's pitfalls. I found it extremely informative and enlightening and to some extent frightening.

You may be startled to learn what information other people are collecting about you and your family may have a profound impact upon their privacy and, indeed, their safety.

Once what may seem to be harmless information has made its way onto the Internet, there is no way of knowing what uses may be put to that information.

Senator MCCAIN and I wrote to the FTC asking them to investigate online privacy issues. Recently, the FTC completed the survey of a number of web sites and found that 89 percent of children's sites collect personal information from children, and less than 10 percent of the sites provide for parental control over the collection and use of this personal information.

I was, frankly, surprised to learn the kinds of information these web sites are collecting from our children. Some were asking where the child went to school, what sports he or she liked, what siblings they had, their pet's name, what kind of time they had after school alone without the supervision of parents.

Others were collecting personal financial information like what the family income was, does the family own stocks or certificates of deposit, did their grandparents give them any financial gifts?

Web sites were using games, contests, and offers of free merchandise to entice children to give them exceedingly personal and private information about themselves and their families. Some even used cartoon characters who asked children for personal information, such as a child's name and address and e-mail address, date of birth, telephone number, and Social Security number.

Much of this information appears to be harmless, but companies are attempting to build a wealth of information about you and your family without an adult's approval—a profile that will enable them to target and to entice your children to purchase a range of products.

The Internet gives marketers the capability of interacting with your children and developing a relationship without your knowledge.

Where can this interactive relationship go? Will your child be receiving birthday cards and communications with online cartoon characters for particular products?

Senator MCCAIN and I believe there must be safeguards against the online collecting of information from children without a parent's knowledge or consent. If a child answers a phone and starts answering questions, a parent automatically becomes suspicious and asks who they are talking to. When a child is on the Internet, parents often have no knowledge of whom their child is interacting.

That is why we are introducing legislation that would require the FTC to come up with rules to govern these kind of activities. The FTC's rules would require commercial web sites to:

(1) Provide notice of its personal information collection and use practices;

(2) Obtain parental consent for the collection, use or disclosure of personnel information from children 12 and under;

(3) Provide parents with an opportunity to opt-out of the collection and/or use of personal information collected from children 13 to 16;

(4) Provide parents access to his or her child's personal information;

(5) Establish and maintain reasonable procedures to ensure the confidentiality, security, accuracy, and integrity of personal information on children.

The FTC must come up with these rules within 1 year. The FTC may provide incentives for industry self-regulatory efforts including safe harbors for industry created guidelines. The bill permits States' attorneys general to enforce the act.

I believe these represent reasonable steps we should take to protect our privacy. Although time is short in this session, I hope we can find a way to enact these commonsense proposals this Congress.

Most people who use online services have positive experiences. The fact that deceptive acts may be committed on the Internet, is not a reason to avoid using the service. To tell children to stop using the Internet would be like telling them to forgo attending college because students are sometimes victimized on campus. A better strategy is for children to learn how to be street smart in order to better safeguard themselves from potentially deceptive situations.

The Internet offers unlimited potential for assisting our child's growth and development. However, we must not send our children off on this adventure without proper guidance and supervision.

Mr. President, in my judgment, the legislation offered today by the senior Senator from Arizona and I provides those reasonable guidelines. I hope colleagues will join with me in making sure this legislation is enacted in this situation.

By Mr. COATS (for himself and Mr. LIEBERMAN):

S. 2327. A bill to provide grants to grassroots organizations in certain cities to develop youth intervention models; to the Committee on the Judiciary.

NATIONAL YOUTH CRIME PREVENTION DEMONSTRATION ACT

Mr. COATS. Mr. President, America currently struggles with a disturbing and growing trend of youth violence. Between 1985 and 1994, the arrest rate for murders by juveniles increased 150 percent, while the rate for adults during this time increased 11 percent. Every day, in our communities and in the media, we see horrific examples of this crime. A 13-year-old girl murders her 3-year-old nephew and dumps him in the trash. A 13-year-old boy is stabbed to death while sitting on his back porch. A group of teenagers hails a cab and, after the driver takes them to their destination, they shoot him dead in an armed robbery.

I did not have to look far for these examples. Each occurred in Indiana, a State generally known as a safe State, a good place to raise a family, not a dangerous place, yet a State where arrests for violent juvenile crimes have skyrocketed 19 percent in the early 1990's. Juvenile violence is no longer a stranger in any ZIP code.

Yet, the problem is expected to grow worse. Crime experts who study demographics warn of a coming crime wave based on the number of children who currently are younger than 10 years old. These experts warn that if current trends are not changed, we might someday look back at our current juvenile crime epidemic as ''the good old days.'' This spiraling upward trend in youth crime and violence is cause for grave concern. So one might ask, what is driving this epidemic?

Over 30 years ago, our colleague DANIEL PATRICK MOYNIHAN, then an official in the Johnson administration, wrote that when a community's families are shattered, crime, violence and rage ''are not only to be expected, they are virtually inevitable.'' He wrote those words in 1965. Since then, arrests of violent juvenile criminals have tripled.

Last Congress, the Subcommittee on Children and Families, which I chair, held a hearing about the role of government in combating juvenile crime. The experts were clear: while government efforts are important, they are also fundamentally limited and incomplete. Government is ultimately powerless to form the human conscience that chooses between right and wrong.

Locking away juveniles might prevent them from committing further crimes, but it does not address the fact that violence is symptomatic of a much deeper, moral and spiritual void in our Nation. In the battle against violent crime, solid families are America's strongest line of defense. But government can be an effective tool if it joins private institutions (families, churches, schools, community groups, and non-profit organizations) in preventing and confronting juvenile crime with the moral ideals that defeat despair and nurture lives.

Today, I rise to introduce the National Youth Crime Prevention Act which will empower local communities to address the rising trend in youth violence. Specifically, this legislation authorizes the Attorney General to award $5 million annually for five years to the National Center for Neighborhood Enterprise to conduct national demonstration projects in eight cities. These projects would aim to end youth crime, violence and family disintegration by building neighborhood capacity and linking proven grassroots organizations within low-income neighborhoods with sources from the public sector, including local housing authorities, law enforcement agencies, and other public entities. The demonstration projects will take place in Washington, DC; Detroit, Michigan; Hartford, Connecticut; Indianapolis, Indiana; Chicago, Illinois; San Antonio, Texas; Dallas, Texas; and Los Angeles, California.

With these funds, the National Center for Neighborhood Enterprise will work with the grassroots organizations in the demonstration cities to establish Violence Free Zone Initiatives. These initiatives would involve successful youth intervention models in partnership with law enforcement, local housing authorities, private foundations, and other public and private partners. To be eligible for the grants, the nonprofit organizations within the demonstration cities must have experience in crime prevention and youth mediation projects and must have a history of cultivating cooperative relationships with other local organizations, housing facilities and law enforcement agencies.

Funds may be used for youth mediation, youth mentoring, life skills training, job creation and entrepreneurship, organizational development and training, development of long-term intervention plans, collaboration with law enforcement, comprehensive support services, local agency partnerships and activities to further community objectives in reducing youth crime and violence.

The success of this approach has already been demonstrated. Last year, The National Center for Neighborhood Enterprise assisted The Alliance for Concerned Men in creating a ''Violence Free Zone'' in Benning Terrace in Southeast DC. The Alliance of Concerned Men brokered peace treaties among the gangs that inhabit, and frequently dominate, the city's public

housing complexes. Benning Terrace in Southeast Washington, known to the DC police department as one of the most dangerous areas of the city, has not had a single murder since the Alliance's peace treaty went into effect early last year. Subsequently, the National Center for Neighborhood Enterprise brought the Alliance, the youths, and the DC Housing Receiver together to develop and implement a plan for jobs and life skills training for the young people and the community itself.

Grassroots organizations are the key to implementing the most effective innovative strategies to address community problems. Their efforts help restore hardpressed inner-city neighborhoods by developing the social, human and economic capital that is key to real, long-term renewal of urban communities. The National Youth Crime Prevention Demonstration Act will provide critical assistance to our Nation's inner-cities as they combat the rising trend in youth violence by linking proven grassroots organizations with established public sector entities.

Mr. President, I urge my colleagues to support this important legislation, and I ask unanimous consent that the text of the National Youth Crime Prevention Demonstration Act be printed in the RECORD.

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

S. 2327

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''National Youth Crime Prevention Demonstration Act''.

SEC. 2. PURPOSES.

The purposes of this Act are as follows:

(1) To establish a demonstration project that establishes violence-free zones that would involve successful youth intervention models in partnership with law enforcement, local housing authorities, private foundations, and other public and private partners.

(2) To document best practices based on successful grassroots interventions in cities, including Washington, District of Columbia; Boston, Massachusetts; Hartford, Connecticut; and other cities to develop methodologies for widespread replication.

(3) To increase the efforts of the Department of Justice, the Department of Housing and Urban Development, and other agencies in supporting effective neighborhood mediating approaches.

SEC. 3. ESTABLISHMENT OF NATIONAL YOUTH CRIME PREVENTION DEMONSTRATION PROJECT.

The Attorney General shall, subject to appropriations, award a grant to the National Center for Neighborhood Enterprise (referred to in this Act as the ''National Center'') to enable the National Center to award grants to grassroots entities in the following 8 cities:

(1) Washington, District of Columbia.

(2) Detroit, Michigan.

(3) Hartford, Connecticut.

(4) Indianapolis, Indiana.

(5) Chicago (and surrounding metropolitan area), Illinois.

(6) San Antonio, Texas.

(7) Dallas, Texas.

(8) Los Angeles, California.

SEC. 4. ELIGIBILITY.

(a) IN GENERAL.—To be eligible to receive a grant under this Act, a grassroots entity referred to in section 3 shall submit an application to the National Center to fund intervention models that establish violence-free zones.

(b) SELECTION CRITERIA.—In awarding grants under this Act, the National Center shall consider—

(1) the track record of a grassroots entity and key participating individuals in youth group mediation and crime prevention;

(2) the engagement and participation of a grassroots entity with other local organizations; and

(3) the ability of a grassroots entity to enter into partnerships with local housing authorities, law enforcement agencies, and other public entities.

SEC. 5. USES OF FUNDS.

(a) IN GENERAL.—Funds received under this Act may be used for youth mediation, youth mentoring, life skills training, job creation and entrepreneurship, organizational development and training, development of long-term intervention plans, collaboration with law enforcement, comprehensive support services and local agency partnerships, and activities to further community objectives in reducing youth crime and violence.

(b) GUIDELINES.—The National Center will identify local lead grassroots entities in each designated city which include the Alliance of Concerned Men of Washington in the District of Columbia; the Hartford Youth Peace Initiative in Hartford, Connecticut; the Family Help-Line in Los Angeles, California; the Victory Fellowship in San Antonio, Texas; and similar grassroots entities in other designated cities.

(c) TECHNICAL ASSISTANCE.—The National Center, in cooperation with the Attorney General, shall also provide technical assistance for startup projects in other cities.

SEC. 6. REPORTS.

The National Center shall submit a report to the Attorney General evaluating the effectiveness of grassroots agencies and other public entities involved in the demonstration project.

SEC. 7. DEFINITIONS.

For purposes of this Act—

(1) the term ''grassroots entity'' means a not-for-profit community organization with demonstrated effectiveness in mediating and addressing youth violence by empowering at-risk youth to become agents of peace and community restoration; and

(2) the term ''National Center for Neighborhood Enterprise'' is a not-for-profit organization incorporated in the District of Columbia.

SEC. 8. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—There are authorized to be appropriated to carry out this Act—

(1) $5,000,000 for fiscal year 1999;

(2) $5,000,000 for fiscal year 2000;

(3) $5,000,000 for fiscal year 2001;

(4) $5,000,000 for fiscal year 2002; and

(5) $5,000,000 for fiscal year 2003.

(b) RESERVATION.—The National Center for Neighborhood Enterprise may use not more than 20 percent of the amounts appropriated pursuant to subsection (a) in any fiscal year for administrative costs, technical assistance and training, comprehensive support services, and evaluation of participating grassroots organizations.

By Mr. JEFFORDS (for himself, Mr. BINGAMAN, and Mr. GRAHAM):

S. 2329. A bill to amend the Internal Revenue Code of 1986 to enhance the portability of retirement benefits, and for other purposes; to the Committee on Finance.

THE RETIREMENT PORTABILITY ACCOUNT (RAP) ACT.

Mr. JEFFORDS. Mr. President, today I am introducing S. 2329, the Retirement Portability Account (RAP) Act. This bill is a close companion to H.R. 3503 introduced by our colleagues EARL POMEROY of North Dakota and JIM KOLBE of Arizona earlier this year. In addition, it contains certain elements of H.R. 3788, the Portman-Cardin bill, which relate to increased pension portability. Generally this bill is intended to be a further iteration of the concepts embodied in both of those bills. It standardizes the rules in the Internal Revenue Code (IRC) which regulate how portable a worker's retirement savings account is, and while it does not make portability of pension benefits perfect, it greatly improves the status quo. Consistent with ''greatly improving the status quo'', this bill contains no mandates. No employer will be ''required'' to accept rollovers from other plans. A rollover will occur when the employee offers, and the employer agrees to accept, a rollover from another plan.

Under current law, it is not possible for an individual to move an accumulated retirement savings account from a section 401(k) (for-profit) plan to a section 457 (state and local government) deferred compensation plan, to an Individual Retirement Account (IRA), then to a section 403(b) (nonprofit organization) plan and ultimately back into a section 401(k) plan, without violating various restrictions on the movement of their money. The RAP Act will make it possible for workers to take their retirement savings with them when they change jobs regardless of the type of employer for which they work.

This bill will also help make IRAs more portable and will improve the uses of conduit IRAs. Conduit IRAs are individual retirement accounts to which certain distributions from a qualified retirement plan or from another individual retirement account have been transferred. RAP changes the rules regulating these IRAs so that workers leaving the for-profit, nonprofit or governmental field can use a conduit IRA as a parking spot for a pre-retirement distribution. These special accounts are needed by many workers until they have another employer-sponsored plan in which to rollover their savings.

In many instances, this bill will allow an individual to rollover an IRA consisting exclusively of tax-deductible contributions into a retirement plan at his or her new place of employment, thus helping the individual consolidate retirement savings in a single account. Under certain circumstances, the RAP Act will also allow workers to rollover any after-tax contributions made at his or her previous workplace, into a new retirement plan.

Current law requires a worker who changes jobs to face a deadline of 60 days within which to roll over any retirement savings benefits either into an Individual Retirement Account, or into the retirement plan of his or her new employer. Failure to meet the deadline can result in both income and excise taxes being imposed on the account. We believe that this deadline should be waived under certain circumstances and we have outlined them in the bill. Consistent with the Pomeroy-Kolbe bill, in case of a Presidentially-declared natural disaster or military service in a combat zone, the Treasury Department will have the authority to disallow imposition of any tax penalty for the account holder. Consistent with the additional change proposed by the Portman-Cardin bill, however, we have included a waiver of tax penalties in the case of undue hardship, such as a serious personal injury or illness and we have given the Department of the Treasury the authority to waive this deadline, as well.

The Retirement Account Portability bill will also change two complicated rules which harm both plan sponsors and plan participants; one dealing with certain business sales (the so-called ''same desk'' rule) and the other dealing with retirement plan distribution options. Each of these rules has impeded true portability of pensions and we believe they ought to be changed.

In addition, this bill will extend the Pension Benefit Guaranty Corporation's (PBGC) Missing Participant program to defined benefit multiemployer pension plans. Under current law, the PBGC has jurisdiction over both single-employer and multiemployer defined benefit pension plans. A few years ago, the agency initiated a program to locate missing participants from terminated, single-employer plans. The program attempts to locate individuals who are due a benefit, but who have not filed for benefits due to them, or who have attempted to find their former employer but failed to receive their benefits. This bill expands the missing participant program to multiemployer pension plans.

I know of no reason why individuals covered by a multiemployer pension plans should not have the same protections as participants of single-employer pension plans and this change will help more former employees receive all the benefits to which they are entitled. This bill does not expand the missing participants program to defined contribution plans. Supervision of defined contribution plans is outside the statutory jurisdiction of the PBGC and I have not heard strong arguments for including those plans within the jurisdiction of the agency.

In a particularly important provision, the Retirement Account Portability bill will allow public school teachers and other state and local employees who move between different states and localities to use their savings in their section 403(b) plan or section 457 deferred compensation arrangement to purchase ''service credit'' in the plan in which they are currently participating, and thus obtain greater pension benefits in the plan in which they conclude their career. However, the bill does not allow the use of a lump sum cash-out from a defined benefit plan to be rolled over to a section 403(b) or section 457 plan.

As a final note, this bill, this bill does not reduce the vesting schedule from the current five year cliff vesting (or seven year graded) to a three year cliff or six year graded vesting schedule. I am not necessarily against the shorter vesting schedules, but I feel that this abbreviated vesting schedule makes a dramatic change to tax law without removing some of the disincentives to maintaining a pension plan that businesses—especially small businesses—desperately need.

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

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

INCREASING PORTABILITY FOR PENSION PLAN PARTICIPANTS: FACILITATING ROLLOVERS

Under current law, an ''eligible rollover distribution'' may be either (1) rolled over by the distributee into an ''eligible retirement plan'' if such rollover occurs within 60 days of the distribution, or (2) directly rolled over by the distributing plan to an ''eligible retirement plan.'' An ''eligible rollover distribution'' does not include any distribution which is required under section 401(a)(9) or any distribution which is part of a series of substantially equal periodic payments made for life, life expectancy or over a period of ten years or more. An ''eligible retirement plan'' is another section 401 plan, a section 403(a) plan or an IRA. (If the distributee is a surviving spouse of a participant, ''eligible retirement plans'' consist only of IRAs.) Under these rules, for example, amounts distributed from a section 401(k) plan may not be rolled over to a section 403(b) arrangement.

In the case of a section 403(b) arrangement, distributions which would be eligible rollover distributions except for the fact that they are distributed from a section 403(b) arrangement may be rolled over to another section 403(b) arrangement or an IRA. Under these rules, amounts distributed from a section 403(b) may not be rolled over into a section 401(k) plan.

When an ''eligible rollover distribution'' is made, the plan administrator must provide a written notice to the distributee explaining the availability of a direct rollover to another plan or an IRA, that failure to exercise that option will result in 20% being withheld from the distribution and that amounts not directly rolled over may be rolled over by the distributee within 60 days.

Under ''conduit IRA'' rules, an amount may be rolled over from a section 401 or 403(a) plan to an IRA and subsequently rolled over to a section 401 or 403(a) plan if amounts in the IRA are attributable only to rollovers from section 401 or 403(a) plans. Also under conduit IRA rules, an amount may be rolled over from a section 403(b) arrangement to an IRA and subsequently rolled over to a section 403(b) arrangement if amounts in the IRA are attributable only to rollovers from section 403(b) arrangements.

In the case of a section 457 deferred compensation plan, distributions may not be rolled over by a distributee; however, amounts may be transferred from one section 457 plan to another section 457 plan without giving rise to income to the plan participant.

A participant in a section 457 plan is taxed on plan benefits that are not transferred when such benefits are paid or when they are made available. In contrast, a participant in a qualified plan or a section 403(b) arrangement is only taxed on plan benefits that are actually distributed.

Under this proposal, ''eligible rollover distributions'' from a section 401 plan could be rolled over to another section 401 plan, a section 403(a) plan, a section 403(b) arrangement, a section 457 deferred compensation plan maintained by a state or local government or an IRA. Likewise, ''eligible rollover distributions'' from a section 403(b) arrangement could be rolled over to the same broad array of plans and IRAs. Thus, an eligible rollover distribution from a section 401(k) plan could be rolled over to a section 403(b) arrangement and vice versa. (As under current law, if the distributee is a surviving spouse of a participant, the distribution could only be rolled over into an IRA.)

Eligible rollover distributions from all section 457 deferred compensation plans could be rolled over to the same broad array of plans and IRAs; however, the rules regarding the mandatory 20% withholding would not apply to the section 457 plans. A section 457 plan maintained by a government would be made an eligible retirement plan for purposes of accepting rollovers from section 401(k), section 403(b) and other plans.

The written notice required to be provided when an ''eligible rollover distribution'' is made would be expanded to apply to section 457 plans and to include a description of restrictions and tax consequences which will be different if the plan to which amounts are transferred is a different type of plan from the distribution plan.

Participants who mix amounts eligible for special capital gains and averaging treatment with amounts not so eligible would lose such treatment.

A participant in a section 457 plan would only be taxed on plan benefits that are not transferred or rolled over when they are actually paid.

These changes would take effect for distributions made after December 31, 1998.

The reason for this expansion of current law rules permitting rollovers is to allow plan participants to put all of their retirement plan savings in one vehicle if they change jobs. Given the increasing mobility of the American workforce, it is important to make pension savings portable for those who change employment. This proposal contains no mandates requiring employers to accept rollovers from their new employees. A rollover occurs when the employee makes an offer to move his/her money and the employer accepts the funds.

Because of the rule that taxes section 457 plan participants on benefits made available, section 457 plans cannot provide plan participants with the flexibility to change benefit payments to fit their changing needs. There is no policy justification for this lack of flexibility.

ROLLOVERS OF INDIVIDUAL RETIREMENT ACCOUNTS TO QUALIFIED PLANS

Under current law, a taxpayer is not permitted to roll amounts held in an individual retirement account (IRA) (other than a conduit IRA), to a section 401 plan, a 403(a) plan, a 403(b) arrangement or a section 457 deferred compensation plan. Currently, the maximum direct IRA contribution is $2,000. Since 1986, generally only individuals with income below certain limits are able to fully deduct

IRA contributions. For others, IRA contributions have been nondeductible or partially deductible in some or all years. To the extent that IRA contributions are non-deductible, they have ''basis'' which is not taxed the second time upon distribution from the IRA. The burden of maintaining records of IRA basis has been the taxpayer's, since only the taxpayer has had the information to determine his or her basis at the outset and as an ongoing matter.

IRAs are generally subject to different regulatory schemes than other retirement savings plans, such as section 401(k)s or section 457 deferred compensation plans, although the 10 percent tax penalty on early distributions applies to both qualified plans and IRAs. For example, one cannot take a loan from an IRA, although a recent change in law will make it easier to make a penalty-free withdrawal from an IRA to finance a first-time home purchase or higher-education expenses.

Under the bill, rollovers of contributory IRAs would be permitted if and only if the individual has never made any nondeductible contributions to his or her IRA and has never had a Roth IRA. The IRA may then be rolled over into a section 401 plan, a section 403(a) plan, a 403(b) arrangement or a section 457 deferred compensation plan. Since the vast majority of IRAs contain only deductible contributions, this change will allow many individuals to consolidate their retirement savings into one account. For those who have both nondeductible and deductible contributions, they may still have two accounts, one containing the majority of funds consolidated in one place and one containing the nondeductible IRA contributions. Once IRA money is rolled over into a plan however, the IRA contributions would become plan money and subject to the rules of the plan except that participants who mix amounts for special capital gains and averaging treatment with amounts not so eligible would lose such treatment. Employers will not be required to accept rollovers for IRAs.

These changes would apply to distributions after December 31, 1998.

The reasons for this change is to take another step toward increased portability of retirement savings. While this proposal would not guarantee that all retirement savings would be completely portable, it will increase the extent to which such savings are portable and fungible. Other rules and requirements affecting IRAs and their differences and similarities to plan money will continue to be the subject of Congressional scrutiny.

ROLLOVERS OF AFTER-TAX CONTRIBUTIONS AND ROLLOVERS NOT MADE WITHIN 60 DAYS OF RECEIPT

Under current law, employees are allowed to make after-tax contributions to IRAs, 401(k) plans, and other plans. They are not permitted to roll over distributions of those after-tax contributions to an IRA or another plan.

Rollovers from qualified plans to an IRA (or from an IRA to another IRA) must occur within 60 days of the initial distribution. Income tax withholding rules apply to certain distributions that are not direct trustee-to-trustee transfers from the qualified plan to an IRA or another plan.

The proposal would allow after-tax contributions to be included in a rollover contribution to an IRA or other types of retirement plans, but it does not require the receiving trustee to track or report the basis. That requirement would be the responsibility of the taxpayer, as in the case of nondeductible IRA contributions.

The IRS is given the authority to extend the 60-day period where the failure to comply with such requirements is attributable to casualty, disaster or other events beyond the reasonable control of the individual subject to such requirements.

These changes would generally apply to distributions made after December 31, 1998. The hardship exception to the 60-day rollover period would apply to such 60-day periods expiring after the date of enactment.

These changes are warranted because after-tax savings in retirement plans enhance retirement security and are particularly attractive to low and middle income taxpayers. Allowing such distributions to be rolled over to an IRA or a plan will increase the chances that those amounts would be retained until needed for retirement.

Often individuals, particularly widows, widowers and individuals with injuries of illnesses, miss the 60-day window. In other instances, individuals miss the 60-day rollover period because of the failure of third parties to perform as directed. Finally, victims of casualty or natural disaster should not be penalized. A failure to satisfy the 60-day rule, by even one day can result in catastrophic tax consequences for a taxpayer that can include immediate taxation of the individual's entire retirement savings (often in a high tax bracket), a 10% early distribution tax, and a substantial depletion of retirement savings. By giving the IRS the authority to provide relief from the 60-day requirement for failures outside the control of the individual, the proposal would give individuals in these situations the ability to retain their retirement savings in an IRA or a qualified plan.

TREATMENT OF FORMS OF DISTRIBUTION

Under current law, section 411(d)(6), the ''anti-cutback'' rule generally provides that when a participant's benefits are transferred from one plan to another, the transferee plan must preserve all forms of distribution that were available under the transferor plan.

Under this proposal, an employee may elect to waive his or her section 411(d)(6) rights and transfer benefits from one defined contribution plan to another defined contribution plan without requiring the transferee plan to preserve the optional forms of benefits under the transferor plan if certain requirements are satisfied to ensure the protection of participants' interests. This proposal would also apply to plan mergers and other transactions having the effect of a direct transfer, including consolidation of benefits attributable to different employers within a multiple employer plan.

These changes would apply to transfers after December 31, 1998.

The requirement that a defined contribution plan preserve all forms of distribution included in transferor plans significantly increases the cost of plan administration, particularly for employers that make numerous business acquisitions. The requirements also causes confusion among plan participants who can have separate parts of their retirement benefits subject to sharply different plan provision and requirements. The increased cost for the plan and the confusion for the participant brought about by the requirement to preserve all forms of distribution are based on a rule intended to protect a participant's right not to have an arbitrary benefit reduction. The current rule sweeps too broadly since it protects both significant and insignificant rights. Where a participant determines the rights to be insignificant and wants to consolidate his or her retirement benefits, there is no reason not to permit his consolidation. This consolidation increases portability and reduces administrative costs.

RATIONALIZATION OF RESTRICTIONS ON DISTRIBUTIONS, THE ''SAME DESK'' RULE

Generally, under current law, distributions from 401(k) plans are limited to separation from service, death, disability, age 59½, hardship, plan termination without maintenance of another plan, and certain corporate transactions. The term ''separation from service'' has been interpreted to include a ''same desk'' rule. Under the ''same desk'' rule, distributions to a terminated employee are not permitted if the employee continues performing the same functions for a successor employer (such as a joint venture owned in part by the former employer or the buyer in a business acquisition). The same desk rule also applies to section 403(b) arrangements and section 457 plans, but does not apply to other types of plans such as defined benefit plans.

Under this proposal, the ''same desk rule'' would be eliminated by replacing ''separation from service'' with ''severance from employment''. Conforming changes would be mad in the comparable provisions of section 403(b) arrangements and eligible deferred compensation plans under section 457. This change would apply to distributions after December 31, 1998.

Under this proposal, affected employees would be able to roll over their 401(k) account balance to an IRA or to their new employer's 401(k) plan. Modifying the same desk rule so that all of a worker's retirement funds can be transferred to the new employer after a business sale has taken place will allow the employee to keep his or her retirement nest egg in a single place. It will also coordinate the treatment of defined benefit plan benefits with the treatment of 401(k) plans in these types of transactions. Employees do not understand why their 401(k) account must remain with the former employer until they terminate employment with their new employer, especially since this restriction does not apply to other plans in which they participate. The corporate transaction exception provides some relief from the same desk rule but is inapplicable in numerous cases.

PURCHASE OF SERVICE CREDIT IN GOVERNMENTAL DEFINED BENEFIT PLANS

Under current law, employees of State and local governments often have the option of purchasing service credits in their State defined benefit plans in order to make up for the time spent in another State or district. These employees cannot currently use the money they have saved in their section 403(b) arrangements or section 457 plans to purchase these service credits.

This proposal would permit State and local government employees the option to use the funds in their section 403(b) arrangements or section 457 deferred compensation plans to purchase service credits.

These changes would apply to trustee-to-trustee transfers after December 31, 1998.

This change will permit employees of State and local governments, particularly teachers, who often move between States and school districts in the course of their careers, to buy a larger defined benefit pension with the savings they have accumulated in a section 403(b) arrangement or section 457 deferred compensation plan. The greater number of years of credit that they purchase would reflect a full career of employment rather than two or more shorter periods of employment in different States or districts. Allowing the more flexible use of existing account balances in 403(b) arrangements or section 457 plans will allow more of these employees to purchase service credits and earn a full defined benefit pension.

MISSING PARTICIPANTS PROGRAM

Under current law in the case of certain terminated single employer defined benefit plans, the Pension Benefit Guaranty Corporation (PBGC) will act as a clearinghouse for benefits due to participants who cannot

be located (''missing participants''). Under the program, when a plan is terminated and is unable to locate former workers who are entitled to benefits, the terminating plan is allowed to transfer these benefits to the PBGC which then attempts to locate the employees in question. The missing participants program is limited to certain defined benefit plans.

This proposal would expand the PBGC's missing participant program to cover multiemployer defined benefit pension plans. The program would not apply to governmental plans or to church plans not covered by the PBGC, however. If a plan covered by the new program has missing participants when the plan terminates, at the option of the plan (or employer, in the case of a single employer plan), the missing participants' benefits could be transferred to the PBGC along with related information.

This change would take effect with respect to distributions from t4erminating multiemployer plans that occur after the PBGC has adopted final regulations implementing the provision.

By permitting sponsors the option of transferring pension funds to the PBGC, the chances that a missing participant will be able to recover benefits could be increased.

DISREGARDING ROLLOVERS FOR PURPOSES OF THE CASH OUT AMOUNT

Under current law, if a terminated participant has a vested accrued benefit of $5,000 or less, the plan may distribute such benefit in a lump sum without the consent of the participant or the participant's spouse. This $5,000 cash-out limit is not indexed for inflation. In applying the $5,000 cash-out rule, the plan sponsor is under regulations required to look back to determine if an individual's account every exceeded $5,000 at the time of any prior distribution. Rollover amounts count in determining the maximum balance which can be involuntarily cashed out.

This proposal would allow a plan sponsor to disregard rollover amounts in determining eligibility for the cash-out rule, that is, whether a participant's vested accrued benefit exceeds $5,000.

This proposal would apply to distributions after December 31, 1998.

The reason for this change is to remove a possible reason for employers to refuse to accept rollovers.

PLAN AMENDMENTS

Under current law, there is generally a short period of time to make plan amendments that reflect the amendments to the law. In addition, the anti-cutback rules can have the unintentioned effect of preventing an employer from amending its plan to reflect a change in the law.

Amendments to a plan or annuity contract made pursuant to any amendment made by this bill are not required to be made before the last day of the first plan year beginning on or after January 1, 2001. In the case of a governmental plan, the date for amendments is extended to the first plan year beginning on or after January 1, 2003. Operational compliance would, of course be required with respect to all plans as of the applicable effective date of any amendment made by this Act.

In addition, timely amendments to a plan or annuity contract made pursuant to any amendment made by this Act shall be deemed to satisfy the anti-cutback rules.

The reason for this change is that plan sponsors need an appropriate amount of time to make changes to their plan documents.

By Mr. LOTT (for Mr. NICKLES, for himself, Mr. FRIST, Ms. COLLINS, Mr. JEFFORDS, Mr. ROTH, Mr. SANTORUM, Mr. HAGEL, Mr. GRAMM, Mr. COATS, Mr. LOTT, Mr. MACK, Mr. CRAIG, Mr. COVERDELL, Mr. ABRAHAM, Mr. ALLARD, Mr. ASHCROFT, Mr. BENNETT, Mr. BOND, Mr. BROWNBACK, Mr. BURNS, Mr. COCHRAN, Mr. DOMENICI, Mr. ENZI, Mr. FAIRCLOTH, Mr. GORTON, Mr. GRAMS, Mr. GRASSLEY, Mr. HATCH, Mr. HELMS, Mr. HUTCHINSON, Mrs. HUTCHISON, Mr. INHOFE, Mr. KEMPTHORNE, Mr. LUGAR, Mr. MCCAIN, Mr. MURKOWSKI, Mr. ROBERTS, Mr. SESSIONS, Mr. SHELBY, Mr. SMITH of New Hampshire, Mr. SMITH of Oregon, Ms. SNOWE, Mr. THOMAS, Mr. THOMPSON, Mr. THURMOND, and Mr. WARNER):

S. 2330. A bill to improve the access and choice of patients to quality, affordable health care; read the first time.

PATIENTS' BILL OF RIGHTS

Mr. NICKLES. Mr. President, today I am introducing the Republican Patients' Bill of Rights. Joining me in this effort are 46 of my colleagues who recognize the importance of ensuring that all Americans are able to not only receive the care they have been promised, but also receive the highest quality of care available. The foundation of this proposal was to address some of the very real concerns that consumers have about their health care needs.

We know that many Americans have believed they were denied coverage that their plans were supposed to cover. We recognize that some individuals fear that their health care plans will not give them access to specialists when they need them. We know that some Americans think their health care plans care more about cost than they do about quality.

In contrast, we also know that many Americans are happy and satisfied with their health care plan. We know that 81 percent of managed care enrollees are satisfied with their current health care plan. Another recent analysis suggest that 79 percent of consumers in HMOs would recommend their coverage. In addition Americans are leery of Washington solutions and increased federal intervention.

Last January, the Leader asked me to put together a group of colleagues to address the issue of health care quality. For the past seven months, Senators FRIST, COLLINS, HAGEL, ROTH, JEFFORDS, COATS, SANTORUM, and GRAMM worked tirelessly to put together a responsible, credible package that would preserve what is best about our Nation's health care while at the same time determine ways to improve upon—without stifling—the quality of care our nation delivers. We set out to rationally examine the issues and develop reasonable solutions without injuring patient access to affordable, high quality care.

This was no easy task. We spent month after month talking to experts who understand the difficulty and complexity of our system. We met with representatives from all aspects of the industry including the Mayo Clinic, the Henry Ford Health Systems, the American Medical Association, the American Hospital Association, the National Committee for Quality Assurance, the Joint Commission on the Accreditation of Healthcare Organizations, Corporate Medical Directors, Commissioners from the President's Quality Commission, Purchasers, Families USA, the Employee Benefit Research Institute and many others.

After many, many months of dissecting serious questions about our system we determined that there were indeed some areas in which we could improve patient access and quality.

We have put together an innovative plan that will answer the problems that exist in the industry while at the same time preserving affordability, which is of utmost importance. Mr. President, I think you agree that if someone loses their health insurance because a politician playing doctor drives prices to an unaffordable level, you have hardly given them more rights or better quality health care.

We are proud of what we have been able to accomplish. For the first time, patients can choose to be unencumbered in their relationship with their doctor. They will be able to choose their own doctor and get the middle man out of the way. There will be no corporate bureaucrat, no government bureaucrat and no lawyer standing between a patient and their doctor.

Mr. President, the bill we introduce today:

Protects consumers in employer-sponsored plans that are exempt from state regulation. People enrolled in such plans will have the right to:

Choose their doctors. Our bill contains both ''point-of-service'' and ''continuity of care'' requirements that will enhance consumer choice.

See their ob-gyns and pediatricians without referral. Our bill will give patients direct access to pediatricians and ob-gyns without prior referral from a ''gatekeeper.''

Have a ''prudent layperson'' standard applied to their claims for emergency care. The GOP alternative will require health plans to cover—without prior authorization—emergency care that a ''prudent layperson'' would consider medically necessary.

Communicate openly with their doctors without ''gag'' clauses.

Holds health plans accountable for their decisions.

Extends to enrollees in ERISA health plans and their doctors the right to appeal adverse coverage decisions to a physician who was not involved in the initial coverage determination.

Allows enrollees to appeal adverse coverage determinations to independent medical experts who have no affiliation with the health plan. Determinations by these experts will be binding on the health plan.

Requires health plans to disclose to enrollees consumer information, including what's covered, what's not,

how much they'll have to pay in deductibles and coinsurance, and how to appeal adverse coverage decisions to independent medical experts.

Guarantees consumers access to their medical records.

Requires health care providers, health plans, employers, health and life insurers, and schools and universities to permit an individual to inspect, copy and amend his or her own medical information.

Requires health care providers, health plans, health oversight agencies, public health authorities, employers, health and life insurers, health researchers, law enforcement officials, and schools and universities to establish appropriate safeguards to protect the confidentiality, security, accuracy and integrity of protected health information and notify enrollees of these safeguards.

Protects patients from genetic discrimination in health insurance. Prohibits health plans from collecting or using predictive genetic information about a patient to deny health insurance coverage or set premium rates.

Promotes quality improvement by supporting research to give patients and physicians better information regarding quality.

Establishes the Agency for Healthcare Quality Research (AHQR), whose purpose is to foster overall improvement in healthcare quality and bridge the gap between what we know and what we do in healthcare today. The Agency is built on the platform of the current Agency for Health Care Policy and Research, but is refocused and enhanced to become the hub and driving force of federal efforts to improve the quality of healthcare in all practice environments—not just managed care.

The role of the Agency is not to mandate a national definition of quality, but to support the science necessary to provide information to patients regarding the quality of the care they receive, to allow physicians to compare their quality outcomes with their peers, and to enable employers and individuals to be prudent purchasers based on quality.

Supports research, screening, treatment, education, and data collection activities to improve the health of women.

Promotes basic and clinical research for osteoporosis; breast and ovarian cancer; and aging processes regarding women.

Expands research efforts into the underlying causes and prevention of cardiovascular diseases in women—the leading cause of death among American women.

Supports data collection through the National Center for Health Statistics and the National Program of Cancer Registries, which are the leading sources of national data on the health status of women in the U.S.

Supports the National Breast and Cervical Cancer Early Detection Program, which provides for regular screening for breast and cervical cancers to underserved women.

Requires that the length of hospital stay after a mastectomy, lumpectomy or lymph node dissection be determined only by the physician, in consultation with the patient, and without the need to obtain authorization from the health plan. If a plan covers mastectomies, it also must cover breast reconstruction after a mastectomy.

Makes health insurance more accessible and affordable by:

Allowing self-employed people to deduct the full amount of their health care premiums.

Making medical savings accounts available to everyone.

Reforming cafeteria plans to let consumers save for future health care costs.

Mr. President, this bill is a comprehensive bill of rights that will benefit all Americans, and I am proud to join with so many of my colleagues in introducing it.

Mr. President, I want to take a moment to address some criticisms that have been made of our bill. These criticisms highlight some significant differences between our bill and the health care bill introduced by Senate Democrats. Mr. President, our bill does differ significantly from the Senate Democrats' bill.

Our bill is the ''Patients' Bill of Rights.'' Theirs is the ''Lawyers' Right to Bill.''

Our bill lets doctors decide whether care is medically necessary. Theirs lets lawyers decide.

Our bill empowers an independent medical expert to order an insurance company to pay for medically necessary care so that patients suffer no harm. Theirs allows trial lawyers to sue health plans after harm is done.

Mr. President, when my insurance company tells me that they won't cover a service for my family, I want the ability to appeal that decision to a doctor who doesn't work for my insurance company. And I want that appeal handled promptly, so that my family receives the benefit. That is what our bill requires.

The Democrats' bill creates new ways for trial lawyers to make money. According to a June 1998 study by Multinational Business Services, the Democrats' bill would create 56 new Federal causes of action—56 new reasons to sue people in Federal court.

That's fine for trial lawyers, but it doesn't do much for patients. Patients want their claim disputes handled promptly and fairly. According to a study by the General Accounting Office, it takes an average of 25 months—more than two years—to resolve a malpractice suit. One cause that the GAO studied took 11 years to resolve! I'm sure the lawyers who handled that case did quite well for themselves. But what about the patient?

Under our bill, patients can appeal directly to an outside medical expert for a prompt review of their claim—without having to incur any legal expenses. In medical malpractice litigation, patients receive an average of only 43 cents of every dollar awarded. The rest goes to lawyers and court fees.

Our bill assures that health care dollars are used to serve patients. Their bill diverts these dollars away from patients and into the pockets of trial lawyers.

Another big difference between our bill and the one introduced by Senate Democrats is that their bill takes a ''big government'' approach to health reform.

Mr. President, it was just four years ago that we debated Clintoncare on the Senate floor. President Clinton wanted government-run health care for all Americans. He wanted it then; he wants it still.

Just last September, President Clinton told the Service Employees Union that he was ''glad'' that he had pushed for the federal government to take over health care. ''Now if what I tried to do before won't work,'' the President said, ''maybe we can do it another way. A step at a time until we eventually finish this.''

The Democrats' bill would take us a step closer to the President's dream of a health care system run by federal bureaucrats and trial lawyers. The study I cited earlier by Multinational Business Services found that their bill would impose 359 new federal mandates, 59 new sets of Federal regulations, and require the government to hire 3,828 new federal bureaucrats.

Our bill relies on State Insurance Commissioners to protect those Americans who are enrolled in state-regulated plans. We protect the unprotected by providing new federal safeguards to the 48 million Americans who are enrolled in plans that the states are not permitted to regulate.

Their bill imposes a risky and complicated scheme that relies on federal bureaucrats at the Health Care Financing Administration (HCFA) to enforce patients' rights in states that do not conform to the federal mandates in their bill.

HCFA is the agency that oversees the federal Medicare and Medicaid programs. Last year, in the Balanced Budget Act, Congress created new consumer protections for Medicare beneficiaries—a ''Patients' Bill of Rights'' for the 38.5 million senior citizens and disabled Americans who rely on Medicare for their health care.

We asked HCFA to protect those rights. How have they done? I regret to say, Mr. President, that they have not done very well at all.

On July 16, a GAO witness testified before the Ways and Means Committee on how well HCFA was doing in enforcing the Medicare patients' bill of rights. According to GAO, HCFA has ''missed 25 percent of the implementation deadlines, including the quality-of-care medical review process for skilled nursing facilities. It is clear

that HCFA will continue to miss implementation deadlines as it attempts to balance the resource demands generated by the Balanced Budget Act with other competing objectives.''

Mr. President, I won't detail all of the ways that HCFA has failed—the fact that it is delaying implementation of a prostate screening program to which Medicare beneficiaries are entitled, the fact that it has failed to establish a quality-of-care medical review process for skilled nursing facilities, the fact that it is far behind schedule in developing a new payment system for home health services. The list goes on and on.

But let me focus on one failure that is especially relevant. All of us agree that people have the right to information about their health plans. When they have the choice of more than one plan, accurate information that compares the plans is critical.

Last year, Congress allocated $95 million to HCFA to develop an information and education program for Medicare beneficiaries. This money was to be used for publishing and mailing handbooks containing comparative plan information to seniors, establishing a toll-free number and Internet website, and sponsoring health information fairs.

Well, there haven't been any information fairs and the toll-free number isn't operational. They do have a website, but they've decided to mail comparative information handbooks only to seniors in 5 states: Washington, Oregon, Ohio, Florida and Arizona. So for the princely sum of a $95 million, only about 5.5 million seniors will receive important information about their health plans, leaving 32.5 million seniors without these handbooks. At that rate, HCFA would need more than $1 billion each year just for handbooks.

Mr. President, if this agency is struggling to protest the rights of 38.5 million Medicare beneficiaries, how can we ask it to protect the rights of up as many as 100 million people enrolled in private health plans?

We believe that consumer protections are too important to entrust to a cumbersome and inefficient federal government. State governments have long been in the business of insurance regulation and the federal government should not usurp their role.

The federal government should protect those who are enrolled in plans that are exempt from state regulation and those enrolled in the programs it runs, like Medicare and Medicaid. The federal government should start protecting the rights of senior citizens under Medicare, instead of meddling in areas where it doesn't belong.

Mr. President, our bill is a truly comprehensive bill of rights for patients, providing new consumer protections for the 48 million Americans who are unprotected by state law, giving the 124 million Americans enrolled in employer-sponsored plans new rights to appeal adverse coverage decisions, protecting the civil rights of consumers to gain access to their medical records, protecting consumers against discrimination based on genetic tests, promoting quality improvement, establishing a new women's health initiative, and giving millions of Americans access to affordable health insurance through medical savings accounts.

The doctor-patient relationship is one of the most important in people's lives. Our legislation preserves and protects that relationship, while taking many common-sense steps forward to affirm and expand quality and access. I look forward with my colleagues and many cosponsors, to the floor debate on this vital issue.

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

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

S. 2330

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patients' Bill of Rights Act''.

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

TITLE I—PATIENT BILL OF RIGHTS

Subtitle A—Right to Advice and Care

SEC. 101. PATIENT RIGHT TO MEDICAL ADVICE AND CARE.

(a) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended—

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

(2) by inserting after subpart B the following:

"Subpart C—Patient Right to Medical Advice and Care

"SEC. 721. PATIENT ACCESS TO EMERGENCY MEDICAL CARE.

''(a) IN GENERAL.—To the extent that the group health plan provides coverage for benefits consisting of emergency medical care (as defined in subsection (c)), except for items or services specifically excluded—

''(1) the plan shall provide coverage for benefits, without requiring preauthorization, for appropriate emergency medical screening examinations (within the capability of the emergency facility) to the extent that a prudent layperson, who possesses an average knowledge of health and medicine, would determine such examinations to be necessary to determine whether emergency medical care (as so defined) is necessary, and

''(2) the plan shall provide coverage for benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under paragraph (1)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in paragraph (2) of subsection (c).

''(b) UNIFORM COST-SHARING REQUIRED.—Nothing in this section shall be construed as preventing a group health plan from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to coverage for benefits described in subsection (a), if such form of cost-sharing is uniformly applied under such plan, with respect to similarly situated participants and beneficiaries, to all benefits consisting of emergency medical care (as defined in subsection (c)) provided to such similarly situated participants and beneficiaries under the plan.

''(c) DEFINITION OF EMERGENCY MEDICAL CARE.—In this section:

''(1) IN GENERAL.—The term ''emergency medical care'' means, with respect to a participant or beneficiary under a group health plan, covered inpatient and outpatient services that—

''(A) are furnished by a provider that is qualified to furnish such services; and

''(B) are needed to evaluate or stabilize an emergency medical condition (as defined in paragraph (2)).

''(2) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical care'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

''(A) placing the health of the participant or beneficiary (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(B) serious impairment to bodily functions, or

''(C) serious dysfunction of any bodily organ or part.

"SEC. 722. OFFERING OF CHOICE OF COVERAGE OPTIONS.

''(a) REQUIREMENT.—

''(1) OFFERING OF POINT-OF-SERVICE COVERAGE OPTION.—Except as provided in paragraph (2), if a group health plan provides coverage for benefits only through a defined set of participating health care professionals, the plan shall offer the participant the option to purchase point-of-service coverage (as defined in subsection (b)) for all such benefits for which coverage is otherwise so limited. Such option shall be made available to the participant at the time of enrollment under the plan and at such other times as the plan offers the participant a choice of coverage options.

''(2) EXCEPTION IN THE CASE OF MULTIPLE ISSUER OR COVERAGE OPTIONS.—Paragraph (1) shall not apply with respect to a participant in a group health plan if the plan offers the participant—

''(A) a choice of health insurance coverage through more than one health insurance issuer; or

''(B) two or more coverage options that differ significantly with respect to the use of participating health care professionals or the networks of such professionals that are used.

''(b) POINT-OF-SERVICE COVERAGE DEFINED.—In this section, the term 'point-of-service coverage' means, with respect to benefits covered under a group health plan, coverage of such benefits when provided by a nonparticipating health care professional.

''(c) SMALL EMPLOYER EXEMPTION.—

''(1) IN GENERAL.—This section shall not apply to any group health plan of a small employer.

''(2) SMALL EMPLOYER.—For purposes of paragraph (1), the term 'small employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. For purposes of this paragraph, the provisions of subparagraph (C) of section 712(c)(1) shall apply in determining employer size.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as requiring coverage for benefits for a particular type of health care professional;

''(2) as requiring an employer to pay any costs as a result of this section or to make equal contributions with respect to different health coverage options;

''(3) as preventing a group health plan from imposing higher premiums or cost-sharing on a participant for the exercise of a point-of-service coverage option; or

''(4) to require that a group health plan include coverage of health care professionals that the plan excludes because of fraud, quality of care, or other similar reasons with respect to such professionals.

"SEC. 723. PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(a) IN GENERAL.—In any case in which a group health plan—

''(1) provides coverage for benefits consisting of—

''(A) gynecological care (such as preventive women's health examinations); or

''(B) obstetric care (such as pregnancy-related services);

provided by a participating physician who specializes in such care; and

''(2) requires or provides for designation by a participant or beneficiary of a participating primary care provider;

if the primary care provider designated by such a participant or beneficiary is not such a physician as described in paragraph (1), then the plan shall meet the requirements of subsection (b).

''(b) REQUIREMENTS.—A group health plan meets the requirements of this subsection, in connection with the coverage of benefits described in subsection (a) consisting of care described in subparagraph (A) or (B) of subsection (a)(1), if the plan—

''(1) does not require authorization or a referral by the primary care provider in order to obtain coverage for such benefits, and

''(2) treats the ordering of other routine care of the same type, by the participating physician providing the care described in subparagraph (A) or (B) of subsection (a)(1), as the authorization of the primary care provider with respect to such care.

''(c) RULE OF CONSTRUCTION.—Nothing in subsection (b)(2) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

"SEC. 724. PATIENT ACCESS TO PEDIATRIC CARE.

''(a) IN GENERAL.—In any case in which a group health plan—

''(1) provides coverage for benefits consisting of pediatric care by a participating pediatrician; and

''(2) requires or provides for designation by a participant or beneficiary of a participating primary care provider;

if the primary care provider designated by such a participant or beneficiary is not a physician as described in paragraph (1), then the plan shall meet the requirements of subsection (b).

''(b) REQUIREMENTS.—A group health plan meets the requirements of this subsection, in connection with the coverage of benefits described in subsection (a) consisting of care described in subsection (a)(1), if the plan—

''(1) does not require authorization or a referral by the primary care provider in order to obtain coverage for such benefits, and

''(2) treats the ordering of other routine care of the same type, by the participating

physician providing the care described in subsection (a)(1), as the authorization of the primary care provider with respect to such care.

''(c) CONSTRUCTION.—Nothing in subsection (b)(2) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care so ordered.

''SEC. 725. CONTINUITY OF CARE.

''(a) IN GENERAL.—

''(1) TERMINATION OF PROVIDER.—If a contract between a group health plan and a health care provider is terminated (as defined in paragraph (2)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant or beneficiary in the plan is undergoing a course of treatment from the provider at the time of such termination, the plan shall—

''(A) notify the individual on a timely basis of such termination, and

''(B) in the case of termination described in paragraph (2), (3), of (4) of subsection (b), and subject to subsection (c), permit the individual to continue or be covered with respect to the course of treatment with the provider's consent during a transitional period (as provided under subsection (b)).

''(2) TERMINATION.—In this section, the term 'terminated' includes, with respect to a contract, the expiration or nonrenewal of the contract by the group health plan, but does not include a termination of the contract by the plan for failure to meet applicable quality standards or for fraud.

''(b) TRANSITIONAL PERIOD.—

''(1) GENERAL RULE.—Except as provided in paragraph (3), the transitional period under this subsection shall extend for up to 90 days from the date of the notice described in subsection (a)(1)(A) of the provider's termination.

''(2) INSTITUTIONAL CARE.—Subject to paragraph (1), the transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and also shall include institutional care provided within a reasonable time of the date of termination of the provider status if the care was scheduled before the date of the announcement of the termination of the provider status under subsection (a)(1)(A) or if the individual on such date was on an established waiting list or otherwise scheduled to have such care.

''(3) PREGNANCY.—Notwithstanding paragraph (1), if—

''(A) a participant or beneficiary has entered the second trimester of pregnancy at the time of a provider's termination of participation; and

''(B) the provider was treating the pregnancy before the date of the termination;

the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

''(4) TERMINAL ILLNESS.—Subject to paragraph (1), if—

''(A) a participant or beneficiary was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) prior to a provider's termination of participation; and

''(B) the provider was treating the terminal illness before the date of termination;

the transitional period under this subsection shall extend for the remainder of the individual's life for care directly related to the treatment of the terminal illness.

''(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan may condition coverage of continued treatment by a provider under subsection (a)(1)(B) upon the provider agreeing to the following terms and conditions:

''(1) The provider agrees to accept reimbursement from the plan and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (b)(2), at the rates applicable under the replacement plan after the date of the termination of the contract with the group health plan) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

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

''(3) The provider agrees otherwise to adhere to such plan's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan.

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider.

''(e) DEFINITION.—In this section, the term 'health care provider' or 'provider' means—

''(1) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State; and

''(2) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

''SEC. 726. PROTECTION OF PATIENT-PROVIDER COMMUNICATIONS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (in relation to a participant or beneficiary) shall not prohibit a health care professional from advising such a participant or beneficiary who is a patient of the professional about the health status of the participant or beneficiary or medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether coverage for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

''(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as requiring a group health plan to provide specific benefits under the terms of such plan.

''SEC. 727. GENERALLY APPLICABLE PROVISIONS.

''(a) APPLICABILITY.—The provisions of this subpart shall apply to group health plans. Such provisions shall not apply to a health insurance issuer that is licensed by a State and subject to State laws that regulate insurance within the meaning of section 514(b)(2), while engaged in the business of insurance in such State.

''(b) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a group health plan that provides benefits under 2 or more coverage options, the requirements of sections 721, 723, 724, 725 and 726 shall apply separately with respect to each coverage option.''.

(b) RULE WITH RESPECT TO CERTAIN PLANS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, health insurance issuers may offer, and eligible individuals may purchase, high deductible health plans described in section 220(c)(2)(A) of the Internal Revenue Code of 1986. Effective for the 4-year period beginning on the date of the enactment of this Act, such health plans shall not be required to provide payment for any health care items or services that are exempt from the plan's deductible.

(2) EXISTING STATE LAWS.—A State law relating to payment for health care items and services in effect on the date of enactment of this Act that is preempted under paragraph (1), shall not apply to high deductible health plans after the expiration of the 4-year period described in such paragraph unless the State reenacts such law after such period.

(c) CONFORMING AMENDMENT.—The table of contents in section 1 of such Act is amended—

(1) in the item relating to subpart C, by striking ''Subpart C'' and inserting ''Subpart D''; and

(2) by adding at the end of the items relating to subpart B of part 7 of subtitle B of title I of such Act the following new items:

''SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

''Sec. 721. Patient access to emergency medical care.
''Sec. 722. Offering of choice of coverage options.
''Sec. 723. Patient access to obstetric and gynecological care.
''Sec. 724. Patient access to pediatric care.
''Sec. 725. Continuity of care.
''Sec. 726. Protection of patient-provider communications.
''Sec. 727. Generally applicable provisions.''.

SEC. 102. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this subtitle, against a group health plan with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations issued in connection with such requirement, if the plan has sought to comply in good faith with such requirement.

Subtitle B—Right to Information About Plans and Providers

SEC. 111. INFORMATION ABOUT PLANS.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

''SEC. 713. HEALTH PLAN COMPARATIVE INFORMATION.

''(a) REQUIREMENT.—A group health plan, or health insurance issuer in connection with group health insurance coverage, shall, not later than 12 months after the date of enactment of this section, provide for the disclosure, in a clear and accurate form to each enrollee, or upon request to a potential enrollee eligible to receive benefits under the plan, or plan sponsor with which the plan or issuer has contracted, of the information described in subsection (b).

''(b) REQUIRED INFORMATION.—The informational materials to be distributed under this section shall include for each health benefit plan the following:

''(1) A description of the covered items and services under each such plan and any in-and out-of-network features of each such plan.

''(2) A description of any cost-sharing, including premiums, deductibles, coinsurance, and copayment amounts, for which the enrollee will be responsible, including any annual or lifetime limits on benefits, for each such plan.

''(3) A description of any optional supplemental benefits offered by each such plan and the terms and conditions (including premiums or cost-sharing) for such supplemental coverage.

''(4) A description of any restrictions on payments for services furnished to an enrollee by a health care professional that is not a participating professional and the liability of the enrollee for additional payments for these services.

''(5) A description of the service area of each such plan, including the provision of any out-of-area coverage.

''(6) A description of the extent to which enrollees may select the primary care provider of their choice, including providers both within the network and outside the network of each such plan (if the plan permits out-of-network services).

''(7) A description of the procedures for advance directives and organ donation decisions if the plan maintains such procedures.

''(8) A description of the requirements and procedures to be used to obtain preauthorization for health services (including telephone numbers and mailing addresses), including referrals for specialty care.

''(9) A summary of the rules and methods for appealing coverage decisions and filing grievances (including telephone numbers and mailing addresses), as well as other available remedies.

''(10) A summary of the rules for access to emergency room care. Also, any available educational material regarding proper use of emergency services.

''(11) A description of whether or not coverage is provided for experimental treatments, investigational treatments, or clinical trials and the circumstances under which access to such treatments or trials is made available.

''(12) A description of the specific preventative services covered under the plan if such services are covered.

''(13) A statement that the following information, and instructions on obtaining such information (including telephone numbers and, if available, Internet websites), shall be made available upon request:

''(A) The names, addresses, telephone numbers, and State licensure status of the plan's participating health care professionals and participating health care facilities, and, if available, the education, training, speciality qualifications or certifications of such professionals.

''(B) A summary description of the methods used for compensating participating health care professionals, such as capitation, fee-for-service, salary, or a combination thereof. The requirement of this subparagraph shall not be construed as requiring plans to provide information concerning proprietary payment methodology.

''(C) A summary description of the methods used for compensating health care facilities, including per diem, fee-for-service, capitation, bundled payments, or a combination thereof. The requirement of this subparagraph shall not be construed as requiring plans to provide information concerning proprietary payment methodology.

''(D) A summary description of the procedures used for utilization review.

''(E) The list of the specific prescription medications included in the formulary of the plan, if the plan uses a defined formulary, and any provision for obtaining off-formulary medications.

''(F) A description of the specific exclusions from coverage under the plan.

''(G) Any available information related to the availability of translation or interpretation services for non-English speakers and people with communication disabilities, including the availability of audio tapes or information in Braille.

''(H) Any information that is made public by accrediting organizations in the process of accreditation if the plan is accredited, or any additional quality indicators that the plan makes available.

''(c) MANNER OF DISTRIBUTION.—

''(1) IN GENERAL.—The information described in this section shall be distributed in an accessible format that is understandable to an average plan enrollee.

''(2) RULE OF CONSTRUCTION.—For purposes of this section, a group health plan, or health insurance issuer in connection with group health insurance coverage, in reliance on records maintained by the plan or issuer, shall be deemed to have met the requirements of this section if the plan or issuer provides the information requested under this section—

''(A) in the case of the plan, to participants and beneficiaries at the address contained in such records with respect to such participants and beneficiaries; or

''(B) in the case of the issuer, to the employer of a participant if the employer provides for the coverage of such participant under the plan involved or to participants and beneficiaries at the address contained in such records with respect to such participants and beneficiaries.

''(d) RULE OF CONSTRUCTION.—Nothing in this section may be construed to prohibit a group health plan, or health insurance issuer in connection with group health insurance coverage, from distributing any other additional information determined by the plan or issuer to be important or necessary in assisting participants and beneficiaries enrollees or upon request potential participants in the selection of a health plan or from providing information under subsection (b)(13) as part of the required information.

''(e) HEALTH CARE PROFESSIONAL.—In this section, the term 'health care professional' means a physician (as defined in section 1861(r) of the Social Security Act) or other health care professional if coverage for the professional's services is provided under the health plan involved for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185(a)) is amended by striking ''section 711, and inserting ''sections 711 and 713''.

(2) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001) is amended by inserting after the item relating to section 712, the following:

''Sec. 713. Health plan comparative information.''.

SEC. 112. INFORMATION ABOUT PROVIDERS.

(a) STUDY.—The Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine for the conduct of a study, and the submission to the Secretary of a report, that includes—

(1) an analysis of information concerning health care professionals that is currently available to patients, consumers, States, and professional societies, nationally and on a State-by-State basis, including patient preferences with respect to information about such professionals and their competencies;

(2) an evaluation of the legal and other barriers to the sharing of information concerning health care professionals; and

(3) recommendations for the disclosure of information on health care professionals, including the competencies and professional qualifications of such practitioners, to better facilitate patient choice, quality improvement, and market competition.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary of Health and Human Services shall forward to the appropriate committees of Congress a copy of the report and study conducted under subsection (a).

Subtitle C—Right to Hold Health Plans Accountable

SEC. 121. AMENDMENT TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended to read as follows:

''SEC. 503. CLAIMS PROCEDURE, COVERAGE DETERMINATION, GRIEVANCES AND APPEALS.

''(a) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every employee benefit plan shall—

''(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

''(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

''(b) COVERAGE DETERMINATIONS UNDER GROUP HEALTH PLANS.—

''(1) PROCEDURES.—

''(A) IN GENERAL.—A group health plan or health insurance issuer conducting utilization review shall ensure that procedures are in place for—

''(i) making determinations regarding whether an enrollee is eligible to receive a payment or coverage for health services under the plan or coverage involved and any cost-sharing amount that the enrollee is required to pay with respect to such service;

''(ii) notifying covered enrollees (or the legal representative of such enrollees) and the treating health care professionals involved regarding determinations made under the plan or issuer and any additional payments that the enrollee may be required to make with respect to such service; and

''(iii) responding to requests, either written or oral, for coverage determinations or for internal appeals from an enrollee (or the legal representative of such enrollee) or the treating health care professional.

''(B) ORAL REQUESTS.—With respect to an oral request described in subparagraph (A)(iii), a group health plan or health insurance issuer may require that the requesting individual provide written evidence of such request.

''(2) TIMELINE FOR MAKING DETERMINATIONS.—

''(A) ROUTINE DETERMINATION.—A group health plan or a health insurance issuer shall maintain procedures to ensure that prior authorization determinations concerning the provision of non-emergency items or services are made within 30 days from the date on

which the request for a determination is submitted, except that such period may be extended where certain circumstances exist that are determined by the Secretary to be beyond control of the plan or issuer.

''(B) EXPEDITED DETERMINATION.—

''(i) IN GENERAL.—A prior authorization determination under this subsection shall be made within 72 hours after a request is received by the plan or issuer under clause (ii) or (iii).

''(ii) REQUEST BY ENROLLEE.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection upon the request of an enrollee if, based on such a request, the plan or issuer determines that the normal time for making such a determination could seriously jeopardize the life or health of the enrollee.

''(iii) DOCUMENTATION BY HEALTH CARE PROFESSIONAL.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection if the request involved indicates that the treating health care professional has documented, based on the medical exigencies, that a determination under the procedures described in subparagraph (A) could seriously jeopardize the life or health of the enrollee.

''(C) CONCURRENT DETERMINATIONS.—A plan or issuer shall maintain procedures to certify or deny coverage of an extended stay or additional services.

''(D) RETROSPECTIVE DETERMINATION.—A plan or issuer shall maintain procedures to ensure that, with respect to the retrospective review of a determination made under paragraph (1), the determination shall be made within 30 working days of the date on which the plan or issuer receives all necessary information.

''(3) NOTICE OF DETERMINATIONS.—

''(A) ROUTINE DETERMINATION.—With respect to a coverage determination of a plan or issuer under paragraph (2)(A), the plan or issuer shall issue notice of such determination to the enrollee (or the legal representative of the enrollee), and consistent with the medical exigencies of the case, to the treating health care professional involved not later than 2 working days after the date on which the determination is made.

''(B) EXPEDITED DETERMINATION.—With respect to a coverage determination of a plan or issuer under paragraph (2)(B), the plan or issuer shall issue notice of such determination to the enrollee (or the legal representative of the enrollee), and consistent with the medical exigencies of the case, to the treating health care professional involved within the 72 hour period described in paragraph (2)(B).

''(C) CONCURRENT REVIEWS.—With respect to the determination under a plan or issuer under paragraph (1) to certify or deny coverage of an extended stay or additional services, the plan or issuer shall issue notice of such determination to the treating health care professional and to the enrollee involved (or the legal representative of the enrollee) within 1 working day of the date on which the initial notice was issued.

''(D) RETROSPECTIVE REVIEWS.—With respect to the retrospective review under a plan or issuer of a determination made under paragraph (1), a determination shall be made within 30 working days of the date on which the plan or issuer receives all necessary information. The plan or issuer shall issue written notice of an approval or disapproval of a determination under this subparagraph to the enrollee (or the legal representative of the enrollee) and health care provider involved within 5 working days of the date on which such determination is made.

''(E) REQUIREMENTS OF NOTICE OF ADVERSE COVERAGE DETERMINATIONS.—A written or electronic notice of an adverse coverage determination under this subsection, or of an expedited adverse coverage determination under paragraph (2)(B), shall be provided to the enrollee (or the legal representative of the enrollee) and treating health care professional (if any) involved and shall include—

''(i) the reasons for the determination (including the clinical or scientific-evidence based rationale used in making the determination) written in a manner to be understandable to the average enrollee;

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

''(iii) notification of the right to appeal the determination and instructions on how to initiate an appeal in accordance with subsection (d).

''(c) GRIEVANCES.—A group health plan or a health insurance issuer shall have written procedures for addressing grievances between the plan and enrollees. Determinations under such procedures shall be non-appealable.

''(d) INTERNAL APPEAL OF COVERAGE DETERMINATIONS.—

''(1) IN GENERAL.—An enrollee (or the legal representative of the enrollee) and the treating health care professional with the consent of the enrollee (or the legal representative of the enrollee), may appeal any adverse coverage determination under subsection (b) under the procedures described in this subsection.

''(2) RECORDS.—A group health plan and a health insurance issuer shall maintain written records, for at least 6 years, with respect to any appeal under this subsection for purposes of internal quality assurance and improvement.

''(3) ROUTINE DETERMINATIONS.—A group health plan or a health insurance issuer shall provide for the consideration of an appeal of an adverse routine determination under this subsection not later than 30 working days after the date on which a request for such appeal is received.

''(4) EXPEDITED DETERMINATION.—

''(A) IN GENERAL.—An expedited determination with respect to an appeal under this subsection shall be made in accordance with the medical exigencies of the case, but in no case more than 72 hours after the request for such appeal is received by the plan or issuer under subparagraph (B) or (C).

''(B) REQUEST BY ENROLLEE.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection upon the request of an enrollee if, based on such a request, the plan or issuer determines that the normal time for making such a determination could seriously jeopardize the life or health of the enrollee.

''(C) DOCUMENTATION BY HEALTH CARE PROFESSIONAL.—A plan or issuer shall maintain procedures for expediting a prior authorization determination under this subsection if the request involved indicates that the treating health care professional has documented, based on the medical exigencies that a determination under the procedures described in paragraph (2) could seriously jeopardize the life or health of the enrollee.

''(5) CONDUCT OF REVIEW.—A review of an adverse coverage determination under this subsection shall be conducted by an individual with appropriate expertise who was not involved in the initial determination.

''(6) LACK OF MEDICAL NECESSITY.—An appeal under this subsection relating to a determination to deny coverage based on a lack of medical necessity or appropriateness, or based on an experimental or investigational treatment, shall be made only by a physician with appropriate expertise in the field of medicine involved who was not involved in the initial determination.

''(7) NOTICE.—

''(A) IN GENERAL.—Written notice of a determination made under an internal review process shall be issued to the enrollee (or the legal representative of the enrollee) and the treating health care professional not later than 2 working days after the completion of the review (or within the 72-hour period referred to in paragraph (4) if applicable).

''(B) ADVERSE COVERAGE DETERMINATIONS.—With respect to an adverse coverage determination made under this subsection, the notice described in subparagraph (A) shall include—

''(i) the reasons for the determination (including the clinical or scientific-evidence based rationale used in making the determination) written in a manner to be understandable to the average enrollee;

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

''(iii) notification of the right to an external review under subsection (e) and instructions on how to initiate such a review.

''(e) EXTERNAL REVIEW.—

''(1) IN GENERAL.—A group health plan or a health insurance issuer shall have written procedures to permit an enrollee (or the legal representative of the enrollee) access to an external review with respect to a coverage determination concerning a particular item or service where the plan, in consultation with the plan's legal representative, has determined that—

''(A) the particular item or service involved, when medically appropriate and necessary, is generally a covered benefit under the terms and conditions of the contract between the plan or issuer and the enrollee;

''(B) the coverage determination involved denied coverage for such item or service because the provision of such item or service—

''(i) does not meet the plan's or issuer's requirements for medical appropriateness or necessity and the amount involved exceeds $1,000; or

''(ii) would constitute experimental or investigational treatment and there is a significant risk of placing the life or health of the enrollee in jeopardy; and

''(C) the enrollee has completed the internal appeals process with respect to such determination.

''(2) INITIATION OF THE EXTERNAL REVIEW PROCESS.—

''(A) FILING OF REQUEST.—An enrollee (or the legal representative of the enrollee) who desires to have an external review conducted under this subsection shall file a written request for such a review with the plan or issuer involved not later than 30 working days after the receipt of a final denial of a claim under subsection (d). Any such request shall include the consent of the enrollee (or the legal representative of the enrollee) for the release of medical information and records to external reviewers regarding the enrollee if such information is necessary for the proper conduct of the external review.

''(B) INFORMATION AND NOTICE.—Not later than 5 working days after the receipt of a request under subparagraph (A), the plan or issuer involved shall select an external appeals entity under paragraph (3)(A) that shall be responsible for designating an external reviewer under paragraph (3)(B).

''(C) PROVISION OF INFORMATION.—The plan or issuer involved shall forward all necessary information (including medical records, any relevant review criteria, the clinical rationale consistent with the terms and conditions of the contract between the plan or issuer and the enrollee for the coverage denial, and evidence of the enrollee's coverage) to the

external reviewer selected under paragraph (3)(B).

''(D) NOTIFICATION.—The plan or issuer involved shall send a written notification to the enrollee (or the legal representative of the enrollee) and the plan administrator, indicating that an external review has been initiated.

''(3) CONDUCT OF EXTERNAL REVIEW.—

''(A) DESIGNATION OF EXTERNAL APPEALS ENTITY BY PLAN OR ISSUER.—A plan or issuer that receives a request for an external review under paragraph (2)(A) shall designate one of the following entities to serve as the external appeals entity:

''(i) An external review entity licensed or credentialed by a State.

''(ii) A State agency established for the purpose of conducting independent external reviews.

''(iii) Any entity under contract with the Federal Government to provide external review services.

''(iv) Any entity accredited as an external review entity by an accrediting body recognized by the Secretary for such purpose.

''(v) Any fully accredited teaching hospital.

''(vi) Any other entity meeting criteria established by the Secretary for purposes of this subparagraph.

''(B) DESIGNATION OF EXTERNAL REVIEWER BY EXTERNAL APPEALS ENTITY.—The external appeals entity designated under subparagraph (A) shall designate one or more individuals to serve as external reviewers with respect to a request receives under paragraph (2)(A). Such reviewers shall be independent medical experts who shall—

''(i) be appropriately credentialed or licensed in any State to deliver health care services;

''(ii) not have any material, professional, familial, or financial affiliation with the case under review, the enrollee involved, the treating health care professional, the institution where the treatment would take place, or the manufacturer or any drug, device, procedure, or other therapy proposed for the enrollee whose treatment is under review;

''(iii) be experts in the treatment of the enrollee's medical condition and knowledgeable about the recommended therapy;

''(iv) receive only reasonable and customary compensation from the group health plan or health insurance issuer in connection with the external review that is not contingent on the decision rendered by the reviewer; and

''(v) not be held liable for decisions regarding medical determinations (but may be held liable for actions that are arbitrary and capricious).

''(4) STANDARD OF REVIEW.—

''(A) IN GENERAL.—An external reviewer shall—

''(i) make a determination based on the medical necessity, appropriateness, experimental or investigational nature of the coverage denial;

''(ii) take into consideration any evidence-based decision making or clinical practice guidelines used by the group health plan or health insurance issuer in conducting utilization review; or

''(iii) submit a report on the final determinations of the review involved to—

''(I) the plan or issuer involved;

''(II) the enrollee involved (or the legal representative of the enrollee); and

''(III) the health care professional involved.

''(B) NOTICE.—The plan or issuer involved shall ensure that the enrollee receives notice, within 30 days after the determination of the independent medical expert, regarding the actions of the plan or issuer with respect to the determination of such expert under the external review.

''(5) TIMEFRAME FOR REVIEW.—An external reviewer shall complete a review of an adverse coverage determination in accordance with the medical exigencies of the case, but in no case later than 30 working days after the later of—

''(A) the date on which such reviewer is designated; or

''(B) the date on which all information necessary to completing such review is received.

''(6) BINDING DETERMINATION.—The determination of an external reviewer under this subsection shall be binding upon the plan or issuer if the provisions of this subsection or the procedures implemented under such provisions were complied with by the external reviewer.

''(7) STUDY.—Not later than 2 years after the date of enactment of this section, the General Accounting Office shall conduct a study of a statistically appropriate sample of completed external reviews. Such study shall include an assessment of the process involved during an external review and the basis of decisionmaking by the external reviewer. The results of such study shall be submitted to the appropriate committees of Congress.

''(8) CONTINUING LEGAL RIGHTS OF ENROLLEES.—Nothing in this section shall be construed as removing any legal rights of participants, beneficiaries, enrollees, and others under State or Federal law, including the right to file judicial actions to enforce rights.

''(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prohibit a plan administrator or plan fiduciary or health plan medical director from requesting an external review by an external reviewer without first completing the internal review process.

''(g) DEFINITIONS.—In this section:

''(1) ADVERSE COVERAGE DETERMINATION.—The term 'adverse coverage determination' means a coverage determination under the plan which results in a denial of coverage or reimbursement.

''(2) COVERAGE DETERMINATION.—The term 'coverage determination' means with respect to items and services for which coverage may be provided under a health plan, a determination of whether or not such items and services are covered or reimbursable under the coverage and terms of the contract.

''(3) ENROLLEE.—The term enrollee means a participant or beneficiary.

''(4) GRIEVANCE.—The term 'grievance' means any enrollee complaint that does not involve a coverage determination.

''(5) PRIOR AUTHORIZATION DETERMINATION.—The term 'prior authorization determination' means a coverage determination prior to the provision of the items and services as a condition of coverage of the items and services under the coverage.

''(6) TREATING HEALTH CARE PROFESSIONAL.—The term 'treating health care professional' with respect to a group health plan, health insurance issuer or provider sponsored organization means a practitioner who is acting within the scope of their State licensure or certification for the delivery of health care services and who is primarily responsible for delivering those services to the enrollee.

''(7) UTILIZATION REVIEW.—The term 'utilization review' with respect to a group health plan or health insurance coverage means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.''.

(b) ENFORCEMENT.—Section 502(c)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)(1)) is amended by inserting after ''or section 101(e)(1)'' the following: '', or fails to comply with a coverage determination as required under section 503(e)(6),''.

(c) CONFORMING AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by strike the item relating to section 503 and inserting the following new item:

''Sec. 503. Claims procedures, coverage determination, grievances and appeals.''.

TITLE II—INDIVIDUAL RIGHTS WITH RESPECT TO PERSONAL MEDICAL INFORMATION

SEC. 201. SHORT TITLE.

This title may be cited as the ''Personal Medical Information Access Act''.

Subtitle A—Access to Medical Records

SEC. 211. INSPECTION AND COPYING OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—At the request of an individual and except as provided in subsection (b), a health care provider, health plan, employer, health or life insurer, school, or university shall permit an individual who is the subject of protected health information or the individual's designee, to inspect and copy protected health information concerning the individual, including records created under section 212 that such entity maintains. Such entity may set forth appropriate procedures to be followed for such inspection or copying and may require an individual to pay reasonable costs associated with such inspection or copying.

(b) EXCEPTIONS.—Unless ordered by a court of competent jurisdiction, an entity described in subsection (a) is not required to permit the inspection or copying of protected health information if any of the following conditions are met:

(1) ENDANGERMENT TO LIFE OR SAFETY.—The entity determines that the disclosure of the information could reasonably be expected to endanger the life or physical safety of an individual.

(2) CONFIDENTIAL SOURCE.—The information identifies, or could reasonably lead to the identification of, a person who provided information under a promise of confidentiality concerning the individual who is the subject of the information.

(3) INFORMATION COMPILED IN ANTICIPATION OF LITIGATION.—The information is compiled principally—

(A) in the reasonable anticipation of a civil, criminal, or administrative action or proceeding; or

(B) for use in such an action or proceeding.

(4) RESEARCH PURPOSES.—The information was collected for a research project monitored by an institutional review board, such project is not complete, and the researcher involved reasonably believes that access to such information would harm the conduct of the research or invalidate or undermine the validity of the research.

(c) DENIAL OF A REQUEST FOR INSPECTION OR COPYING.—If an entity described in subsection (a) denies a request for inspection or copying pursuant to subsection (b), the entity shall inform the individual in writing of—

(1) the reasons for the denial of the request for inspection or copying;

(2) any procedures for further review of the denial; and

(3) the individual's right to file with the entity a concise statement setting forth the request for inspection or copying.

(d) STATEMENT REGARDING REQUEST.—If an individual has filed a statement under subsection (c)(3), the entity in any subsequent disclosure of the portion of the information requested under subsection (a) shall include—

(1) a copy of the individual's statement; and

(2) a concise statement of the reasons for denying the request for inspection or copying.

(e) INSPECTION AND COPYING OF SEGREGABLE PORTION.—An entity described in subsection (a) shall permit the inspection and copying under subsection (a) of any reasonably segregable portion of protected health information after deletion of any portion that is exempt under subsection (b).

(f) DEADLINE.—An entity described in subsection (a) shall comply with or deny, in accordance with subsection (c), a request for inspection or copying of protected health information under this section not later than 45 days after the date on which the entity receives the request.

(g) RULES GOVERNING AGENTS.—An agent of an entity described in subsection (a) shall not be required to provide for the inspection and copying of protected health information, except where—

(1) the protected health information is retained by the agent; and

(2) the agent has received in writing a request from the entity involved to fulfill the requirements of this section;

at which time such information shall be provided to the requesting entity. Such requesting entity shall comply with subsection (f) with respect to any such information.

(h) RULE OF CONSTRUCTION.—This section shall not be construed to require an entity described in subsection (a) to conduct a formal, informal, or other hearing or proceeding concerning a request for inspection or copying of protected health information.

SEC. 212. AMENDMENT OF PROTECTED HEALTH INFORMATION.

(a) REQUIREMENT.—

(1) IN GENERAL.—Except as provided in subsection (b) and subject to paragraph (2), a health care provider, health plan, employer, health or life insurer, school, or university that receives from an individual a request in writing to amend protected health information shall—

(A) amend such information as requested;

(B) inform the individual of the amendment that has been made; and

(C) make reasonable efforts to inform any person to whom the unamended portion of the information was previously disclosed, of any nontechnical amendment that has been made.

(2) COMPLIANCE.—An entity described in paragraph (1) shall comply with the requirements of such paragraph within 45 days of the date on which the request involved is received if the entity—

(A) created the protected health information involved; and

(B) determines that such information is in fact inaccurate.

(b) REFUSAL TO AMEND.—If an entity described in subsection (a) refuses to make the amendment requested under such subsection, the entity shall inform the individual in writing of—

(1) the reasons for the refusal to make the amendment;

(2) any procedures for further review of the refusal; and

(3) the individual's right to file with the entity a concise statement setting forth the requested amendment and the individual's reasons for disagreeing with the refusal.

(c) STATEMENT OF DISAGREEMENT.—If an individual has filed a statement of disagreement under subsection (b)(3), the entity involved, in any subsequent disclosure of the disputed portion of the information—

(1) shall include a copy of the individual's statement; and

(2) may include a concise statement of the reasons for not making the requested amendment.

(d) RULES GOVERNING AGENTS.—The agent of an entity described in subsection (a) shall not be required to make amendments to protected health information, except where—

(1) the protected health information is retained by the agent; and

(2) the agent has been asked by such entity to fulfill the requirements of this section.

If the agent is required to comply with this section as provided for in paragraph (2), such agent shall be subject to the 45-day deadline described in subsection (a).

(e) REPEATED REQUESTS FOR AMENDMENTS.—If an entity described in subsection (a) receives a request for an amendment of information as provided for in such subsection and a statement of disagreement has been filed pursuant to subsection (c), the entity shall inform the individual of such filing and shall not be required to carry out the procedures required under this section.

(f) RULES OF CONSTRUCTION.—This section shall not be construed to—

(1) require that an entity described in subsection (a) conduct a formal, informal, or other hearing or proceeding concerning a request for an amendment to protected health information;

(2) require a provider to amend an individual's protected health information as to the type, duration, or quality of treatment the individual believes he or she should have been provided; or

(3) permit any deletions or alterations of the original information.

SEC. 213. NOTICE OF CONFIDENTIALITY PRACTICES.

(a) PREPARATION OF WRITTEN NOTICE.—A health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, school or university shall post or provide, in writing and in a clear and conspicuous manner, notice of the entity's confidentiality practices, that shall include—

(1) a description of an individual's rights with respect to protected health information;

(2) the procedures established by the entity for the exercise of the individual's rights; and

(3) the right to obtain a copy of the notice of the confidentiality practices required under this subtitle.

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

Subtitle B—Establishment of Safeguards

SEC. 221. ESTABLISHMENT OF SAFEGUARDS.

A health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, law enforcement official, school or university shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of protected health information created, received, obtained, maintained, used, transmitted, or disposed of by such entity.

Subtitle C—Enforcement; Definitions

SEC. 231. CIVIL PENALTY.

(a) VIOLATION.—A health care provider, health researcher, health plan, health oversight agency, public health agency, law enforcement agency, employer, health or life insurer, school, or university, or the agent of any such individual or entity, who the Secretary, in consultation with the Attorney General, determines has substantially and materially failed to comply with this Act shall, for a violation of this title, be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $500 for each such violation, but not to exceed $5,000 in the aggregate for multiple violations.

(b) PROCEDURES FOR IMPOSITION OF PENALTIES.—Section 1128A of the Social Security Act, other than subsections (a) and (b) and the second sentence of subsection (f) of that section, shall apply to the imposition of a civil, monetary, or exclusionary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A of such Act.

SEC. 232. DEFINITIONS.

In this title:

(1) AGENT.—The term ''agent'' means a person who represents and acts for another under the contract or relation of agency, or whose function is to bring about, modify, affect, accept performance of, or terminate contractual obligations between the principal and a third person, including a contractor.

(2) DISCLOSE.—The term ''disclose'' means to release, transfer, provide access to, or otherwise divulge protected health information to any person other than the individual who is the subject of such information. Such term includes the initial disclosure and any subsequent redisclosures of protected health information.

(3) EMPLOYER.—The term ''employer'' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(5)), except that such term shall include only employers of 2 or more employees.

(4) HEALTH CARE PROVIDER.—The term ''health care provider'' means a person who, with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of—

(A) a person who is licensed, certified, registered, or otherwise authorized by Federal or State law to provide an item or service that constitutes health care in the ordinary course of business, or practice of a profession;

(B) a Federal, State, or employer-sponsored program that directly provides items or services that constitute health care to beneficiaries; or

(C) an officer, employee, or agent of a person described in subparagraph (A) or (B).

(5) HEALTH OR LIFE INSURER.—The term ''health or life insurer'' means a health insurance issuer as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91) or a life insurance company as defined in section 816 of the Internal Revenue Code of 1986.

(6) HEALTH PLAN.—The term ''health plan'' means any health insurance plan, including any hospital or medical service plan, dental or other health service plan or health maintenance organization plan, provider sponsored organization, or other program providing or arranging for the provision of health benefits, whether or not funded through the purchase of insurance.

(7) PERSON.—The term ''person'' means a government, governmental subdivision,

agency or authority; corporation; company; association; firm; partnership; society; estate; trust; joint venture; individual; individual representative; tribal government; and any other legal entity.

(8) PROTECTED HEALTH INFORMATION.—The term ''protected health information'' means any information (including demographic information) whether or not recorded in any form or medium—

(A) that relates to the past, present or future—

(i) physical or mental health or condition of an individual (including the condition or other attributes of individual cells or their components);

(ii) provision of health care to an individual; or

(iii) payment for the provision of health care to an individual;

(B) that is created by a health care provider, health plan, health researcher, health oversight agency, public health authority, employer, law enforcement official, health or life insurer, school or university; and

(C) that is not nonidentifiable health information.

(9) SCHOOL OR UNIVERSITY.—The term ''school or university'' means an institution or place for instruction or education, including an elementary school, secondary school, or institution of higher learning, a college, or an assemblage of colleges united under one corporate organization or government.

(10) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(11) WRITING.—The term ''writing'' means writing in either a paper-based or computer-based form, including electronic signatures.

TITLE III—GENETIC INFORMATION AND SERVICES

SEC. 301. SHORT TITLE.

This title may be cited as the ''Genetic Information Nondiscrimination in Health Insurance Act of 1998''.

SEC. 302. AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION OR GENETIC SERVICES.—

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

(2) NO DISCRIMINATION IN GROUP PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) (as amended by section 111) is further amended by adding at the end the following:

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

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

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

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

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

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

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

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

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

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan or health insurance issuer shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in sections 213 and 221 of the Patients' Bill of Rights Act, of such individually identifiable information.''.

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

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

''(A) the spouse of the individual;

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

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

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

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

''(8) PREDICTIVE GENETIC INFORMATION.—

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

''(i) information about an individual's genetic tests which are associated with a statistically significant increased risk of developing a disease or disorder;

''(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 that predicts a statistically significant increased risk of a disease or disorder in the individual.

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

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

''(ii) information derived from routine physical tests, such as the chemical, blood, or urine analyses of the individual, unless such analyses are genetic tests; and

''(iii) information about physical exams of the individual and other information relevant to determining the current health status of the individual so long as such information does not include information described in clauses (i), (ii), or (iii) of subparagraph (A).

''(9) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, in order to detect disease-related genotypes, mutations, phenotypes, or karyotypes.''.

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

SEC. 303. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

(a) AMENDMENTS RELATING TO THE GROUP MARKET.—

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

(A) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.) is amended by adding at the end the following:

''SEC. 2706. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION IN THE GROUP MARKET.

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

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

''(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or receipt of genetic services), see section 2706.''.

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

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

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

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

''(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan or health insurance issuer that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose,

or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan or health insurance issuer shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in sections 213 and 221 of the Patients' Bill of Rights Act, of such individually identifiable information.''.

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

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

''(A) the spouse of the individual;

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

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

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

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

''(18) PREDICTIVE GENETIC INFORMATION.—

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

''(i) information about an individual's genetic tests which is associated with a statistically significant increased risk of developing a disease or disorder;

''(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 that predicts a statistically significant increased risk of a disease or disorder in the individual.

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

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

''(ii) information derived from routine physical tests, such as the chemical, blood, or urine analyses of the individual, unless such analyses are genetic tests; and

''(iii) information about physical exams of the individual and other information relevant to determining the current health status of the individual so long as such information does not include information described in clauses (i), (ii), or (iii) of subparagraph (A).

''(19) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, in order to detect disease-related genotypes, mutations, phenotypes, or karyotypes.''.

(b) AMENDMENT RELATING TO THE INDIVIDUAL MARKET.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-11 et seq.) (relating to other requirements) is amended—

(1) by redesignating such subpart as subpart II; and

(2) by adding at the end the following:

''SEC. 2752. PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

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

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

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

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

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

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

''(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the health insurance issuer shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in sections 213 and 221 of the Patients' Bill of Rights Act, of such individually identifiable information.''.

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

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

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

SEC. 304. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

(a) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.—

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

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

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

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

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

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

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

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

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

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

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

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

''(B) NOTICE OF CONFIDENTIALITY PRACTICES; DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan or health insurance issuer shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in sections 213 and 221 of the Patients' Bill of Rights Act, of such individually identifiable information.''.

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

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

''(A) the spouse of the individual;

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

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

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

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

''(9) PREDICTIVE GENETIC INFORMATION.—

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

''(i) information about an individual's genetic tests which is associated with a statistically significant increased risk of developing a disease or disorder;

''(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 that predicts a statistically significant increased risk of a disease or disorder in the individual.

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

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

''(ii) information derived from routine physical tests, such as the chemical, blood, or urine analyses of the individual, unless such analyses are genetic tests; and

''(iii) information about physical exams of the individual and other information relevant to determining the current health status of the individual so long as such information does not include information described in clauses (i), (ii), or (iii) of subparagraph (A).

''(10) GENETIC TEST.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, in order to detect disease-related genotypes, mutations, phenotypes, or karyotypes.''.

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

TITLE IV—HEALTHCARE QUALITY RESEARCH

SEC. 401. SHORT TITLE.

This title may be cited as the ''Healthcare Quality Research Act of 1998''.

SEC. 402. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended to read as follows:

''TITLE IX—AGENCY FOR HEALTHCARE QUALITY RESEARCH

''PART A—ESTABLISHMENT AND GENERAL DUTIES

''SEC. 901. MISSION AND DUTIES.

''(a) IN GENERAL.—There is established within the Public Health Service an agency to be known as the Agency for Healthcare Quality Research. In carrying out this subsection, the Secretary shall redesignate the Agency for Health Care Policy and Research as the Agency for Healthcare Quality Research.

''(b) MISSION.—The purpose of the Agency is to enhance the quality, appropriateness, and effectiveness of healthcare services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical practice, including the prevention of diseases and other health conditions. The Agency shall promote healthcare quality improvement by—

''(1) conducting and supporting research that develops and presents scientific evidence regarding all aspects of healthcare, including—

''(A) the development and assessment of methods for the purposes of enhancing patient participation in their own care and for facilitating shared patient-physician decision-making;

''(B) the outcomes, effectiveness, and cost-effectiveness of healthcare practices, including preventive measures and primary care;

''(C) existing and innovative technologies;

''(D) the costs and utilization of, and access to healthcare;

''(E) the ways in which healthcare services are organized, delivered, and financed and the interaction and impact of these factors on the quality of patient care;

''(F) methods for measuring quality and strategies for improving quality; and

''(G) ways in which patients, consumers, and practitioners acquire new information about best practices and health benefits, and the determinants of their use of this information;

''(2) synthesizing and disseminating available scientific evidence for use by patients, consumers, practitioners, providers, purchasers, policy makers, and educators; and

''(3) advancing private and public efforts to improve healthcare quality.

''(c) REQUIREMENTS WITH RESPECT TO RURAL AREAS AND PRIORITY POPULATIONS.—In carrying out subsection (b), the Director shall undertake and support research, demonstration projects, and evaluations with respect to—

''(1) the delivery of health services in rural areas (including frontier areas);

''(2) health services for low-income groups, and minority groups;

''(3) the health of children;

''(4) the elderly; and

''(5) people with special healthcare needs, including chronic care and end-of-life healthcare.

''(d) APPOINTMENT OF DIRECTOR.—There shall be at the head of the Agency an official to be known as the Director for Healthcare Quality Research. The Director shall be appointed by the Secretary. The Secretary, acting through the Director, shall carry out the authorities and duties established in this title.

''SEC. 902. GENERAL AUTHORITIES.

''(a) IN GENERAL.—In carrying out section 901(b), the Director shall support demonstration projects, conduct and support research, evaluations, training, research networks, multi-disciplinary centers, technical assistance, and the dissemination of information, on healthcare, and on systems for the delivery of such care, including activities with respect to—

''(1) the quality, effectiveness, efficiency, appropriateness and value of healthcare services;

''(2) quality measurement and improvement;

''(3) the outcomes, cost, cost-effectiveness, and use of healthcare services and access to such services;

''(4) clinical practice, including primary care and practice-oriented research;

''(5) healthcare technologies, facilities, and equipment;

''(6) healthcare costs, productivity, and market forces;

''(7) health promotion and disease prevention, including clinical preventive services;

''(8) health statistics, surveys, database development, and epidemiology; and

''(9) medical liability.

''(b) HEALTH SERVICES TRAINING GRANTS.—The Director may provide training grants in the field of health services research related to activities authorized under subsection (a), to include pre- and post-doctoral fellowships and training programs, young investigator awards, and other programs and activities as appropriate. In carrying out this subsection, the Director shall make use of funds made available under section 478.

''(c) MULTIDISCIPLINARY CENTERS.—The Director may provide financial assistance to assist in meeting the costs of planning and establishing new centers, and operating existing and new centers, for multidisciplinary health services research, demonstration projects, evaluations, training, and policy analysis with respect to the matters referred to in subsection (a).

''(d) RELATION TO CERTAIN AUTHORITIES REGARDING SOCIAL SECURITY.—Activities authorized in this section may include, and shall be appropriately coordinated with experiments, demonstration projects, and other related activities authorized by the Social Security Act and the Social Security Amendments of 1967. Activities under subsection (a)(2) of this section that affect the programs under titles XVIII and XIX of the Social Security Act shall be carried out consistent with section 1142 of such Act.

''(e) DISCLAIMER.—Nothing in this title shall be construed to imply that the Agency's role is to mandate national standards of clinical practice or quality healthcare standards. Recommendations resulting from projects funded and published by the Agency shall include a corresponding disclaimer.

''(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to imply that quality measurement is a science of uniform national standards. In research and quality improvement activities, the Agency shall consider a wide range of choices, providers, healthcare delivery systems, and individual preferences.

''PART B—HEALTHCARE IMPROVEMENT RESEARCH

''SEC. 911. HEALTHCARE OUTCOME IMPROVEMENT RESEARCH.

''(a) EVIDENCE RATING SYSTEMS.—In collaboration with experts from the public and private sector, the Agency shall identify and disseminate methods or systems used to assess healthcare research results, particularly to rate the strength of the scientific evidence behind healthcare practice and technology recommendations in the research literature. The Agency shall make methods or systems for evidence rating widely available. Agency publications containing healthcare recommendations shall indicate the level of substantiating evidence using such methods or systems.

''(b) HEALTHCARE IMPROVEMENT RESEARCH CENTERS AND PROVIDER-BASED RESEARCH NETWORKS.—

''(1) IN GENERAL.—In order to address the full continuum of care and outcomes research, to link research to practice improvement, and to speed the dissemination of research findings to community practice settings, the Agency shall employ research strategies and mechanisms that will link research directly with clinical practice in geographically diverse locations throughout the United States, including—

''(A) Healthcare Improvement Research Centers that combine demonstrated multidisciplinary expertise in outcomes or quality improvement research with linkages to relevant sites of care;

''(B) Practice-based Research Networks, including plan, facility, or delivery system sites of care (especially primary care), that can evaluate and promote quality improvement; and

''(C) other innovative mechanisms or strategies.

''(2) REQUIREMENTS.—The Director is authorized to establish the requirements for entities applying for grants under this subsection.

''(c) EXPANSION OF THE HEALTH SERVICES RESEARCH WORKFORCE.—

''(1) GRANTS.—The Agency shall, through the awarding of grants, support eligible entities at geographically diverse locations throughout the United States to enable such entities to carry out research training programs that are dedicated to health services research training at the doctoral, post-doctoral, and junior faculty levels.

''(2) REQUIREMENTS.—In developing priorities for the allocation of training funds under this subsection, the Director shall take into consideration shortages in the number of trained researchers addressing the priority populations.

"SEC. 912. PRIVATE-PUBLIC PARTNERSHIPS TO IMPROVE ORGANIZATION AND DELIVERY.

''(a) SUPPORT FOR EFFORTS TO DEVELOP INFORMATION ON QUALITY.—

''(1) SCIENTIFIC AND TECHNICAL SUPPORT.—In its role as the principal agency for healthcare quality research, the Agency shall provide scientific and technical support for private and public efforts to improve healthcare quality, including accrediting organizations.

''(2) ROLE OF THE AGENCY.—With respect to paragraph (1), the role of the Agency shall include—

''(A) the identification and assessment of methods for the evaluation of the health of enrollees in health plans by type of plan, provider, and provider arrangements;

''(B) the ongoing development, testing, and dissemination of quality measures, including measures of health and functional outcomes, that take into account appropriate variations in individual preferences;

''(C) the compilation and dissemination of healthcare quality measures developed in the private and public sector;

''(D) assistance in the development of improved healthcare information systems;

''(E) the development of survey tools for the purpose of measuring participant and beneficiary assessments of their healthcare; and

''(F) the integration of information on quality into purchaser and consumer decision-making processes.

''(b) DEMONSTRATION PROGRAM REGARDING CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS.—

''(1) IN GENERAL.—The Secretary, acting through the Director and in consultation with the Commissioner of Food and Drugs, shall establish a demonstration program for the purpose of making one or more grants for the establishment and operation of one or more centers to carry out the activities specified in paragraph (2).

''(2) REQUIRED ACTIVITIES.—The activities referred to in this paragraph are the following:

''(A) The conduct of state-of-the-art clinical research for the following purposes:

''(i) To increase awareness of—

''(I) new uses of drugs, biological products, and devices;

''(II) ways to improve the effective use of drugs, biological products, and devices; and

''(III) risks of new uses and risks of combinations of drugs and biological products.

''(ii) To provide objective clinical information to the following individuals and entities:

''(I) Healthcare practitioners and other providers of Healthcare goods or services.

''(II) Pharmacy benefit managers and purchasers.

''(III) Health maintenance organizations and other managed healthcare organizations.

''(IV) Healthcare insurers and governmental agencies.

''(V) Patients and consumers.

''(iii) To improve the quality of healthcare while reducing the cost of Healthcare through—

''(I) the appropriate use of drugs, biological products, or devices; and

''(II) the prevention of adverse effects of drugs, biological products, and devices and the consequences of such effects, such as unnecessary hospitalizations.

''(B) The conduct of research on the comparative effectiveness, cost-effectiveness, and safety of drugs, biological products, and devices.

''(C) Such other activities as the Secretary determines to be appropriate, except that a grant may not be expended to assist the Secretary in the review of new drugs.

''(3) APPLICATION FOR GRANT.—A grant under paragraph (1) may be made only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

''(4) PEER REVIEW.—A grant under paragraph (1) may be made only if the application for the grant has undergone appropriate technical and scientific peer review.

''(c) REDUCING ERRORS IN MEDICINE.—The Director shall conduct and support research and build private-public partnerships to—

''(1) identify the causes of preventable healthcare errors and patient injury in healthcare delivery systems;

''(2) develop, demonstrate, and evaluate strategies for reducing errors and improving patient safety; and

''(3) promote the implementation of effective strategies throughout the healthcare industry.

"SEC. 913. INFORMATION ON QUALITY AND COST OF CARE.

''(a) IN GENERAL.—In carrying out 902(a), the Director shall—

''(1) collect data from a nationally representative sample of the population on the cost and use of healthcare, including the types of healthcare services Americans use, their access to healthcare services, frequency of use, how much is paid for the services used, the source of those payments, the types and costs of private health insurance, access, satisfaction, and quality of care for the general population and also for children, uninsured persons, poor and near-poor individuals, and persons with special healthcare needs, including end-of-life healthcare;

''(2) develop databases and tools that enable States to track the quality, access, and use of healthcare services provided to their residents; and

''(3) enter into agreements with public or private entities to use, link, or acquire databases for research authorized under this title.

''(b) QUALITY AND OUTCOMES INFORMATION.—

''(1) IN GENERAL.—To enhance the understanding of the quality of care, the determinants of health outcomes and functional status, the needs of special populations as well as an understanding of these changes over time, their relationship to healthcare access and use, and to monitor the overall national impact of Federal and State policy changes on healthcare, the Director, beginning in fiscal year 2000, shall ensure that the survey conducted under subsection (a)(1) will—

''(A) provide information on the quality of care and patient outcomes for frequently occurring clinical conditions for a nationally representative sample of the population; and

''(B) provide reliable national estimates for children and persons with special healthcare needs through the use of supplements or periodic expansions of the survey.

''(2) ANNUAL REPORT.—Beginning in fiscal year 2002, the Secretary, acting through the Director, shall submit to Congress an annual report on national trends in the quality of healthcare provided to the American people.

"SEC. 914. INFORMATION SYSTEMS FOR HEALTHCARE IMPROVEMENT.

''In order to foster a range of innovative approaches to the management and communication of health information, the Agency shall support research to evaluate and initiatives to advance—

''(1) the use of information systems for the study of healthcare quality, including the generation of both individual provider and plan-level comparative performance measures;

''(2) training for healthcare practitioners and researchers in the use of information systems;

''(3) the creation of effective linkages between various sources of health information, including the development of information networks;

''(4) the delivery and coordination of evidence-based healthcare services, using real-time decision-support programs;

''(5) the structure, content, definition, and coding of health information data and medical vocabularies and shall consult with other Federal entities;

''(6) the evaluation and use of computer-based health records in outpatient and inpatient settings as a personal health record for individual health assessment and maintenance, and for monitoring public health and outcomes of care within populations; and

''(7) the protection of individually identifiable information in health services research and healthcare quality improvement.

"SEC. 915. RESEARCH SUPPORTING PRIMARY CARE DELIVERY AND ACCESS IN UNDERSERVED AREAS.

''(a) PREVENTIVE SERVICES TASK FORCE.—

''(1) PURPOSE.—The Agency shall provide ongoing administrative, research, and technical support for the operation of the Preventive Services Task Force. The Agency shall coordinate and support the dissemination of the Preventive Services Task Force recommendations.

''(2) OPERATION.—The Preventive Services Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations, and updating previous recommendations, regarding their usefulness in daily clinical practice. In carrying out its responsibilities under paragraph (1), the Task Force shall not be subject to the provisions of Appendix 2 of title 5, United States Code.

''(b) PRIMARY CARE DELIVERY RESEARCH.—

''(1) IN GENERAL.—There is established within the Agency a Center for Primary Care Delivery Research (referred to in this subsection as the 'Center') that shall serve as the principal source of funding for primary care delivery research in the Department of Health and Human Services. For purposes of this paragraph, primary care delivery research focuses on the first contact when illness or health concerns arise, the diagnosis, treatment or referral to specialty care, preventive care, and the relationship between the clinician and the patient in the context of the family and community.

''(2) RESEARCH.—In carrying out this section, the Center shall conduct and support research on—

''(A) the nature and characteristics of primary care delivery practice;

''(B) producing evidence for the management of commonly occurring clinical problems;

''(C) the management of undifferentiated clinical problems;

''(D) the continuity and coordination of health services; and

''(E) the application and impact of telemedicine and other distance technologies.

''(3) DEMONSTRATION.—The Agency shall support demonstrations into the use of new information tools aimed at improving shared decision-making between patients and their care-givers.

"SEC. 916. CLINICAL PRACTICE AND TECHNOLOGY INNOVATION.

''(a) IN GENERAL.—The Director shall promote innovation in evidence-based clinical practice and healthcare technologies by—

''(1) conducting and supporting research on the development, diffusion, and use of healthcare technology;

''(2) developing, evaluating, and disseminating methodologies for healthcare practice and technology assessment;

''(3) conducting intramural and supporting extramural assessments of existing and new healthcare practices and technologies;

''(4) promoting education, training, and providing technical assistance in the use of healthcare practice and healthcare technology assessment methodologies and results; and

''(5) working with the National Library of Medicine and the public and private sector to develop an electronic clearinghouse of currently available assessments and those in progress.

''(b) SPECIFICATION OF PROCESS.—

''(1) IN GENERAL.—Not later than June 1, 1999, the Director shall develop and publish a description of the methods used by the Agency and its contractors for practice and technology assessment.

''(2) CONSULTATIONS.—In carrying out this subsection, the Director shall cooperate and consult with the Administrator of the Health Care Financing Administration, the Director of the National Institutes of Health, the Commissioner of Food and Drugs, and the heads of any other interested Federal department or agency, professional societies, and other private and public entities.

''(3) METHODOLOGY.—The methods employed in practice and technology assessments under paragraph (1) shall consider—

''(A) safety, efficacy, and effectiveness;

''(B) legal, social, and ethical implications;

''(C) costs, benefits, and cost-effectiveness;

''(D) comparisons to alternative technologies and practices; and

''(E) requirements of Food and Drug Administration approval to avoid duplication.

''(c) SPECIFIC ASSESSMENTS.—

''(1) IN GENERAL.—The Director shall conduct and support specific assessments of healthcare technologies and practices.

''(2) GRANTS AND CONTRACTS.—The Director may make grants to, or enter into cooperative agreements or contracts with, entities described in paragraph (3) for the establishment of collaborative arrangements for the purpose of conducting assessments of experimental, emerging, existing, or potentially outmoded healthcare technologies, and for related activities.

''(3) ELIGIBLE ENTITIES.—An entity described in this paragraph is an entity that is determined to be appropriate by the Director, including academic medical centers, research institutions, professional organizations, third party payers, other governmental agencies, and consortia of appropriate research entities established for the purpose of conducting technology assessments.

''SEC. 917. COORDINATION OF FEDERAL GOVERNMENT QUALITY IMPROVEMENT EFFORTS.

''(a) REQUIREMENT.—

''(1) IN GENERAL.—The Secretary, acting through the Director, shall coordinate all research, evaluations, and demonstrations related to health services research and quality measurement and improvement activities undertaken and supported by the Federal Government.

''(2) SPECIFIC ACTIVITIES.—The Director, in collaboration with the appropriate Federal officials representing all concerned executive agencies and departments, shall develop and manage a process to—

''(A) improve interagency coordination, priority setting, and the use and sharing of research findings and data pertaining to Federal quality improvement programs and health services research;

''(B) strengthen the research information infrastructure, including databases, pertaining to Federal health services research and healthcare quality improvement initiatives;

''(C) set specific goals for participating agencies and departments to further health services research and healthcare quality improvement; and

''(D) strengthen the management of Federal healthcare quality improvement programs.

''(b) STUDY BY THE INSTITUTE OF MEDICINE.—

''(1) IN GENERAL.—To provide the Department of Health and Human Services with independent, expert advice in redesigning its quality oversight functions, and pertinent research programs, the Secretary shall enter into a contract with the Institute of Medicine—

''(A) to describe and evaluate current quality improvement research and monitoring processes through—

''(i) an overview of pertinent health services research activities and quality improvement efforts with particular attention paid to those performed by the peer review organizations;

''(ii) an analysis of the various partnership activities that the Department of Health and Human Services has pursued with private sector accreditation and other quality measurement organizations;

''(iii) the exploration of programmatic areas where partnership activities could be pursued to improve quality oversight of the medicare and medicaid programs under titles XVIII and XIX of the Social Security Act; and

''(iv) an identification of opportunities for enhancing health system efficiency through simplification and reduction in redundancy of public and private sector quality improvement efforts; and

''(B) to identify options and make recommendations to improve the efficiency and effectiveness of such quality improvement programs and to optimize public/private sector accreditation bodies through—

''(i) the improved coordination of activities across the medicare and medicaid programs under titles XVIII and XIX of the Social Security Act and various health services research programs;

''(ii) greater consistency and standardization of oversight activities across traditional fee-for-service and managed care components of these programs;

''(iii) the strengthening of patient choice and participation by incorporating state-of-the-art quality monitoring tools and making information on quality available; and

''(iv) the enhancement of the most effective programs, consolidation as appropriate, and elimination of duplicative activities within various federal agencies.

''(2) REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary shall enter into a contract with the Institute of Medicine for the preparation—

''(i) not later than 12 months after the date of enactment of this title, of a report providing an overview of the quality improvement programs of the Department of Health and Human Services for the medicare, medicaid, and CHIP programs under titles XVIII, XIX, and XXI of the Social Security Act; and

''(ii) not later than 24 months after the date of enactment of this title, of a final report containing recommendations for a comprehensive system and public-private partnerships for healthcare quality improvement.

''(B) REPORTS.—The Secretary shall submit the reports described in subparagraph (A) to the Committee on Finance and the Committee on Labor and Human Resources of the Senate and the Committee on Ways and Means and the Committee on Commerce of the House of Representatives.

''PART C—FOUNDATION FOR HEALTHCARE QUALITY RESEARCH

''SEC. 921. FOUNDATION FOR HEALTHCARE QUALITY RESEARCH.

''(a) IN GENERAL.—The Secretary shall, acting through the Director of the Agency for Healthcare Quality Research, establish a nonprofit corporation to be known as the Foundation for Healthcare Research (hereafter in this section referred to as the 'Foundation'). The Foundation shall not be an agency or instrumentality of the United States Government.

''(b) PURPOSE OF FOUNDATION.—The purpose of the Foundation shall be to—

''(1) support the Agency for Healthcare Quality Research in its mission;

''(2) foster public-private partnerships to support the programs and activities of the Agency;

''(3) advance collaboration with healthcare researchers from universities, industry, and nonprofit organizations; and

''(4) develop linkages with users of healthcare and quality research, including patients, consumers, practitioners and other healthcare providers, health plans and insurers, large private or public sector purchasers of healthcare, healthcare policy makers, and healthcare educators.

''(c) CERTAIN ACTIVITIES OF FOUNDATION.—In carrying out subsection (b), the Foundation may solicit and accept gifts, grants, and other donations, establish accounts, and invest and expend funds in support of a broad range of research, training, dissemination, and other activities with respect to the purpose described in such subsection. In addition, the Foundation is authorized to support the following:

''(1) A program to provide and administer endowed positions that are associated with the research program of the Agency for Healthcare Quality Research. Such endowments may be expended for the compensation of individuals holding the positions, for staff, equipment, quarters, travel, and other expenditures that are appropriate in supporting the endowed positions.

''(2) A program to provide and administer fellowships and grants to research personnel in order to work and study in association with the Agency for Healthcare Quality Research. Such fellowships and grants may include stipends, travel, health insurance benefits, and other appropriate expenses. The recipients of fellowships shall be selected by the donors and the Foundation upon the recommendation of the Agency for Healthcare Quality Research, and shall be subject to the agreement of the Director of the Agency for Healthcare Quality Research and the Executive Director of the Foundation.

''(d) GENERAL STRUCTURE OF FOUNDATION; NONPROFIT STATUS.—

''(1) BOARD OF DIRECTORS.—The Foundation shall have a Board of Directors (in this section referred to as the Board), which shall be established and conducted in accordance with subsection (e). The Board shall establish the general policies of the Foundation for carrying out subsection (b), including the establishment of the bylaws of the Foundation.

''(2) EXECUTIVE DIRECTOR.—The Foundation shall have an executive director (in this section referred to as the 'Director'), who shall be appointed by the Board, who shall serve at the pleasure of the Board, and for whom the Board shall establish the rate of compensation. Subject to compliance with the policies and bylaws established by the Board pursuant to paragraph (1), the Director shall be responsible for the daily operations of the Foundation in carrying out subsection (b).

''(3) NONPROFIT STATUS.—In carrying out subsection (b), the Board shall establish such

policies and bylaws under paragraph (1), and the Director shall carry out such activities under paragraph (2), as may be necessary to ensure that the Foundation maintains status as an organization that—

''(A) is described in subsection (c)(3) of section 501 of the Internal Revenue Code of 1986; and

''(B) is, under subsection (a) of such section, exempt from taxation.

''(e) BOARD OF DIRECTORS.—

''(1) CERTAIN BYLAWS.—

''(A) IN GENERAL.—The Board shall ensure that bylaws established under subsection (a)(1) include bylaws for the following:

''(i) Policies for the selection of the officers, employees, agents, and contractors of the Foundation.

''(ii) Policies, including ethical standards, for the acceptance and disposition of donations to the Foundation and for the disposition of the assets of the Foundation.

''(iii) Policies for the conduct of the general operations of the Foundation.

''(iv) Policies for writing, editing, printing, and publishing of books and other materials, and the acquisition of patents and licenses for devices and procedures developed by the Foundation.

''(B) REQUIREMENTS.—The Board shall ensure that the bylaws established under subsection (d)(1) (and activities carried out under such bylaws) do not—

''(i) reflect unfavorably upon the ability of the Foundation, or the Agency for Healthcare Quality Research, to carry out its responsibilities or official duties in a fair and objective manner; or

''(ii) compromise, or appear to compromise, the integrity of any governmental program or any officer or employee involved in such program.

''(2) COMPOSITION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Board shall be composed of 7 individuals, appointed in accordance with paragraph (4), who collectively possess education or experience appropriate for representing the constituencies described in subsection (b). Each such individual shall be a voting member of the Board.

''(B) ADDITIONAL MEMBERS.—The Board may, through amendments to the bylaws of the Foundation, provide that the number of members of the Board shall be a greater number than the number specified in subparagraph (A).

''(3) CHAIR.—The Board shall, from among the members of the Board, designate an individual to serve as the chair of the Board (in this subsection referred to as the 'Chair').

''(4) APPOINTMENTS, VACANCIES, AND TERMS.—The following shall apply to the Board:

''(A) Any vacancy in the membership of the Board shall be filled by appointment by the Board, after consideration of suggestions made by the Chair and the Director regarding the appointments. Any such vacancy shall be filled not later than the expiration of the 180-day period beginning on the date on which the vacancy occurs.

''(B) The term of office of each member of the Board appointed under subparagraph (A) shall be 5 years. A member of the Board may continue to serve after the expiration of the term of the member until the expiration of the 180-day period beginning on the date on which the term of the member expires.

''(C) A vacancy in the membership of the Board shall not affect the power of the Board to carry out the duties of the Board. If a member of the Board does not serve the full term applicable under subparagraph (B), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

''(5) COMPENSATION.—Members of the Board may not receive compensation for service on the Board. The members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Board.

''(f) CERTAIN RESPONSIBILITIES OF EXECUTIVE DIRECTOR.—In carrying out subsection (d)(2), the Director shall carry out the following functions:

''(1) Hire, promote, compensate, and discharge officers and employees of the Foundation, and define the duties of the officers and employees.

''(2) Accept and administer donations to the Foundation, and administer the assets of the Foundation.

''(3) Establish a process for the selection of candidates for holding endowed positions under subsection (c).

''(4) Enter into such financial agreements as are appropriate in carrying out the activities of the Foundation.

''(5) Take such action as may be necessary to acquire patents and licenses for devices and procedures developed by the Foundation and the employees of the Foundation.

''(6) Adopt, alter, and use a corporate seal, which shall be judicially noticed.

''(7) Commence and respond to judicial proceedings in the name of the Foundation.

''(8) Other functions that are appropriate in the determination of the Director.

''(g) GENERAL PROVISIONS.—

''(1) AUTHORITY FOR ACCEPTING FUNDS.—The Director of the Agency for Healthcare Quality Research may accept and utilize, on behalf of the Federal Government, any gift, donation, bequest, or devise of real or personal property from the Foundation for the purpose of aiding or facilitating the work of such Agency. Funds may be accepted and utilized by such Director under the preceding sentence without regard to whether the funds are designated as general-purpose funds or special-purpose funds. Any funds transferred under this paragraph shall be subject to all Federal limitations relating to federally funded research.

''(2) AUTHORITY FOR ACCEPTANCE OF VOLUNTARY SERVICES.—

''(A) IN GENERAL.—The Director of the Agency for Healthcare Quality Research may accept, on behalf of the Federal Government, any voluntary services provided to such Agency by the Foundation for the purpose of aiding or facilitating the work of such Agency. In the case of an individual, such Director may accept the services provided under the preceding sentence by the individual for not more than 2 years.

''(B) LIMITATION.—The limitation established in subparagraph (A) regarding the period of time in which services may be accepted applies to each individual who is not an employee of the Federal Government and who serves in association with the Agency for Healthcare Quality Research pursuant to financial support from the Foundation.

''(3) ADMINISTRATIVE CONTROL.—No officer, employee, or member of the Board of the Foundation may exercise any administrative or managerial control over any Federal employee.

''(4) APPLICABILITY OF CERTAIN STANDARDS TO NON-FEDERAL EMPLOYEES.—In the case of any individual who is not an employee of the Federal Government and who serves in association with the Agency for Healthcare Quality Research pursuant to financial support from the Foundation, the Foundation shall negotiate a memorandum of understanding with the individual and the Director of the Agency for Healthcare Quality Research specifying that the individual—

''(A) shall be subject to the ethical and procedural standards regulating Federal employment, scientific investigation, and research findings (including publications and patents) that are required of individuals employed by the Agency for Healthcare Quality Research, including standards under this Act, the Ethics in Government Act, and the Technology Transfer Act; and

''(B) shall be subject to such ethical and procedural standards under chapter 11 of title 18, United States Code (relating to conflicts of interest), as the Director of such Agency determines is appropriate, except such memorandum may not provide that the individual shall be subject to the standards of section 209 of such chapter.

''(5) FINANCIAL CONFLICTS OF INTEREST.—Any individual who is an officer, employee, or member of the Board of the Foundation may not directly or indirectly participate in the consideration or determination by the Foundation of any question affecting—

''(A) any direct or indirect financial interest of the individual; or

''(B) any direct or indirect financial interest of any business organization or other entity of which the individual is an officer or employee or in which the individual has a direct or indirect financial interest.

''(6) AUDITS; AVAILABILITY OF RECORDS.—The Foundation shall—

''(A) provide for biennial audits of the financial condition of the Foundation; and

''(B) make such audits, and all other records, documents, and other papers of the Foundation, available to the Secretary and the Comptroller General of the United States for examination or audit.

''(7) REPORTS.—

''(A) IN GENERAL.—Not later than February 1 of each fiscal year, the Foundation shall publish a report describing the activities of the Foundation during the preceding fiscal year. Each such report shall include for the fiscal year involved a comprehensive statement of the operations, activities, financial condition, and accomplishments of the Foundation.

''(B) FINANCIAL REQUIREMENT.—With respect to the financial condition of the Foundation, each report under subparagraph (A) shall include the source, and a description of, all gifts to the Foundation each report under subparagraph (A) shall include the source, and a description of, all gifts to the Foundation of real or personal property, and the source and amount of all gifts to the Foundation of money. Each such report shall include a specification of any restrictions on the purposes for which gifts to the Foundation may be used.

''(C) PUBLIC INSPECTION.—The Foundation shall make copies of each report submitted under subparagraph (A) available for public inspection, and shall upon request provide a copy of the report to any individual for a charge not exceeding the cost of providing the copy.

''(8) LIAISON FROM THE AGENCY FOR HEALTHCARE QUALITY RESEARCH.—The Director of the Agency for Healthcare Quality Research shall serve as the liaison representative of such Agency and the Foundation.

''(h) FEDERAL FUNDING.—

''(1) AUTHORITY FOR FINANCIAL SUPPORT.—

''(A) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Quality Research, shall—

''(i) for fiscal year 1999, support the work of the Committee, established pursuant to subsection (i); and

''(ii) for fiscal year 2000 and each subsequent fiscal year, make a grant to the Foundation.

''(B) LIMITATIONS.—Financial support under subparagraph (A) may be expended—

''(i) in the case of the Committee, only for the purpose of carrying out the duties established in subsection (i); and

''(ii) in the case of the Foundation, only for the purpose of the administrative expenses of the Foundation.

''(C) REMAINING FUNDS.—For the purposes described in subparagraph (B), any portion of the financial support provided to the Committee under subparagraph (A)(i) for fiscal year 1999 that remains unobligated after the Committee completes the duties established in subsection (i) shall be available to the Foundation.

''(2) FUNDS.—

''(A) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of providing financial support under paragraph (1), there is authorized to be appropriated for the Foundation $500,000 for each fiscal year.

''(B) GRANTS.—For the purpose of grants under paragraph (1), the Secretary may for each fiscal year make available not more than $500,000 from the amounts appropriated for the fiscal year for the programs of the Department of Health and Human Services. Such amounts may be made available without regard to whether amounts have been appropriated under subparagraph (A).

''(3) CERTAIN RESTRICTION.—If the Foundation receives Federal funds for the purpose of serving as a fiscal intermediary between Federal agencies, the Foundation may not receive such funds for the indirect costs of carrying out such purpose in an amount exceeding 10 percent of the direct costs of carrying out such purpose. The preceding sentence may not be construed as authorizing the expenditure of any grant under paragraph (1) for such purpose.

''(i) ESTABLISHMENT OF COMMITTEE.—

''(1) IN GENERAL.—The Secretary shall establish in accordance with this subsection a committee (referred to in this subsection as the 'Committee') to carry out the functions described in paragraph (2).

''(2) FUNCTIONS.—The functions referred to in paragraph (1) for the Committee are as follows:

''(A) To carry out such activities as may be necessary to incorporate the Foundation under the laws of the State involved, including serving as incorporators for the Foundation. Such activities shall include ensuring that the articles of incorporation for the Foundation require that the Foundation be established and operated in accordance with the applicable provisions of this part (or any successor to this part), including such provisions as may be in effect pursuant to amendments enacted after the date of the enactment of the Healthcare Quality Research Act of 1998.

''(B) To ensure that the Foundation qualifies for and maintains the status described in subsection (d)(3) (regarding taxation).

''(C) To establish the general policies and initial bylaws of the Foundation, which bylaws shall include the bylaws described in subsections (d)(3) and (e)(1).

''(D) To provide for the initial operation of the Foundation, including providing for quarters, equipment, and staff.

''(E) To appoint the initial members of the Board in accordance with the requirements established in subsection (e)(2)(A) for the composition of the Board and establish their respective terms, and other such qualifications as the Committee may determine to be appropriate.

''(3) COMPLETION OF FUNCTIONS OF COMMITTEE; INITIAL MEETING OF BOARD.—

''(A) IN GENERAL.—The Committee shall complete the functions required in paragraph (1) not later than 1 year following the appointment of the last member of the Committee. The Committee shall terminate upon the expiration of the 30-day period beginning on the date on which the Secretary determines that the functions have been completed.

''(B) INITIAL MEETING.—The initial meeting of the Board shall be held not later than 90 days after the Committee has completed its functions.

''(4) COMPOSITION.—The Committee shall be composed of 7 members, each of whom shall be a voting member. Of the members of the Committee—

''(A) not fewer than 2 members shall have broad, general experience in healthcare; and

''(B) not fewer than 2 members shall have broad, general experience in the creation of a nonprofit private organization, one of whom shall have expertise in the legal structuring of nonprofit organizations (without regard to whether the individuals have experience in healthcare).

''(5) CHAIR.—The Committee shall, from among the members of the Committee, designate an individual to serve as the chair of the Committee.

''(6) TERMS; VACANCIES.—The term of members of the Committee shall be for the duration of the Committee. A vacancy in the membership of the Committee shall not affect the power of the Committee to carry out the duties of the Committee. If a member of the Committee does not serve the full term, the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

''(7) COMPENSATION.—Members of the Committee may not receive compensation for service on the Committee. Members of the Committee may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Committee.

''(8) COMMITTEE SUPPORT.—The Director of the Agency for Healthcare Quality Research may, from amounts available to the Director for the general administration of such Agency, provide staff and financial support to assist the Committee with carrying out the functions described in paragraph (2). In providing such staff and support, the Director may both detail employees and contract for assistance.

''PART D—GENERAL PROVISIONS

''SEC. 931. ADVISORY COUNCIL FOR HEALTHCARE QUALITY RESEARCH.

''(a) ESTABLISHMENT.—There is established an advisory council to be known as the Advisory Council for Healthcare Quality Research.

''(b) DUTIES.—

''(1) IN GENERAL.—The Advisory Council shall advise the Secretary and the Director with respect to activities to carry out the purpose of the Agency under section 901(b).

''(2) CERTAIN RECOMMENDATIONS.—Activities of the Advisory Council under paragraph (1) shall include making recommendations to the Director regarding—

''(A) priorities regarding healthcare research, especially studies related to quality, outcomes, cost and the utilization of, and access to, healthcare services;

''(B) the field of healthcare research and related disciplines, especially issues related to training needs, and dissemination of information on quality; and

''(C) the appropriate role of the Agency in each of these areas in light of private sector activity and identification of opportunities for public-private sector partnerships.

''(c) MEMBERSHIP.—

''(1) IN GENERAL.—The Advisory Council shall, in accordance with this subsection, be composed of appointed members and ex officio members. All members of the Advisory Council shall be voting members other than the individuals designated under paragraph (3)(B) who shall be ex officio members of the Advisory Council.

''(2) APPOINTED MEMBERS.—The Secretary shall appoint to the Advisory Council 21 appropriately qualified individuals. At least 17 members of the Advisory Council shall be representatives of the public who are not officers or employees of the United States. The Secretary shall ensure that the appointed members of the Council, as a group, are representative of professions and entities concerned with, or affected by, activities under this title and under section 1142 of the Social Security Act. Of such members—

''(A) 4 shall be individuals distinguished in the conduct of research, demonstration projects, and evaluations with respect to healthcare;

''(B) 4 shall be individuals distinguished in the practice of medicine of which at least 1 shall be a primary care practitioner;

''(C) 3 shall be individuals distinguished in the health professions;

''(D) 4 shall be individuals either representing the private healthcare sector, including health plans, providers, and purchasers or individuals distinguished as administrators of healthcare delivery systems;

''(E) 4 shall be individuals distinguished in the fields of healthcare quality improvement, economics, information systems, law, ethics, business, or public policy; and

''(F) 2 shall be individuals representing the interests of patients and consumers of healthcare.

''(3) EX OFFICIO MEMBERS.—The Secretary shall designate as ex officio members of the Advisory Council—

''(A) the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Care Financing Administration, the Assistant Secretary of Defense (Health Affairs), and the Chief Medical Officer of the Department of Veterans Affairs; and

''(B) such other Federal officials as the Secretary may consider appropriate.

''(d) TERMS.—Members of the Advisory Council appointed under subsection (c)(2) shall serve for a term of 3 years. A member of the Council appointed under such subsection may continue to serve after the expiration of the term of the members until a successor is appointed.

''(e) VACANCIES.—If a member of the Advisory Council appointed under subsection (c)(2) does not serve the full term applicable under subsection (d), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

''(f) CHAIR.—The Director shall, from among the members of the Advisory Council appointed under subsection (c)(2), designate an individual to serve as the chair of the Advisory Council.

''(g) MEETINGS.—The Advisory Council shall meet not less than once during each discrete 4-month period and shall otherwise meet at the call of the Director or the chair.

''(h) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—

''(1) APPOINTED MEMBERS.—Members of the Advisory Council appointed under subsection (c)(2) shall receive compensation for each day (including travel time) engaged in carrying out the duties of the Advisory Council unless declined by the member. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for GS–18 of the General Schedule.

''(2) EX OFFICIO MEMBERS.—Officials designated under subsection (c)(3) as ex officio members of the Advisory Council may not receive compensation for service on the Advisory Council in addition to the compensation otherwise received for duties carried out as officers of the United States.

''(i) STAFF.—The Director shall provide to the Advisory Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

"SEC. 932. PEER REVIEW WITH RESPECT TO GRANTS AND CONTRACTS.

"(a) REQUIREMENT OF REVIEW.—

"(1) IN GENERAL.—Appropriate technical and scientific peer review shall be conducted with respect to each application for a grant, cooperative agreement, or contract under this title.

"(2) REPORTS TO DIRECTOR.—Each peer review group to which an application is submitted pursuant to paragraph (1) shall report its finding and recommendations respecting the application to the Director in such form and in such manner as the Director shall require.

"(b) APPROVAL AS PRECONDITION OF AWARDS.—The Director may not approve an application described in subsection (a)(1) unless the application is recommended for approval by a peer review group established under subsection (c).

"(c) ESTABLISHMENT OF PEER REVIEW GROUPS.—

"(1) IN GENERAL.—The Director shall establish such technical and scientific peer review groups as may be necessary to carry out this section. Such groups shall be established without regard to the provisions of title 5, United States Code, that govern appointments in the competitive service, and without regard to the provisions of chapter 51, and subchapter III of chapter 53, of such title that relate to classification and pay rates under the General Schedule.

"(2) MEMBERSHIP.—The members of any peer review group established under this section shall be appointed from among individuals who by virtue of their training or experience are eminently qualified to carry out the duties of such peer review group. Officers and employees of the United States may not constitute more than 25 percent of the membership of any such group. Such officers and employees may not receive compensation for service on such groups in addition to the compensation otherwise received for duties carried out as such officers and employees.

"(3) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, peer review groups established under this section shall continue in existence until otherwise provided by law.

"(4) QUALIFICATIONS.—Members of any peer-review group shall, at a minimum, meet the following requirements:

"(A) Such members shall agree in writing to treat information received, records, reports, and recommendations as confidential information.

"(B) Such members shall agree in writing to recuse themselves from participation in the peer-review of specific applications which present a potential personal conflict of interest or appearance of such conflict, including employment in the applicant organization, stock ownership, or any financial or other arrangement that might introduce bias in the process of peer-review.

"(d) AUTHORITY FOR PROCEDURAL ADJUSTMENTS IN CERTAIN CASES.—In the case of applications described in subsection (a)(1) for financial assistance whose direct costs will not exceed $100,000, the Director may make appropriate adjustments in the procedures otherwise established by the Director for the conduct of peer review under this section. Such adjustments may be made for the purpose of encouraging the entry of individuals into the field of research, for the purpose of encouraging clinical practice-oriented research, and for such other purposes as the Director may determine to be appropriate.

"(e) REGULATIONS.—The Secretary shall issue regulations for the conduct of peer review under this section.

"SEC. 933. CERTAIN PROVISIONS WITH RESPECT TO DEVELOPMENT, COLLECTION, AND DISSEMINATION OF DATA.

"(a) STANDARDS WITH RESPECT TO UTILITY OF DATA.—

"(1) IN GENERAL.—With respect to data developed or collected by any entity for the purpose described in section 901(b), the Director shall, in order to assure that utility, accuracy, and sufficiency of such data for all interested entities, establish recommendations for methods of developing and collecting such data. Such recommendations shall include recommendations for the development and collection of data on the outcomes of healthcare services and procedures. Such recommendations shall recognize the differences between types of healthcare plans, delivery systems, healthcare providers, and provider arrangements.

"(2) RELATIONSHIP WITH MEDICARE PROGRAM.—In any case where recommendations under paragraph (1) may affect the administration of the program under title XVIII of the Social Security Act, they shall be in the form of recommendations to the Secretary for such program.

"(b) STATISTICS.—The Director shall—

"(1) take such action as may be necessary to assure that statistics developed under this title are of high quality, timely, and comprehensive, as well as specific, standardized, and adequately analyzed and indexed; and

"(2) publish, make available, and disseminate such statistics on as wide a basis as is practicable.

"(c) AUTHORITY REGARDING CERTAIN REQUESTS.—Upon request of a public or private entity, the Director may undertake research or analyses otherwise authorized by this title pursuant to arrangements under which such entity will pay the cost of the services provided. Amounts received by the Director under such arrangements shall be available to the Director for obligation until expended.

"SEC. 934. DISSEMINATION OF INFORMATION.

"(a) IN GENERAL.—The Administrator shall—

"(1) without regard to section 501 of title 44, United States Code, promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this title;

"(2) promptly make available to the public data developed in such research, demonstration projects, and evaluations;

"(3) building upon, but without duplicating, information services provided by the National Library of Medicine and considering applicable interagency agreements, provide indexing, abstracting, translating, publishing, and other services leading to a more effective and timely dissemination of information on research, demonstration projects, and evaluations with respect to healthcare to public and private entities and individuals engaged in the improvement of healthcare delivery and the general public, and undertake programs to develop new or improved methods for making such information available; and

"(4) as appropriate, provide technical assistance to State and local government and health agencies and conduct liaison activities to such agencies to foster dissemination.

"(b) PROHIBITION AGAINST RESTRICTIONS.—Except as provided in subsection (c), the Director may not restrict the publication or dissemination of data from, or the results of, projects conducted or supported under this title.

"(c) LIMITATION ON USE OF CERTAIN INFORMATION.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this title may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Director) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined regulations of the Director) to its publication or release in other form.

"(d) PENALTY.—Any person who violates subsection (c) shall be subject to a civil monetary penalty of not more than $10,000 for each such violation involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the Social Security Act are imposed and collected under that section.

"SEC. 935. ADDITIONAL PROVISIONS WITH RESPECT TO GRANTS AND CONTRACTS.

"(a) PRIORITIES.—In establishing priorities to carry out this title, subject to the availability of funds, the Director shall consider—

"(1) the needs and priorities of healthcare programs that are operated by or supported, in whole or in part, by Federal agencies;

"(2) the healthcare needs of low-income groups, minority groups, children, the elderly, and persons with special healthcare needs and issues related to the delivery of healthcare services in rural areas (including frontier areas).

"(b) FINANCIAL CONFLICTS OF INTEREST.—With respect to projects for which awards of grants, cooperative agreements, or contracts are authorized to be made under this title, the Director shall by regulation define—

"(1) the specific circumstances that constitute financial interests in such projects that will, or may be reasonably expected to, create a bias in favor of obtaining results in the projects that are consistent with such interests; and

"(2) the actions that will be taken by the Director in response to any such interests identified by the Director.

"(c) REQUIREMENT OF APPLICATION.—The Director may not, with respect to any program under this title authorizing the provision of grants, cooperative agreements, or contracts, provide any such financial assistance unless an application for the assistance is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Director determines to be necessary to carry out the program in involved.

"(d) PROVISION OF SUPPLIES AND SERVICES IN LIEU OF FUNDS.—

"(1) IN GENERAL.—Upon the request of an entity receiving a grant, cooperative agreement, or contract under this title, the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the entity in carrying out the project involved and, for such purpose, may detail to the entity any officer or employee of the Department of Health and Human Services.

"(2) CORRESPONDING REDUCTION IN FUNDS.—With respect to a request described in paragraph (1), the Secretary shall reduce the amount of the financial assistance involved by an amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services provided by the Director. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

"(e) APPLICABILITY OF CERTAIN PROVISIONS WITH RESPECT TO CONTRACTS.—Contracts may be entered into under this part without

regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

"SEC. 936. CERTAIN ADMINISTRATIVE AUTHORITIES.

''(a) DEPUTY DIRECTOR AND OTHER OFFICERS AND EMPLOYEES.—

''(1) DEPUTY DIRECTOR.—The Director may appoint a deputy director for the Agency.

''(2) OTHER OFFICERS AND EMPLOYEES.—The Director may appoint and fix the compensation of such officers and employees as may be necessary to carry out this title. Except as otherwise provided by law, such officers and employees shall be appointed in accordance with the civil service laws and their compensation fixed in accordance with title 5, United States Code.

''(b) FACILITIES.—The Secretary, in carrying out this title—

''(1) may acquire, without regard to the Act of March 3, 1877 (40 U.S.C. 34), by lease or otherwise through the Director of General Services, buildings or portions of buildings in the District of Columbia or communities located adjacent to the District of Columbia for use for a period not to exceed 10 years; and

''(2) may acquire, construct, improve, repair, operate, and maintain laboratory, research, and other necessary facilities and equipment, and such other real or personal property (including patents) as the Secretary deems necessary.

''(c) PROVISION OF FINANCIAL ASSISTANCE.—The Director, in carrying out this title, may make grants to public and nonprofit entities and individuals, and may enter into cooperative agreements or contracts with public and private entities and individuals.

''(d) UTILIZATION OF CERTAIN PERSONNEL AND RESOURCES.—

''(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Director, in carrying out this title, may utilize personnel and equipment, facilities, and other physical resources of the Department of Health and Human Services, permit appropriate (as determined by the Secretary) entities and individuals to utilize the physical resources of such Department, and provide technical assistance and advice.

''(2) OTHER AGENCIES.—The Director, in carrying out this title, may use, with their consent, the services, equipment, personnel, information, and facilities of other Federal, State, or local public agencies, or of any foreign government, with or without reimbursement of such agencies.

''(e) CONSULTANTS.—The Secretary, in carrying out this title, may secure, from time to time and for such periods as the Director deems advisable but in accordance with section 3109 of title 5, United States Code, the assistance and advice of consultants from the United States or abroad.

''(f) EXPERTS.—

''(1) IN GENERAL.—The Secretary may, in carrying out this title, obtain the services of not more than 50 experts or consultants who have appropriate scientific or professional qualifications. Such experts or consultants shall be obtained in accordance with section 3109 of title 5, United States Code, except that the limitation in such section on the duration of service shall not apply.

''(2) TRAVEL EXPENSES.—

''(A) IN GENERAL.—Experts and consultants whose services are obtained under paragraph (1) shall be paid or reimbursed for their expenses associated with traveling to and from their assignment location in accordance with sections 5724, 5724a(a), 5724a(c), and 5726(C) of title 5, United States Code.

''(B) LIMITATION.—Expenses specified in subparagraph (A) may not be allowed in connection with the assignment of an expert or consultant whose services are obtained under paragraph (1) unless and until the expert agrees in writing to complete the entire period of assignment, or 1 year, whichever is shorter, unless separated or reassigned for reasons that are beyond the control of the expert or consultant and that are acceptable to the Secretary. If the expert or consultant violates the agreement, the money spent by the United States for the expenses specified in subparagraph (A) is recoverable from the expert or consultant as a debt of the United States. The Secretary may waive in whole or in part a right of recovery under this subparagraph.

''(g) VOLUNTARY AND UNCOMPENSATED SERVICES.—The Director, in carrying out this title, may accept voluntary and uncompensated services.

"SEC. 937. FUNDING.

''(a) INTENT.—To ensure that the United States's investment in biomedical research is rapidly translated into improvements in the quality of patient care, there must be a corresponding investment in research on the most effective clinical and organizational strategies for use of these findings in daily practice. The authorization levels in subsections (b) and (c) provide for a proportionate increase in healthcare research as the United State's investment in biomedical research increases.

''(b) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this title, there are authorized to be appropriated $180,000,000 for fiscal year 1999, and such sums as may be necessary for each of the fiscal years 2000 through 2003.

''(c) EVALUATIONS.—In addition to amounts available pursuant to subsection (b) for carrying out this title, there shall be made available for such purpose, from the amounts made available pursuant to section 241 (relating to evaluations), an amount equal to 40 percent of the maximum amount authorized in such section 241 to be made available for a fiscal year.

''(d) CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS.—For the purpose of carrying out the demonstration program regarding centers for education and research on therapeutics under section 912(b), there are authorized to be appropriated $2,000,000 for fiscal year 1998, and $3,000,000 for fiscal year 1999, and such sums as may be necessary for each of the fiscal years 2000 through 2003.

"SEC. 938. DEFINITIONS.

''In this title:

''(1) ADVISORY COUNCIL.—The term 'Advisory Council' means the Advisory Council on Healthcare Quality Research established under section 931.

''(2) AGENCY.—The term 'Agency' means the Agency for Healthcare Quality.

''(3) DIRECTOR.—The term 'Director' means the Director for the Agency for Healthcare Quality Research.''.

SEC. 403. REFERENCES.

Effective upon the date of enactment of this Act, any reference in law to the ''Agency for Health Care Policy and Research'' shall be deemed to be a reference to the ''Agency for Healthcare Quality Research''.

SEC. 404. STUDY.

(a) STUDY.—Not later than 30 days after the date of enactment of any Act providing for a qualifying health care benefit (as defined in subsection (b), the Secretary of Health and Human Services, in consultation with the Agency for Healthcare Quality Research, the National Institutes of Health, and the Institute of Medicine, shall conduct a study concerning such benefit that scientifically evaluates—

(1) the safety and efficacy of the benefit, particularly the effect of the benefit on outcomes of care;

(2) the cost, benefits and value of such benefit;

(3) the benefit in comparison to alternative approaches in improving care; and

(4) the overall impact that such benefit will have on health care as measured through research.

(b) QUALIFYING HEALTH CARE BENEFIT.—In this section, the term ''qualifying health care benefit'' means a health care benefit that—

(1) is disease- or health condition-specific;

(2) requires the provision of or coverage for health care items or services;

(3) applies to group health plan, individual health plans, or health insurance issuers under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.) or under title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.); and

(4) was provided under an Act (or amendment) enacted on or after January 1, 1998.

(c) REPORTS.—Not later than 3 years after the date of enactment of any Act described in subsection (a), the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report based on the study conducted under such subsection with respect to the qualifying health care benefit involved.

TITLE V—WOMEN'S HEALTH RESEARCH AND PREVENTION

SEC. 501. SHORT TITLE.

This title may be cited as the ''Women's Health Research and Prevention Amendments of 1998''.

Subtitle A—Provisions Relating to Women's Health Research at the National Institutes of Health

SEC. 511. EXTENSION OF PROGRAM FOR RESEARCH AND AUTHORIZATION OF NATIONAL PROGRAM OF EDUCATION REGARDING THE DRUG DES.

(a) IN GENERAL.—Section 403A(e) of the Public Health Service Act (42 U.S.C. 283a(e)) is amended by striking ''1996'' and inserting ''2001''.

(b) NATIONAL PROGRAM FOR EDUCATION OF HEALTH PROFESSIONALS AND PUBLIC.—From amounts appropriated for carrying out section 403A of the Public Health Service Act (42 U.S.C. 283a), the Secretary of Health and Human Services, acting through the heads of the appropriate agencies of the Public Health Service, shall carry out a national program for the education of health professionals and the public with respect to the drug diethylstilbestrol (commonly known as DES). To the extent appropriate, such national program shall use methodologies developed through the education demonstration program carried out under such section 403A. In developing and carrying out the national program, the Secretary shall consult closely with representatives of nonprofit private entities that represent individuals who have been exposed to DES and that have expertise in community-based information campaigns for the public and for health care providers. The implementation of the national program shall begin during fiscal year 1999.

SEC. 512. RESEARCH ON OSTEOPOROSIS, PAGET'S DISEASE, AND RELATED BONE DISORDERS.

Section 409A(d) of the Public Health Service Act (42 U.S.C. 284e(d)) is amended by striking ''and 1996'' and inserting ''through 2001''.

SEC. 513. RESEARCH ON CANCER.

(a) IN GENERAL.—Section 417B(a) of the Public Health Service Act (42 U.S.C. 286a–8(a)) is amended by striking ''and 1996'' and inserting ''through 2001''.

(b) RESEARCH ON BREAST CANCER.—Section 417B(b)(1) of the Public Health Service Act (42 U.S.C. 286a–8(b)(1)) is amended—

(1) in subparagraph (A), by striking ''and 1996'' and inserting ''through 2001''; and

(2) in subparagraph (B), by striking ''and 1996'' and inserting ''through 2001''.

(c) RESEARCH ON OVARIAN AND RELATED CANCER RESEARCH.—Section 417B(b)(2) of the Public Health Service Act (42 U.S.C. 286a–8(b)(2)) is amended by striking ''and 1996'' and inserting ''through 2001''.

SEC. 514. RESEARCH ON HEART ATTACK, STROKE, AND OTHER CARDIOVASCULAR DISEASES IN WOMEN.

Subpart 2 of part C of title IV of the Public Health Service Act (42 U.S.C. 285b et seq.) is amended by inserting after section 424 the following:

''HEART ATTACK, STROKE, AND OTHER CARDIOVASCULAR DISEASES IN WOMEN

''SEC. 424A. (a) IN GENERAL.—The Director of the Institute shall expand, intensify, and coordinate research and related activities of the Institute with respect to heart attack, stroke, and other cardiovascular diseases in women.

''(b) COORDINATION WITH OTHER INSTITUTES.—The Director of the Institute shall coordinate activities under subsection (a) with similar activities conducted by the other national research institutes and agencies of the National Institutes of Health to the extent that such Institutes and agencies have responsibilities that are related to heart attack, stroke, and other cardiovascular diseases in women.

''(c) CERTAIN PROGRAMS.—In carrying out subsection (a), the Director of the Institute shall conduct or support research to expand the understanding of the causes of, and to develop methods for preventing, cardiovascular diseases in women. Activities under such subsection shall include conducting and supporting the following:

''(1) Research to determine the reasons underlying the prevalence of heart attack, stroke, and other cardiovascular diseases in women, including African-American women and other women who are members of racial or ethnic minority groups.

''(2) Basic research concerning the etiology and causes of cardiovascular diseases in women.

''(3) Epidemiological studies to address the frequency and natural history of such diseases and the differences among men and women, and among racial and ethnic groups, with respect to such diseases.

''(4) The development of safe, efficient, and cost-effective diagnostic approaches to evaluating women with suspected ischemic heart disease.

''(5) Clinical research for the development and evaluation of new treatments for women, including rehabilitation.

''(6) Studies to gain a better understanding of methods of preventing cardiovascular diseases in women, including applications of effective methods for the control of blood pressure, lipids, and obesity.

''(7) Information and education programs for patients and health care providers on risk factors associated with heart attack, stroke, and other cardiovascular diseases in women, and on the importance of the prevention or control of such risk factors and timely referral with appropriate diagnosis and treatment. Such programs shall include information and education on health-related behaviors that can improve such important risk factors as smoking, obesity, high blood cholesterol, and lack of exercise.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated such sums as may be necessary for each of the fiscal years 1999 through 2001. The authorization of appropriations established in the preceding sentence is in addition to any other authorization of appropriation that is available for such purpose.''.

SEC. 515. AGING PROCESSES REGARDING WOMEN.

Section 445I of the Public Health Service Act (42 U.S.C. 285e–11) is amended by striking ''and 1996'' and inserting ''through 2001''.

SEC. 516. OFFICE OF RESEARCH ON WOMEN'S HEALTH.

Section 486(d)(2) of the Public Health Service Act (42 U.S.C. 287d(d)(2)) is amended by striking ''Director of the Office'' and inserting ''Director of the National Institutes of Health''.

Subtitle B—Provisions Relating to Women's Health at the Centers for Disease Control and Prevention

SEC. 521. NATIONAL CENTER FOR HEALTH STATISTICS.

Section 306(n) of the Public Health Service Act (42 U.S.C. 242k(n)) is amended—

(1) in paragraph (1), by striking ''through 1998'' and inserting ''through 2002''; and

(2) in paragraph (2), by striking ''through 1998'' and inserting ''through 2002''.

SEC. 522. NATIONAL PROGRAM OF CANCER REGISTRIES.

Section 399L(a) of the Public Health Service Act (42 U.S.C. 280e–4(a)) is amended by striking ''through 1998'' and inserting ''through 2002''.

SEC. 523. NATIONAL BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM.

(a) GRANTS.—Section 1501(b) of the Public Health Service Act (42 U.S.C. 300k(b)) is amended—

(1) in paragraph (1), by striking ''nonprofit''; and

(2) in paragraph (2), by striking ''that are not nonprofit entities''.

(b) PREVENTIVE HEALTH.—Section 1509(d) of the Public Health Service Act (42 U.S.C. 300n–4a(d)(1)) is amended by striking ''through 1998'' and inserting ''through 2002''.

(c) GENERAL PROGRAM.—Section 1510(a) of the Public Health Service Act (42 U.S.C. 300n–5(a)) is amended by striking ''through 1998'' and inserting ''through 2002''.

SEC. 524. CENTERS FOR RESEARCH AND DEMONSTRATION OF HEALTH PROMOTION.

Section 1706(e) of the Public Health Service Act (42 U.S.C. 300u–5(e)) is amended by striking ''through 1998'' and inserting ''through 2002''.

SEC. 525. COMMUNITY PROGRAMS ON DOMESTIC VIOLENCE.

Section 318(h)(2) of the Family Violence Prevention and Services Act (42 U.S.C. 10418(h)(2)) is amended by striking ''fiscal year 1997'' and inserting ''for each of the fiscal years 1997 through 2002''.

Subtitle C—Women's Health and Cancer Rights

SEC. 531. SHORT TITLE.

This subtitle may be cited as the ''Women's Health and Cancer Rights Act of 1998''.

SEC. 532. FINDINGS.

Congress finds that—

(1) the offering and operation of health plans affect commerce among the States;

(2) health care providers located in a State serve patients who reside in the State and patients who reside in other States; and

(3) in order to provide for uniform treatment of health care providers and patients among the States, it is necessary to cover health plans operating in 1 State as well as health plans operating among the several States.

SEC. 533. AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by sections 111 and 302, is further amended by adding at the end the following new section:

''SEC. 715. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the surgical treatment of breast cancer (including a mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer) is provided for a period of time as is determined by the attending physician, in his or her professional judgment consistent with scientific evidence-based practices or guidelines, in consultation with the patient, to be medically appropriate.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician in consultation with the patient determine that a shorter period of hospital stay is medically appropriate.

''(b) RECONSTRUCTIVE SURGERY.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall ensure that, in a case in which a mastectomy patient elects breast reconstruction, coverage is provided for—

''(1) all stages of reconstruction of the breast on which the mastectomy has been performed;

''(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

''(3) the costs of prostheses and complications of mastectomy including lymphedemas;

in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

''(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 1999;

whichever is earlier.

''(d) NO AUTHORIZATION REQUIRED.—

''(1) IN GENERAL.—An attending physician shall not be required to obtain authorization from the plan or issuer for prescribing any length of stay in connection with a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

''(2) PRENOTIFICATION.—Nothing in this section shall be construed as preventing a group health plan from requiring prenotification of an inpatient stay referred to in this section if such requirement is consistent with terms

and conditions applicable to other inpatient benefits under the plan, except that the provision of such inpatient stay benefits shall not be contingent upon such notification.

''(e) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

''(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to individuals to encourage such individuals to accept less than the minimum protections available under this section;

''(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

''(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; and

''(5) subject to subsection (f)(2), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

''(f) RULES OF CONSTRUCTION.—

''(1) IN GENERAL.—Nothing in this section shall be construed to require a patient who is a participant or beneficiary—

''(A) to undergo a mastectomy or lymph node dissection in a hospital; or

''(B) to stay in the hospital for a fixed period of time following a mastectomy or lymph node dissection.

''(2) COST SHARING.—Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with a mastectomy or lymph node dissection for the treatment of breast cancer under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

''(3) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

''(g) PREEMPTION, RELATION TO STATE LAWS.—

''(1) IN GENERAL.—Nothing in this section shall be construed to preempt any State law with respect to health insurance coverage that—

''(A) relates to hospital length of stays after a mastectomy, lumpectomy, or lymph node dissection;

''(B) relates to coverage of reconstructive breast surgery after a mastectomy, lumpectomy, of lymph node dissection; or

''(C) requires coverage for breast cancer treatments (including breast reconstruction) in accordance with scientific evidence-based practices or guidelines recommended by established medical associations.

''(2) APPLICATION OF SECTION.—With respect to a State law—

''(A) described in paragraph (1)(A), the provisions of this section relating to breast reconstruction shall apply in such State; and

''(B) described in paragraph (1)(B), the provisions of this section relating to length of stays for surgical breast treatment shall apply in such State.

''(3) ERISA.—Nothing in this section shall be construed to affect or modify the provisions of section 514 with respect to group health plans.''.

(b) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 note) is amended by inserting after the item relating to section 714 the following new item:

''Sec. 715. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for reconstructive surgery following mastectomies.''.

(c) EFFECTIVE DATES.—The amendments made by this section shall apply with respect to plan years beginning on or after the date of enactment of this Act.

SEC. 534. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-4 et seq.), as amended by section 303(a), is further amended by adding at the end the following new section:

''SEC. 2707. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the surgical treatment of breast cancer (including a mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer) is provided for a period of time as is determined by the attending physician, in his or her professional judgment consistent with scientific evidence-based practices or guidelines, in consultation with the patient, to be medically appropriate.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician in consultation with the patient determine that a shorter period of hospital stay is medically appropriate.

''(b) RECONSTRUCTIVE SURGERY.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall ensure that, in a case in which a mastectomy patient elects breast reconstruction, coverage is provided for—

''(1) all stages of reconstruction of the breast on which the mastectomy has been performed;

''(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

''(3) the costs of prostheses and complications of mastectomy including lymphedemas;

in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the enrollee upon enrollment and annually thereafter.

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

''(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 1999;

whichever is earlier.

''(d) NO AUTHORIZATION REQUIRED.—

''(1) IN GENERAL.—An attending physician shall not be required to obtain authorization from the plan or issuer for prescribing any length of stay in connection with a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

''(2) PRENOTIFICATION.—Nothing in this section shall be construed as preventing a plan or issuer from requiring prenotification of an inpatient stay referred to in this section if such requirement is consistent with terms and conditions applicable to other inpatient benefits under the plan, except that the provision of such inpatient stay benefits shall not be contingent upon such notification.

''(e) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

''(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to individuals to encourage such individuals to accept less than the minimum protections available under this section;

''(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

''(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; and

''(5) subject to subsection (f)(2), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

''(f) RULES OF CONSTRUCTION.—

''(1) IN GENERAL.—Nothing in this section shall be construed to require a patient who is a participant or beneficiary—

''(A) to undergo a mastectomy or lymph node dissection in a hospital; or

''(B) to stay in the hospital for a fixed period of time following a mastectomy or lymph node dissection.

''(2) COST SHARING.—Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with a mastectomy or lymph node dissection for the treatment of breast cancer under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing

for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

''(3) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

''(g) PREEMPTION, RELATION TO STATE LAWS.—

''(1) IN GENERAL.—Nothing in this section shall be construed to preempt any State law with respect to health insurance coverage that—

''(A) relates to a hospital length of stay after a mastectomy, lumpectomy, or lymph node dissection;

''(B) relates to coverage of reconstructive breast surgery after a mastectomy, lumpectomy, or lymph node dissection; or

''(C) requires coverage for breast cancer treatments (including breast reconstruction) in accordance with scientific evidence-based practices or guidelines recommended by established medical associations.

''(2) APPLICATION OF SECTION.—With respect to a State law—

''(A) described in paragraph (1)(A), the provisions of this section relating to breast reconstruction shall apply in such State; and

''(B) described in paragraph (1)(B), the provisions of this section relating to length of stays for surgical breast treatment shall apply in such State.

''(3) ERISA.—Nothing in this section shall be construed to affect or modify the provisions of section 514 with respect to group health plans.''.

(b) EFFECTIVE DATES.—The amendments made by this section shall apply to group health plans for plan years beginning on or after the date of enactment of this Act.

SEC. 535. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE INDIVIDUAL MARKET.

(a) IN GENERAL.—Subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-51 et seq.), as amended by section 303(b), is further amended by adding at the end the following new section:

''SEC. 2753. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER.

''The provisions of section 2707 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the date of enactment of this Act.

SEC. 536. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

(a) IN GENERAL.—Subchapter A of chapter 100 of the Internal Revenue Code of 1986 (relating to group health plan portability, access, and renewability requirements) is amended by inserting after section 9803 the following new section:

''SEC. 9804. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.

''(a) INPATIENT CARE.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the surgical treatment of breast cancer (including a mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer) is provided for a period of time as is determined by the attending physician, in his or her professional judgment consistent with scientific evidence-based practices or guidelines, in consultation with the patient, to be medically appropriate.

''(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician in consultation with the patient determine that a shorter period of hospital stay is medically appropriate.

''(b) RECONSTRUCTIVE SURGERY.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall ensure that, in a case in which a mastectomy patient elects breast reconstruction, coverage is provided for—

''(1) all stages of reconstruction of the breast on which the mastectomy has been performed;

''(2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

''(3) the costs of prostheses and complications of mastectomy including lymphedemas;

in the manner determined by the attending physician and the patient to be appropriate. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

''(c) NOTICE.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

''(1) in the next mailing made by the plan or issuer to the participant or beneficiary;

''(2) as part of any yearly informational packet sent to the participant or beneficiary; or

''(3) not later than January 1, 1999;

whichever is earlier.

''(d) NO AUTHORIZATION REQUIRED.—

''(1) IN GENERAL.—A, attending physician shall not be required to obtain authorization from the plan or issuer for prescribing any length of stay in connection with a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

''(2) PRENOTIFICATION.—Nothing in this section shall be construed as preventing a plan or issuer from requiring prenotification of an inpatient stay referred to in this section if such requirement is consistent with terms and conditions applicable to other inpatient benefits under the plan, except that the provision of such inpatient stay benefits shall not be contingent upon such notification.

''(e) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

''(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

''(2) provide monetary payments or rebates to individuals to encourage such individuals to accept less than the minimum protections available under this section;

''(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

''(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; and

''(5) subject to subsection (f)(2), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

''(f) RULES OF CONSTRUCTION.—

''(1) IN GENERAL.—Nothing in this section shall be construed to require a patient who is a participant or beneficiary—

''(A) to undergo a mastectomy or lymph node dissection in a hospital; or

''(B) to stay in the hospital for a fixed period of time following a mastectomy or lymph node dissection.

''(2) COST SHARING.—Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with a mastectomy or lymph node dissection for the treatment of breast cancer under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

''(3) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

''(g) PREEMPTION, RELATION TO STATE LAWS.—

''(1) IN GENERAL.—Nothing in this section shall be construed to preempt any State law with respect to health insurance coverage that—

''(A) relates to a hospital length of stay after a mastectomy, lumpectomy, or lymph node dissection;

''(B) relates to coverage of reconstructive breast surgery after a mastectomy, lumpectomy, or lymph node dissection; or

''(C) requires coverage for breast cancer treatments (including breast reconstruction) in accordance with scientific evidence-based practices or guidelines recommended by established medical associations.

''(2) APPLICATION OF SECTION.—With respect to a State law—

''(A) described in paragraph (1)(A), the provisions of this section relating to breast reconstruction shall apply in such State; and

''(B) described in paragraph (1)(B), the provisions of this section relating to length of stays for surgical breast treatment shall apply in such State.

''(3) ERISA.—Nothing in this section shall be construed to affect or modify the provisions of section 514 with respect to group health plans.''.

(b) CONFORMING AMENDMENTS.—

(1) The heading for subtitle K of such Code is amended to read as follows:

"Subtitle K—Group Health Plan Portability, Access, Renewability, and Other Requirements".

(2) The heading for chapter 100 of such Code is amended to read as follows:

''CHAPTER 100—GROUP HEALTH PLAN PORTABILITY, ACCESS, RENEWABILITY, AND OTHER REQUIREMENTS''.

(3) Section 4980D(a) of such Code is amended by striking ''and renewability'' and inserting ''renewability, and other''.

(c) CLERICAL AMENDMENTS.—

(1) The table of contents for chapter 100 of such Code is amended inserting after the item relating to section 9803 the following new item:

''Sec. 9804. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for reconstructive surgery following mastectomies.''.

(2) The item relating to subtitle K in the table of subtitles for such Code is amended by striking ''and renewability'' and inserting ''renewability, and other''.

(3) The item relating to chapter 100 in the table of chapters for subtitle K of such Code is amended by striking ''and renewability'' and inserting ''renewability, and other''.

(d) EFFECTIVE DATES.—The amendments made by this section shall apply with respect to plan years beginning on or after the date of enactment of this Act.

SEC. 537. RESEARCH STUDY ON THE MANAGEMENT OF BREAST CANCER.

(a) STUDY.—To improve survival, quality of life and patient satisfaction in the care of patients with breast cancer, the Agency for Health Care Policy and Research shall conduct a study of the scientific issues relating to—

(1) disease management strategies for breast cancer that can achieve better patient outcomes;

(2) controlled clinical evidence that links specific clinical procedures to improved health outcomes;

(3) the definition of quality measures to evaluate plan and provider performance in the management of breast cancer;

(4) the identification of quality improvement interventions that can change the process of care to achieve better outcomes for individuals with breast cancer;

(5) preventive strategies utilized by health plans for the treatment of breast cancer; and

(6) the extent of clinical practice variation including its impact on cost, quality and outcomes.

(b) REPORT.—Not later than January 1, 2000, the Agency for Health Care Policy and Research shall prepare and submit to the appropriate committees of Congress a report concerning the results of the study conducted under subsection (a).

TITLE VI—ENHANCED ACCESS TO HEALTH INSURANCE COVERAGE

SEC. 601. CARRYOVER OF UNUSED BENEFITS FROM CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND HEALTH FLEXIBLE SPENDING ACCOUNTS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended by redesignating subsections (h) and (i) as subsections (i) and (j) and by inserting after subsection (g) the following new subsection:

''(h) ALLOWANCE OF CARRYOVERS OF UNUSED BENEFITS TO LATER TAXABLE YEARS.—

''(1) IN GENERAL.—For purposes of this title—

''(A) a plan or other arrangement shall not fail to be treated as a cafeteria plan or flexible spending or similar arrangement, and

''(B) no amount shall be required to be included in gross income by reason of this section or any other provision of this chapter,

solely because under such plan or other arrangement any nontaxable benefit which is unused as of the close of a taxable year may be carried forward to 1 or more succeeding taxable years.

''(2) LIMITATION.—Paragraph (1) shall not apply to amounts carried from a plan to the extent such amounts exceed $500 (applied on an annual basis). For purposes of this paragraph, all plans and arrangements maintained by an employer or any related person shall be treated as 1 plan.

''(3) ALLOWANCE OF ROLLOVER.—

''(A) IN GENERAL.—In the case of any unused benefit described in paragraph (1) which consists of amounts in a health flexible spending account or dependent care flexible spending account, the plan or arrangement shall provide that a participant may elect, in lieu of such carryover, to have such amounts distributed to the participant.

''(B) AMOUNTS NOT INCLUDED IN INCOME.—Any distribution under subparagraph (A) shall not be included in gross income to the extent that such amount is transferred in a trustee-to-trustee transfer, or is contributed within 60 days of the date of the distribution, to—

''(i) an individual retirement plan other than a Roth IRA (as defined in section 408A(b)),

''(ii) a qualified cash or deferred arrangement described in section 401(k),

''(iii) a plan under which amounts are contributed by an individual's employer for an annuity contract described in section 403(b),

''(iv) an eligible deferred compensation plan described in section 457, or

''(v) a medical savings account (within the meaning of section 220).

Any amount rolled over under this subparagraph shall be treated as a rollover contribution for the taxable year from which the unused amount would otherwise be carried.

''(C) TREATMENT OF ROLLOVER.—Any amount rolled over under subparagraph (B) shall be treated as an eligible rollover under section 219, 220, 401(k), 403(b), or 457, whichever is applicable, and shall not be taken into account in applying any limitation (or participation requirement) on employer or employee contributions under such section or any other provision of this chapter for the taxable year of the rollover.

''(4) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 1998, the $500 amount under paragraph (2) shall be adjusted at the same time and in the same manner as under section 415(d)(2), except that the base period taken into account shall be the calendar quarter beginning October 1, 1997, and any increase which is not a multiple of $50 shall be rounded to the next lowest multiple of $50.''

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998.

SEC. 602. FULL DEDUCTION OF HEALTH INSURANCE COSTS FOR SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Section 162(l)(1) of the Internal Revenue Code of 1986 (relating to allowance of deductions) is amended to read as follows:

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

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998.

SEC. 603. FULL AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.

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

(1) IN GENERAL.—Section 220(c)(1)(A) of the Internal Revenue Code of 1986 (relating to eligible individual) is amended to read as follows:

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

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

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

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

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

(2) CONFORMING AMENDMENTS.—

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

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

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

(b) REMOVAL OF LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Section 220 of the Internal Revenue Code of 1986 (relating to medical savings accounts) is amended by striking subsections (i) and (j).

(2) MEDICARE+CHOICE.—Section 138 of such Code (relating to Medicare+Choice MSA) is amended by striking subsection (f).

(c) REDUCTION IN HIGH DEDUCTIBLE PLAN MINIMUM ANNUAL DEDUCTIBLE.—Section 220(c)(2)(A) of the Internal Revenue Code of 1986 (relating to high deductible health plan) is amended—

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

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

(d) INCREASE IN CONTRIBUTION LIMIT TO 100 PERCENT OF ANNUAL DEDUCTIBLE.—

(1) IN GENERAL.—Section 220(b)(2) of the Internal Revenue Code of 1986 (relating to monthly limitation) is amended to read as follows:

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

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

(e) LIMITATION ON ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Section 220(f)(4) of the Internal Revenue Code of 1986 (relating to additional tax on distributions not used for qualified medical expenses) is amended by adding at the end the following:

''(D) EXCEPTION IN CASE OF SUFFICIENT ACCOUNT BALANCE.—Subparagraph (A) shall not apply to any payment or distribution in any taxable year, but only to the extent such payment or distribution does not reduce the fair market value of the assets of the medical savings account to an amount less than the annual deductible for the high deductible

health plan of the account holder (determined as of January 1 of the calendar year in which the taxable year begins).''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998.

SEC. 604. PERMITTING CONTRIBUTION TOWARDS MEDICAL SAVINGS ACCOUNT THROUGH FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP).

(a) GOVERNMENT CONTRIBUTION TO MEDICAL SAVINGS ACCOUNT.—

(1) IN GENERAL.—Section 8906 of title 5, United States Code, is amended by adding at the end the following:

''(j)(1) In the case of an employee or annuitant who is enrolled in a catastrophic plan described by section 8903(5), there shall be a Government contribution under this subsection to a medical savings account established or maintained for the benefit of the individual. The contribution under this subsection shall be in addition to the Government contribution under subsection (b).

''(2) The amount of the Government contribution under this subsection with respect to an individual is equal to the amount by which—

''(A) the maximum contribution allowed under subsection (b)(1) with respect to any employee or annuitant, exceeds

''(B) the amount of the Government contribution actually made with respect to the individual under subsection (b) for coverage under the catastrophic plan.

''(3) The Government contributions under this subsection shall be paid into a medical savings account (designated by the individual involved) in a manner that is specified by the Office and consistent with the timing of contributions under subsection (b).

''(4) Subsections (f) and (g) shall apply to contributions under this section in the same manner as they apply to contributions under subsection (b).

''(5) For the purpose of this subsection, the term 'medical savings account' has the meaning given such term by section 220(d) of the Internal Revenue Code of 1986.''.

(2) ALLOWING PAYMENT OF FULL AMOUNT OF CHARGE FOR CATASTROPHIC PLAN.—Section 8906(b)(2) of such title is amended by inserting ''(or 100 percent of the subscription charge in the case of a catastrophic plan)'' after ''75 percent of the subscription charge''.

(b) OFFERING OF CATASTROPHIC PLANS.—

(1) IN GENERAL.—Section 8903 of title 5, United States Code, is amended by adding at the end the following:

''(5) CATASTROPHIC PLANS.—One or more plans described in paragraph (1), (2), or (3), but which provide benefits of the types referred to by paragraph (5) of section 8904(a), instead of the types referred to in paragraphs (1), (2), and (3) of such section.''.

(2) TYPES OF BENEFITS.—Section 8904(a) of such title is amended by inserting after paragraph (4) the following new paragraph:

''(5) CATASTROPHIC PLANS.—Benefits of the types named under paragraph (1) or (2) of this subsection or both, to the extent expenses covered by the plan exceed $500.''.

(3) DISREGARDING CATASTROPHIC PLANS IN DETERMINING LEVEL OF GOVERNMENT CONTRIBUTIONS.—Section 8906(a)(3) of such title is amended by inserting ''described by section 8903(3)'' after ''plans''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contract terms beginning on or after January 1, 1999.

Mr. FRIST. Mr. President, I am pleased to rise today to introduce the ''Patients' Bill of Rights'' with my colleague from Oklahoma, Senator DON NICKLES, the members of the Senate Republican Task Force on Health Care Quality, and our distinguished Majority Leader, Senator TRENT LOTT.

This bill is a product of several months of thoughtful discussion and debate among Republican members to reach a consensus proposal to improve health care quality.

As a physician who has practiced medicine for twenty years, I know that health care is delivered best when the relationship between doctor and patient is given the highest priority. My goal is to provide the necessary support to empower doctors and patients to make important health care decisions.

This proposal includes a ''Patients' Bill of Rights'' which offers protection for patients by insuring them full access to information about their health plan; making sure patients receive necessary emergency care; allowing patients to keep their doctor during a pregnancy or extended illness, even if their doctor is dropped by their plan; and allowing patients direct access to obstetric and gynecological care and pediatric care without having to obtain a referral from a gatekeeper.

Many consumers fear that their health care plans will not give them access to care when they need it most, that they will be denied the benefits they have paid for and been promised, and that their health plans care more about cost than they do about quality. A critical measure of this bill is to hold health plans accountable for the coverage decisions they make and to take the power of denial of care out of the hands of HMOs and place it in the hands of independent medical experts. Our bill requires health plans to make coverage determinations in less than 72 hours if a doctor determines that further delay could jeopardize the life or health of a patient. We want to protect patients before harm occurs by setting up a process for patients and their families to get an immediate answer. Furthermore, we require health plans to provide quick internal grievance and independent external appeals processes in cases where a plan may deny coverage for necessary medical action or because it is an experimental procedure.

Our bill fills a need by providing protections for patients who rely on plans that states cannot touch. Our bill provides independent review of health plans for 125 million Americans without lining the pockets of trial lawyers in the process. Further litigation serves to divert billions of dollars away from health care and puts in the pockets of trial lawyers.

Our bill guarantees patients the right to have access to their own medical information and the right to amend their medical information if mistakes are made. We require health plans to inform a patient of the plan's practices to protect the confidentiality of their medical record and requires health plans to establish safeguards to protect the confidentiality and security of health information.

Our bill has a strong focus on quality and a firm commitment to improve quality. Some believe that quality can be legislated. Some here in Washington believe they know how to define quality. Yet the risk of writing today's concept of quality into law, is that it is an evolving science and if we are too rigid, we fail to capture the innovation that improves quality of care and our ability to measure it.

Our legislation promotes quality improvement by supporting research to give patients and physicians better information regarding quality. The ''Patients' Bill of Rights'' establishes an Agency for Health Care Quality Research (AHQR), whose purpose is to foster overall improvement in health care quality through supporting pertinent research and disseminating information. The Agency is built on the platform of the current Agency for Health Care Policy and Research, but is refocused and enhanced to become the hub and driving force of federal efforts to improve quality of health care in all practice environments—from managed care to solo private practice, from urban to rural settings, and from federal to non-federal programs.

The role of the Agency is not to mandate a national definition of quality, but to support the science necessary to provide information to patients regarding the quality of the care they receive; to allow physicians to compare their quality outcomes with their peers; and to enable employers and individuals to be prudent purchasers based on quality.

The new Agency will build public-private partnerships to advance and share quality measures. Quality means different things to different people. Therefore, in collaboration with the private sector, the Agency shall conduct research that can figure out what quality really means to patients and clinicians, how to measure quality, and what actions can improve care.

It will promote quality by sharing information. While proven medical advances are made daily, patients wait too long to benefit from these discoveries. We must get the science to the people by better sharing of information and more effective dissemination. The Agency is required to develop evidence-rating systems to help people judge the quality of science.

The Agency plays an important role in facilitating innovation in patient care with streamlined assessment of new technologies. Patients should benefit from breakthrough technologies sooner, while inefficient methods should be phased out faster. The Agency will be accessible to both private and public entities for technology assessments and will share information on assessment methodologies.

Currently, quality measurement too often requires manual chart reviews for such simple data as frequently of procedures, infection rates, or other complications. Improved computer systems will advance quality scoring and facilitate decision-making in patient care.

The Agency will aggressively support the development of state-of-the-art information systems systems for health care quality.

While most policy discussions this year are targeting managed care, quality improvement is just as important to the solo private practitioner. The Agency will focus on primary care delivery research to examine how science is translated in the doctor's office. The agency will specifically address quality in rural and other underserved areas by advancing telemedicine services and other distance technologies.

Most of the many federal health care programs today support some kind of health services research and conduct various quality improvement projects. The Agency shall coordinate these initiatives to avoid disjointed, uncoordinated, or duplicative efforts.

Finally, this debate is due to the fact that patients want to know if they receive quality health care. But compared to what? Statistically accurate, sample-based national surveys will efficiently provide reliable and affordable data—without excessive, overly intrusive, and potentially destructive, mandatory reporting requirements. This is accomplished through an expansion of the current Medical Expenditure Panel Survey to require that outcomes be measured and reported to Congress so the public may better determine the state of quality, and cost, of the nation's health care.

The role of the AHQR is not to mandate national standards of clinical practice. Definitions and measures of quality are an evolving science, a science critically important to making educated and appropriate choices in a rapidly changing and dynamic health care system. This bill will go a long way in bridging the gap between what we know and what we do in health care today.

The bill we are introducing today has a strong focus on women's health issues. On March 6, 1998, I introduced S. 1722, the ''Women's Health Research and Prevention Amendments of 1998'' with our Majority Leader, Senator TRENT LOTT, to increase awareness of some of the most pressing diseases and health issues that women in our country face. These provisions, which have been included in the Patients' Bill of Rights Act, focus on women's health research and prevention activities at the National Institutes of Health and the Centers for Disease Control and Prevention. The goal of these provisions is to create greater awareness of women's health issues and to highlight the critical role our public health agencies, the NIH and CDC, play in providing a broad spectrum of activities to improve women's health—including research, screening, prevention, treatment, education, and data collection.

Among others, these provisions promote basic and clinical research for osteoporosis and breast and ovarian cancer. We expand our research efforts into the underlying causes and prevention of cardiovascular diseases in women—the leading cause of death in U.S. women. The bill reauthorizes the National Breast and Cervical Cancer Screening Program which provides for crucial screening services for breast and cervical cancers to underserved women and supports data collection through the National Center for Health Statistics and the National Program of Cancer Registries which are the leading sources of national data on the health status of U.S. women.

The reauthorization of these research programs will help assure scientific progress in our fight against these diseases and will lessen their burden on women and their families. We have the support of nearly the full Senate Labor and Human Resources committee and many members of the United States Senate from both sides of the aisle for these provisions. The level of support for these programs is a testament to the need to combat the disease affecting women and to maintain the crucial health services that help prevent these diseases.

One of the provisions I am most proud to include in this bill is the prohibition on genetic discrimination in healthy insurance practices. We as a nation must face the fear of discrimination in health insurance practices based on our increasing ability to gather genetic information about ourselves and our families. Our ability to predict what diseases individuals may be at risk for in the future has caused great concern that this powerful information—the information we all carry in our genes—may be used against us.

I am deeply troubled when I hear from the Tennessee Breast Cancer Coalition that genetic counselors are facing women everyday who are afraid of the consequences of genetic testing. Women are avoiding genetic testing due to concerns about loss of health insurance coverage for themselves or their families—even though a genetic test might reveal that a woman is not at high risk and therefore allow her to make more informed health care choices.

I am a strong advocate for legislation which would prohibit discrimination in health insurance against healthy individuals and their families based on their genetic information. We all carry genetic mutations that may place us at risk for future disease—therefore we are all at risk for discrimination. If I receive a genetic test which shows I am at risk for cancer, diabetes, or heart disease, should this predictive information be used against me or my family? Particularly when I am currently healthy and, in fact, may never develop the illness? I think the American public has answered quite clearly, ''no.''

The Senate Republican Task Force made the same decision to say ''no.'' Not only are we addressing the rights of patients today—but we are thinking forward to future concerns of patients. I must commend the efforts of my colleague Senator SNOWE whose original bill, S. 89, has provided a framework and the sound principles for the basis of the legislation. She has supported the Task Force effort and worked with us step by step to craft this legislation. I must also commend the members of the Task Force, particularly Senator JEFFORDS, who had the foresight to include these provisions.

Our bill prohibits health insurers from collecting genetic information about a patient; prohibits health insurers from using predictive genetic information to deny coverage; prohibits health insurers from using predictive genetic information in setting premiums or rates; and requires health insurers to inform patients of the health plans' confidentiality practices and safeguards in place if a patient wishes to disclose genetic information for purposes of treatment.

Preventing genetic discrimination has enormous implications for improving the quality of care patients receive. As a physician and researcher, I am particularly concerned that the fear of discrimination will prevent individuals from participating in research studies and therefore hinder the scientific answers we need which hold the promise of higher quality medical care. I am concerned that individuals feel safe taking advantage of new genetic technologies to improve their medical care.

The goal of our bill is to provide the public with peace of mind. If families or individuals want to undergo genetic testing, this bill will ensure that insurance companies cannot discriminate based on this information. We must act now. Only with these measures can we ensure that knowledge about our genetic heritage will be used to improve our health—and not force us to hide in fear that this information will cause us harm.

Finally, our bill enhances access and choice of health insurance coverage by increasing access to and affordability of health care. The bill includes provisions to allow self-employed individuals to fully deduct their health care expenses; provides greater flexibility to employees who utilize flexible spending accounts to pay for health care; and gives incentives to individuals to have control over their health care decisions and costs through expansion of the use of Medical Savings Accounts. This option will allow a patient to access the physician of their choice and choose the medical treatment they need without any interference from a gatekeeper.

The ''Patient's Bill of Rights'' offers all Americans: quality improvement built on a foundation of science, patient protection to access the care they need from the provider of choice, trust in the health care delivery system, and access to affordable health insurance coverage. I am pleased that this bill represents a forward-looking approach to provide for continuous improvement in health care quality. It meets our goal of assuring that the doctor and patient define quality, not HMOs, not bureaucrats and not trial attorneys.

Mr. JEFFORDS. Mr. President, I want to begin by commending Senator NICKLES and all of the Members who participated in putting the ''Patients' Bill of Rights'' legislation together. I think it is solid legislation that will result in a greatly improved health care system for Americans and I am proud to be a co-sponsor of the ''Patients' Bill of Rights.''

As always, there has been a flurry of work over the past few weeks as we have put this legislation together. But this last minute work is only possible because we have laid a solid foundation throughout the entire 105th Congress.

Over the past 14 months, the Labor and Human Resources Committee has held 11 hearings related to the issues of health care quality, confidentiality, genetic discrimination and the Health Care Financing Administration's (HCFA) implementation of its new health insurance responsibilties. Senator BILL FRIST's Public Health and Safety Subcommittee has also held three hearings on the work of the Agency of Health Care Policy and Research (AHCPR). Each of these hearings helped us in developing the separate pieces of legislation that are reflected in our ''Patients'' Bill of Rights.''

Other colleagues here and on the House side, have worked ont this subject for an extended period of time. Many of the protections that are included in the ''Patients' Bill of Rights'' are similar to those fashioned by Senator ROTH and the Finance Committee last year when we provided many of these same protections to plans that serve Medicare patients.

As we prepared this legislation we had three goals in mind. First, give families the protections they want and need. Second, ensure that medical decisions are made by physicians in consultation with their patients. And finally, keep the cost of this legislation low so it does not displace anyone from being able to get health-care coverage.

Information about products or services is the keystone to any well functioning market. This bill requires full information disclosure by an employer about the health plans he or she offers to employees. People need to know what the plan will cover and what their out-of-pocket expenses will be. They need to know where and how they will get their health care and who will be providing those services. They also need to know how adverse decisions by the plan can be appealed, both internally and externally to an independent reviewer.

This aspect of our bill, that gives enrollees a new ERISA remedy of an external grievance and appeals process, is one of which I am particularly proud since it is the cornerstone of S 1712, the Health Care QUEST Act, that I introduced with Senator LIEBERMAN. Under the ''Patients' Bill of Rights,'' enrollees will get timely decisions about what will be covered. Furthermore, if an individual disagrees with the plan's decision, that individual may ultimately appeal the decision to an independent external reviewer. The reviewer's decision will be binding on the part of the health plan. But, the patient maintains his or her current rights under ERISA to go to court.

The medical records provisions, which my committee has also worked on for the past year and are contained in S. 1921, the Health Care PIN Act, which I introduced with Senator DODD, will give people the right to inspect and copy their personal medical information and it will allow them to amend the record if there is inaccurate information. The bill will ensure that the holders of the information safeguard the medical records. It requires them to share, in writing, their confidentiality policies and procedures with individuals.

The 104th Congress enacted the Kassebaum/Kennedy legislation, also known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Many consider this legislation to be the most significant federal health insurance reform of the past decade. During this Congress, I have tried to closely monitor the impact of HIPAA over the past year to ensure its successful implementation and consistency with legislative intent.

The federal regulators at HCFA have faced an overwhelming new set of health insurance duties under HIPAA. In the five states that have failed to or chosen not to pass the legislation required by HIPAA (California, Massachusetts, Michigan, Rhode Island, and Missouri), the Department of Health and Human Services is now required to act as insurance regulator for the state HIPAA provisions.

Based on the findings of a GAO report that I will be releasing next week, our experience under HIPAA demonstrates that HCFA is ill equipped to carry out the role of insurance regulator. Building a dual system of overlapping state and federal health insurance regulation is in no one's best interest. The principle that the states should continue to regulate the private health insurance market guided the design of our ''Patients' Bill of Rights'' legislation.

Our legislation creates new federal managed care standards to cover those 48 million Americans covered by ERISA plans that the states cannot protect. We feel that it would be inappropriate to set federal health insurance standards that duplicate the responsibility of the 50 state insurance departments and have HCFA enforce them.

A recent example demonstrates why this is such a concern. The Balanced Budget Act of 1997 establishes a prospective payment system (PPS) for home health care in fiscal year 2000. The payment system designed for the interim period is proving to be an intolerable burden for the home health agencies that serve Vermont's Medicare beneficiaries. At a July 16th House Ways and Means hearing, HCFA's administrator stated that she intended to postpone the development of a Medicare prospective payment systems for home health services. Her statement that she is delaying this mandate will result in many home health providers not receiving the reimbursement that they deserve and puts many of those providers at risk.

Given HCFA's inability to carry out its current responsibilities, I believe it would be irresponsible to promise the American people that they will be able to receive new federal guarantees in the private health insurance system if we are relying on HCFA to enforce these rights.

Our proposal, by keeping the regulation of health insurance where it belongs—at the state level—provides the American people with a real Patients' Bill of Rights that they can have the confidence in knowing will be enforced.

I am afraid that the political battle over this legislation will be the subject that dominates the headlines. But the real issue here is to give Americans the protections they want and need in a package that they can afford and that we can enact. That is why I and others here have been working on this legislation since the beginning of this Congress, and why I hope the ''Patients' Bill of Rights'' we have introduced today will be adopted before the end of the Congress and signed into law by the President.

By Mr. LUGAR:

S. 2331. A bill to provide a limited waiver for certain foreign students of the requirement to reimburse local educational agencies for the costs of the students' education; to the Committee on the Judiciary.

LIMITED WAIVER OF COSTS REQUIREMENTS FOR FOREIGN STUDENTS

● Mr. LUGAR. Mr. President, I rise today to introduce a bill to permit local school districts to waive the cost requirements of foreign students studying in our public high schools in the United States on F–1 visas. The law now mandates that all foreign students who are not in a government-funded exchange program must pay or reimburse the costs of their education in American public schools.

In those public school districts flooded with foreign students who pay no taxes, this requirement makes good sense. However, in those school districts which enroll a small number of foreign students and bear a tolerable burden there may be no need or desire for reimbursement. The decision to enroll and to require cost reimbursement should be made at the local level. Current law, however, does not permit this local discretion. The bill I am introducing will allow local school districts to waive the requirement that foreign students must pay for the cost of their education. The decision to waive or not waive this requirement should be made at the grass roots level, not in Washington and my bill seeks to preserve this principle. It would amend the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA).

Foreign exchange students bring knowledge, cultural exposure and understanding to American students, schools and communities. I have been a proponent of cultural and educational exchanges and have supported most international exchange programs over the years—both those which bring foreign visitors here and those which send American students, scholars and practitioners abroad. I remain committed to these programs.

In 1996, I supported the Illegal Immigration Reform and Immigrant Responsibility Act. This law states that as of November 30, 1996, IIRIRA prohibits any alien from receiving an F–1 student visa to attend a public elementary school, grades K–8, or a publicly-funded adult education program unless they pay the unsubsidized, per capita cost of their education in advance. My bill would not change current law relating to elementary schools or adult education. It would not pertain to students on formal, government-funded international exchanges. It would simply allow high school officials to waive the cost of education of high school-level foreign students in order to enroll an exchange student, should they wish to do so. I believe this has been an unintended consequence of IIRIRA.

Several cities have ''Sister City'' arrangements between American cities and cities in foreign countries. One valuable component of these arrangements is an exchange program for high school students enabling American youth to spend a year in a foreign high school while students from abroad spend a year in a high school here. No tuition is generally exchanged under the sister city agreement, but current U.S. law states that visitors to our country must pay the unsubsidized cost of their education, even though American students are exempted from the cost requirement.

Along the Alaska-Yukon, Alaska-British Columbia and U.S.-Mexican borders there are schools serving very remote communities on both sides of the border. After enactment of the 1996 law, Canadian or Mexican students were no longer eligible to enter the United States to attend the local public school even though governments and the local school districts agreed to enroll the students.

Many school districts prefer to enroll one or two exchange students a year. Reciprocal exchange agreements are beneficial and host families enjoy these students in their homes. American exchange students attending schools in Germany, for example, are not subjected to the same tuition requirements for their schooling, yet they gain an understanding of German history and culture and benefit from their travels. Currently, U.S. law requires foreign students to pay tuition before they arrive in the United States. The extra paper work, the up-front costs and the extra burden these requirements place on foreign students tend to undermine the purposes of cultural exchanges.

I remain mindful to past abuses of F–1 visas and am sympathetic to the burden that large enrollments of foreign students place on American public schools. My purpose in introducing this bill today is not to weaken the law as it currently reads, but to provide an outlet for our schools to give an educational opportunity for enrolling international exchange students.●

ADDITIONAL COSPONSORS

S. 358

At the request of Mr. DEWINE, the name of the Senator from Arizona [Mr. MCCAIN] was added as a cosponsor of S. 358, a bill to provide for compassionate payments with regard to individuals with blood-clotting disorders, such as hemophilia, who contracted human immunodeficiency virus due to contaminated blood products, and for other purposes.

S. 852

At the request of Mr. LOTT, the name of the Senator from Arizona [Mr. MCCAIN] was added as a cosponsor of S. 852, a bill to establish nationally uniform requirements regarding the titling and registration of salvage, nonrepairable, and rebuilt vehicles.

S. 1459

At the request of Mr. GRASSLEY, the name of the Senator from Florida [Mr. MACK] was added as a cosponsor of S. 1459, a bill to amend the Internal Revenue Code of 1986 to provide a 5-year extension of the credit for producing electricity from wind and closed-loop biomass.

S. 1464

At the request of Mr. LAUTENBERG, his name was added as a cosponsor of S. 1464, a bill to amend the Internal Revenue Code of 1986 to permanently extend the research credit, and for other purposes.

S. 1482

At the request of Mr. COATS, the name of the Senator from Arizona [Mr. MCCAIN] was added as a cosponsor of S. 1482, a bill to amend section 223 of the Communications Act of 1934 to establish a prohibition on commercial distribution on the World Wide Web of material that is harmful to minors, and for other purposes.

S. 2154

At the request of Mrs. BOXER, the name of the Senator from Illinois [Ms. MOSELEY-BRAUN] was added as a cosponsor of S. 2154, a bill to promote research to identify and evaluate the health effects of silicone breast implants, and to ensure that women and their doctors receive accurate information about such implants.

SENATE CONCURRENT RESOLUTION 97

At the request of Mrs. FEINSTEIN, the name of the Senator from New York [Mr. MOYNIHAN] was added as a cosponsor of Senate Concurrent Resolution 97, a concurrent resolution expressing the sense of Congress concerning the human rights and humanitarian situation facing the women and girls of Afghanistan.

SENATE CONCURRENT RESOLUTION 105

At the request of Mr. BIDEN, his name was added as a cosponsor of Senate Concurrent Resolution 105, a concurrent resolution expressing the sense of the Congress regarding the culpability of Slobodan Milosevic for war crimes, crimes against humanity, and genocide in the former Yugoslavia, and for other purposes.

SENATE RESOLUTION 189

At the request of Mr. TORRICELLI, the names of the Senator from Wyoming [Mr. ENZI] and the Senator from North Dakota [Mr. CONRAD] were added as cosponsors of Senate Resolution 189, a resolution honoring the 150th anniversary of the United States Women's Rights Movement that was initiated by the 1848 Women's Rights Convention held in Seneca Falls, New York, and calling for a national celebration of women's rights in 1998.

AMENDMENT NO. 3199

At the request of Mr. BINGAMAN his name was added as a cosponsor of Amendment No. 3199 proposed to S. 2168, an original bill making appropriations for the Departments of Veterans Affairs and Housing and Urban Development, and for sundry independent agencies, commissions, corporations, and offices for the fiscal year ending September 30, 1999, and for other purposes.

SENATE CONCURRENT RESOLUTION 108—RECOGNIZING THE 50TH ANNIVERSARY OF THE NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

Mr. DORGAN (for himself and Mr. FRIST) submitted the following concurrent resolution; which was referred to the Committee on the Judiciary.

S. CON. RES. 108

Whereas in 1948 the Congress, by its enactment of the National Heart Act and creation of the National Heart Institute, recognized the urgent need to establish a national program of research and demonstration projects relating to the causes, diagnosis, treatment, and prevention of diseases of the heart and circulation;

Whereas the Congress has consistently and generously supported the purposes of the National Heart Act;

Whereas, since the creation of the National Heart Institute, the Congress changed the name of the Institute to the National Heart, Lung, and Blood Institute and expanded and clarified the Institute's role in advancing human understanding or awareness of diseases of the heart and blood vessels, diseases of the lungs, diseases of the blood, the use of blood and blood products, the management of blood resources, and sleep disorders through research, research training, demonstration projects, and public education activities;

Whereas June of 1998 marks the 50th anniversary of the creation of the National Heart Institute which was established to lead a national effort to prevent, diagnose, and treat heart diseases;

Whereas research supported by the National Heart, Lung, and Blood Institute has