Too many important historical sites, especially Revolutionary War battlefields, have already been lost to residential and commercial development. The citizens of Malvern, through the Paoli Battlefield Preservation Fund, have already raised in excess of $1 million to acquire the site. Thus, if the expected $2.5 million price is maintained, adding the Paoli Battlefield to Valley Forge National Historical Park would cost the federal government no more than $1.5 million. The bill also authorizes the Secretary of the Interior to enter into a cooperative agreement with the Borough of Malvern, which has agreed to manage the 45-acre site in perpetuity, thereby ensuring that Valley Forge will not have to expend additional federal resources for Park operations on the Paoli Battlefield.

Mr. President, this Congress has made a commitment to protecting battlefield sites. I have been pleased to support these efforts as well as the effort to obtain funding in the FY99 Interior and Related Agencies Appropriations bill to conduct the Revolutionary War and War of 1812 Historic Preservation Study. Paoli Battlefield played an important role in the Revolutionary War, and I therefore urge my colleagues to support this effort to protect an important piece of American history. Simply put, in a $1.7 trillion federal budget, I believe that we should be able to find a maximum of $1.5 million in federal funds to preserve a rich part of our history.

By Mr. DOMENICI (for himself and Mr. BINGAMAN):

S. 2402. A bill to direct the Secretary of Agriculture to convey certain lands in San Juan County, New Mexico, to San Juan College; to the Committee on Agriculture, Nutrition, and Forestry.

THE OLD JICARILLA ADMINISTRATIVE SITE CONVEYANCE ACT OF 1998

Mr. DOMENICI. Mr. President, today I am introducing a bill to direct the Secretary of Agriculture to convey a ten acre parcel of land, known as the old Jicarilla administrative site, to San Juan College. This legislation will provide long-term benefits for the people of San Juan County, New Mexico, and especially the students and faculty of San Juan College.

This legislation allows for transfer by the Secretary of Agriculture real property and improvements at an abandoned and surplus administrative site of the Carson National Forest to San Juan College. The site is known as the old Jicarilla Ranger District Station, near the village of Gobanador, New Mexico. The Jicarilla Station will continue to be used for public purposes, including educational and recreational purposes of the college.

Mr. President, the Forest Service has determined that this site is of no further use to them, since the Jicarilla District Ranger moved into a new administrative facility in the town of Bloomfield, New Mexico. The facility has had no occupants for several years, and it is my understanding that the Forest Service reported to the General Services Administration that the improvements on the site were considered surplus, and would be available for disposal under their administrative procedures.

This legislation is patterned after S. 1510, approved by the Senate earlier this month, by which the property and improvements of a similarly abandoned Forest Service facility in New Mexico will be transferred to Rio Arriba County. The administration has indicated its support for the passage of that bill, and I hope that this bill will gain their support, as well.

Mr. President, since the Forest Service has no interest in maintaining Federal ownership of this land and the surplus facilities, and San Juan College could put this small tract to good use, this legislation is a win-win situation for the federal government and northwestern New Mexico. I look the Senate's rapid consideration of this legislation, and urge my colleagues to support its passage.

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

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

S. 2402

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

SECTION 1. OLD JICARILLA ADMINISTRATIVE SITE.

(a) CONVEYANCE OF PROPERTY.—Not later than one year after the date of enactment of this Act, the Secretary of Agriculture (herein ''the Secretary'') shall convey to San Juan College, in Farmington, New Mexico, subject to the terms and conditions under subsection (c), all right, title, and interest of the United States in and to a parcel of real property (including any improvements on the land) consisting of approximately ten acres known as the ''Old Jicarilla Administrative Site'' located in San Juan County, New Mexico (T29N; R5W; Section 29 Southwest of Southwest ¼).

(b) DESCRIPTION OF PROPERTY.—The exact acreage and legal description of the real property conveyed under subsection (a) shall be determined by a survey satisfactory to the Secretary and the President of San Juan College. The cost of the survey shall be borne by San Juan College.

(c) TERMS AND CONDITIONS.—

(1) Notwithstanding exceptions of application under the Recreation and Public Purposes Act (43 U.S.C. 869(c)), consideration for the conveyance described in subsection (a) shall be—

(A) an amount that is consistent with the Bureau of Land Management special pricing program for Governmental entities under the Recreation and Public Purposes Act; and,

(B) an agreement between the Secretary and San Juan College indemnifying the Government of the United States from all liability of the Government that arises from the property.

(2) The lands conveyed by this Act shall be used for educational and recreational purposes. If such lands cease to be used for such purposes, at the option of the United States, such lands will revert to the United States.

SAN JUAN COLLEGE,
OFFICE OF THE PRESIDENT,
Farmington, NM, August 21, 1997.

Hon. PETE V. DOMENICI,
U.S. Senate,
Washington, DC.

DEAR SENATOR DOMENICI: The United States Forest Service has indicated a willingness to turn some property over to San Juan College. The property was formerly the Carson National Forest Jicarilla District Visitor Center Site. It is located in Gobernador and was formerly the headquarters for the Forest Service for this area. The office has subsequently moved into Bloomfield, and the property has had no occupants for several years.

At the suggestion of Phil Settles, the Forest Service Director, I would like to request that some legislation be introduced that would allow for the transfer of the property from the Forest Service to San Juan College. The College would use the area for educational and recreational purposes. A description of the property is attached.

Please let me know what additional steps must be taken in order to expedite the transfer. Thank you very much.

Sincerely,

JAMES C. HENDERSON, Ed.D.

By Mr. SANTORUM:

S. 2403. A bill to prohibit discrimination against health care entities that refuse to provide, provide coverage for, pay for, or provide referrals for abortions; to the Committee on Labor and Human Resources.

THE HEALTH CARE ENTITY PROTECTION ACT

● Mr. SANTORUM. Mr. President, I am introducing legislation today that will offer protection from government discrimination to health care providers who have religious or moral objections to performing abortions.

As HCFA prepares to implement the Medicare+Choice program, the need for this bill has become evident. Congress created Medicare+Choice to give beneficiaries more options in their health plans. The Balanced Budget Act of 1997 (BBA) requires all health care providers who participate in the program to provide all services covered under Medicare Parts A and B, except hospice care. HCFA is interpreting this mandate to require coverage for abortion, consistent with the Hyde restrictions. The problem is that many religious health care systems—and even some secular providers—have strong misgivings about performing, providing coverage for, or paying for any elective abortions. Absent specific legislative clarification, these providers will be shut out of the Medicare+Choice program.

HCFA's interpretation of the BBA has come as a surprise to many health systems wishing to participate in the Medicare+Choice program. The issue of whether providers would have to cover abortion services was never addressed during last summer's extensive debate. Instead, this Congress focused on designing a program which would give seniors the broadest possible range of health care choices, so they could

choose a provider based on their own individual needs.

In 1996, Congress prohibited government discrimination against health care providers who choose not to teach abortion procedures in their graduate medical programs. The Senate approved this legislation as an amendment to the Omnibus Consolidated Rescissions and Appropriations Act by a vote of 63–37. The Health Care Entity Protection Act merely clarifies that these protections extend to all providers who have religious or moral objections to performing, providing coverage of, or paying for induced abortions. I would emphasise that nothing in this bill prevents providers from voluntarily offering abortion services; it simply gives them a right to choose whether they will so do.

I believe that my colleagues on both sides of the abortion debate can support the Health Care Entity Protection Act. I would like to reiterate that this bill simply clarifies protections that already exist under current law. I hope the Senate will recognize the moral gravity of the abortion issue and forge a consensus across party and ideological lines to protect institutions, doctors, and health systems who, as a matter of conscience, cannot perform or provide for abortions.●

By Mr. MACK (for himself and Mr. GRAHAM):

S. 2404. A bill to establish designations for United States Postal Service buildings located in Coconut Grove, Opa Locka, Carol City, and Miami, Florida; to the Committee on Governmental Affairs.

UNITED STATES POSTAL SERVICE LEGISLATION

Mr. GRAHAM. Mr. President, I rise today together with my friends and distinguished colleague, Senator MACK, to introduce legislation to name five United States Post Offices in Miami-Dade County, Florida after five prominent civic and community leaders. By doing so, we are joining the entire Florida delegation in the United States House of Representatives in honoring these individuals of great importance to our state.

This legislation honors these five individuals service, commitment, and dedication to their communities. Athalie Range is a multi-faceted local community leader and humanitarian Garth Reeves, Sr. is a publisher, banker, and entrepreneur. William R. ''Billy'' Rolle was a teacher, coach, and community education leader. Essie Silva was a leader and proponent of business development for South Florida's Africa-American community. Helen Miller was the first African-American female Mayor in Dade County, Florida.

While these five individuals come from different backgrounds and professions they have one similar quality: dedication to their communities. Through their service, they have made immeasurable contributions to South Florida and our entire state. Mr. President, let me say a few words about each of these outstanding individuals:

Athalie Range has been a leader in South Florida for over 30 years. She was the first African-American and second woman to be elected to the Miami City Commission. Governor Reubin Askew appointed her the first African-American department head in the state of Florida. Ms. Range has also been the recipient of over 160 awards and honors. I have had the pleasure of knowing and learning from Ms. Range for many years. Her commitment to improving the quality of life for all citizens has been constant and meaningful.

Garth Reeves has been committed to excellence and achievement in South Florida for over 50 years. As the owner and publisher of the Miami Times, he has covered many of the important news stories of the last half-century. He has also been an exemplary civic leader who served on the Boards of Trustees of Miami-Dade Community College, Barry University, Bethune-Cookman College, and Florida Memorial College.

Essie D. Silva was a proponent of South Florida economic development her whole life. She chaired the Government Affairs Department of the Miami-Dade Chamber of Commerce and led groups to lobby in Tallahassee and Washington. In addition to her business activities, Ms. Silva was instrumental in establishing the Sunstreet Carnival, a popular family festival held in Miami.

Helen Miller became the first African-American female Mayor elected in Miami-Dade County when Opa Locka residents chose her as their Mayor in 1982. She has served on over forty different community boards dedicated to improving the quality of life in South Florida. She was a woman of tremendous vigor and leadership who was recognized as the elder stateswoman of Opa Locka, Florida. She passed away on October 2, 1996, in Opa Locka, Florida.

William R. ''Billy'' Rolle dedicated his life in one of our most important professions—teaching. He spent over thirty five years as a teacher, coach, band instructor, and assistant principal. In all these different roles he continued to inspire young people to reach their full potential. Also, Mr. Rolle helped organize the First Annual Goombay Festival, a popular Caribbean event held in Miami. He passed away on January 20, 1998, in Miami, Florida.

Mr. President, the accomplishments of these five individuals are worthy of having a post office designation. All of these post offices that will bear the names of the individuals will be located in the communities where they lived. It is appropriate that we grant this honor to salute their life long commitment to their community. I urge all my colleagues to join Senator MACK and me in supporting this important legislation.

By Mr. FAIRCLOTH:

S. 2405. A bill to amend the Fair Labor Standards Act of 1938 to exempt licensed funeral directors from the minimum wage and overtime compensation requirements of that Act; to the Committee on Labor and Human Resources.

FAIR LABOR STANDARDS ACT AMENDMENTS

● Mr. FAIRCLOTH. Mr. President, today I am introducing legislation together with my good friend, Senator DEWINE, to exempt licensed funeral directors from the overtime provisions of the Fair Labor Standards Act.

Under current law, licensed funeral directors do not meet the test for the ''professionals'' exemption under the Wage and Hour regulations of the Fair Labor Standards Act. Consequently, they are not exempt from minimum wage and overtime requirements. Given the nature of their work—on-duty or on-call 24 hours a day, 7 days a week, 365 days a year—this requirement places an economic hardship on small funeral homes and the families of licensed funeral directors. With erratic and unpredictable work hours, most licensed funeral directors would prefer the option of comp time in lieu of overtime pay in order to spend more time with their families.

Requiring licensed funeral directors to be paid for overtime work forces small business owners to allocate revenues for that purpose, thereby inhibiting salaries and bonuses. To avoid the financial strain, some even resort to using only part-time funeral directors.

Over the years, Congress has provided 17 exemptions to the Act. Included are such diverse exemptions as employees of amusement or recreational establishments, outside salespeople, seasonal agricultural workers, apprentices, employees of newspapers with a circulation of less than 4,000, switchboard operators of independently-owned telephone companies with fewer than 750 stations, and the more recent amendments related to criminal investigators, computer analysts, programmers, and software engineers.

Mr. President, I strongly believe that small businesses, such as funeral homes, must be given flexibility to provide their key employees with the options for alternative overtime compensation in order for them to survive, grow, and remain the premier source of employment in our communities.

In that regard and on behalf of your local funeral homes and their licensed funeral directors, I urge my colleagues to support this legislation.●

By Mr. BOND (for himself, Mr. COVERDELL, Mr. DOMENICI, Mr. KEMPTHORNE, and Ms. SNOWE):

S. 2407. A bill to amend the Small Business Act and the Small Business Investment Act of 1958 to improve the programs of the Small Business Administration; to the Committee on Small Business.

SMALL BUSINESS PROGRAMS RESTRUCTURING AND REFORM ACT OF 1998

● Mr. BOND. Mr. President, today, I have been joined by Senators COVERDELL, DOMENICI, KEMPTHORNE, and SNOWE to introduce ''The Small Business Programs Restructuring and Reform Act of 1998'' to restructure and refine Small Business Administration programs that are designed to help small businesses succeed. In drafting this legislation, I followed one key principle—will the change help small businesses? Many of SBA's programs are dependent upon the private sector to make loans and investments or to provide services to small businesses. ''The Small Business Programs Restructuring and Reform Act of 1998'' is intended to make Federal small business programs work more effectively while stimulating greater interest in the private sector to support small business owners and their employees.

The small business sector is the fastest growing segment of our economy. Its sustained growth throughout this decade has enabled our Nation to experience one of its greatest periods of prosperity. During this time span, small businesses have been responsible for the net increase of new jobs in the United States. Today, small businesses employ over ½ of all American workers. Small businesses produce 55 percent of our Nation's gross domestic product. Our Nation's sustained economic growth would not be possible were it not for the strength of the small business sector. One would hate to imagine where we would be without a robust small business community.

The Committee on Small Business opened the 105th Congress with a hearing on Homebased and Women-owned businesses. We received testimony on the significant economic contribution being made by the 8 million women-owned businesses and on the importance of business education, training, and financial assistance to this growing segment of our economy.

To assist the rapid growth of small businesses owned by women, Section 2 of ''The Small Business Programs Restructuring and Reform Act of 1998'' would increase the authorization level to $12 million from $8 million per year for the Women's Business Center program. This increase would ensure that new Center sites will be opened without jeopardizing the currently funded Centers from receiving funds for five years.

To verify the SBA provides the Women's Business Center program with the staff and administrative support required to support a $12 million program, the bill directs the General Accounting Office to undertake a baseline and follow-up study of the SBA's administration of the program. These independent audits will assist Congress in its oversight of SBA's supervision and administration of the program. Knowing that the Administration has previously recommended a budget that would have shut down the program, we want to make sure it is receiving the appropriate level of staffing and agency resources.

Last year, Congress passed the ''Small Business Reauthorization Act of 1997,'' which increased the authorization for the Women Business Center Program to $8 million from $4 million and extended the number of years grantees can receive grants to five years from three years. The goal was to have a Women's Business Center operating in every state and additional sites in states where there is sufficient demand. Consistent with our view, the Administration's budget request for Fiscal Year 1999 recommended an increase in the authorization level to $9 million. Senators KERRY and CLELAND introduced S. 2157 which would authorize the Administration's request and would go one step further by increasing the authorization level to $10.5 million in FY 2000, and $12 million in FY 2001. I am encouraged to see such a strong show of support for the program—only two years after Congress killed the Administration's recommendation to strike all funding for the program.

Section 2 of the bill includes a new provision to provide parity between Centers operating under three-year agreements with SBA when the Reauthorization Act was enacted and those Centers awarded five-year grants since that time. Section 2 amends the law to provide the same matching requirement in year four for all Centers receiving SBA grants. Under the 1997 Act, Centers that receive a two-year extension at the conclusion of a three-year grant have to raise two non-federal dollars for every federal dollar awarded; under Section 2, they will have to raise one non-federal dollar for each federal dollar—which is the fourth year matching requirement for Centers receiving newly awarded five year grants. The 2 non-federal dollars to one federal dollar matching requirement will remain in force for the fifth year of all awardees.

Section 3 of ''The Small Business Programs Restructuring and Reform Act of 1998'' would make the SBIR Program permanent. Testimony before the Committee on Small Business and the findings of the General Accounting Office clearly support this Congressional action. The bill would also increase the set aside from 2.5 percent to 3.5 percent. Beginning in FY 2001, the program would be increased by ¼ of 1 percent in each of the next four fiscal years.

Congress established the SBIR Program in 1982 because small businesses are a principal source of innovation in the United States. Under this program, Federal agencies with extramural research and development budgets of $100 million or more are required to set aside no less than 2.5 percent of that amount for small businesses. The SBIR Program was last re-authorized in 1992 and will terminate in FY 2000 unless Congress acts first.

In April 1998, the General Accounting Office issued its comprehensive report on the state of the SBIR Program, and in June 1998, GAO addressed that report in testimony before the Committee on Small Business. The unmistakable message was very clear—this is a good program that is running well. There are ten Federal agencies that participate in the program, and GAO concluded they are all adhering to the program's funding requirements. Competition has been intense among small business R&D firms in response to solicitations from the ten agencies. GAO found, however, it was very rare for an agency to make an award when the agency received only one proposal in response to a solicitation was received.

The bill would make a significant change in the program to encourage better outreach to states that receive few awards each year. GAO reported in FY 1996 that California received a total of 904 awards for a total of $207 million and Massachusetts received 628 awards for a total of $148 million. On the other hand, there were a great number of states receiving 11 or fewer awards. The bill would permit each of the ten participating agencies to spend up to 2% of the SBIR set aside pool of funds to support an outreach program, to promote better commercialization of the R&D awards, and to offset some administrative expenses. At least one-third of these non-award funds must be spent on outreach in those states that receive 25 or fewer awards each year.

Earlier this year, I introduced S. 2173, the ''Assistive and Universally Designed Technology Improvement Act,'' to encourage the development and production of actual products for the marketplace for assistive technology end-users. As part of my effort to reach that goal, the ''Small Business Programs Restructuring and Reform Act of 1998'' includes a provision encouraging all ten Federal agencies participating in the SBIR Program to solicit proposals to advance research and development in this critical area.

In 1958, Congress created the SBIC Program to assist small business owners obtain investment capital. Forty years later, small businesses continue to experience difficulty in obtaining investment capital from banks and traditional investment sources. SBICs are frequently their only sources of investment capital. In 1992 and 1996, the Committee on Small Business worked closely with SBA to correct earlier deficiencies in the law in order to ensure the future of the program. Today, the SBIC Program is booming. Its performance since 1994 has been astounding.

Section 4 of ''The Small Business Programs Restructuring and Reform Act of 1998'' would make a relatively small change in the operation of the program. This change, however, would help smaller, small businesses to be more attractive to investors. The bill would permit SBICs to accept royalty payments contingent on future performance from companies in which they invest as a form of equity return for their investment.

SBA already permits SBICs to receive warrants from small businesses, which give the investing SBIC the right to acquire a portion of the equity of the small business. By pledging royalties or warrants, the small business is able to reduce the interest that would otherwise be payable by the small business to the SBIC. Importantly, the royalty feature provides the smaller, small business with an incentive to attract SBIC investments when the return may otherwise be insufficient to attract venture capital.

Section 5 of ''The Small Business Programs Restructuring and Reform Act of 1998'' would require the SBA to make permanent a pilot program initiated two years ago to permit certain Certified Development Companies (CDCs) to foreclose and liquidate defaulted loans that they have originated under the 504 Loan Program. This is a necessary step to ensure the 504 program remains viable.

Currently, SBA liquidates and forecloses almost every loan made under the 504 Loan Program. SBA has been performing this task poorly. The Administration's FY 1999 budget submission estimates that recoveries on defaulted loans under the 504 Loan Program will decline from 34.27% in FY 1998 to 30.67% in FY 1999. It is important to note that all loans made under the 504 loan program are fully secured by real estate. It is inconceivable that SBA recovers only thirty cents on the dollar on fully-secured real estate loans.

Because the 504 Program is self-funded through user fees, with no appropriation required by Congress, borrowers must pay higher fees to compensate for the SBA's inability to recover a reasonable portion of defaulted loans. As borrower fees have increased, the 504 Loan Program has been priced out of the reach of certain small businesses. The 504 Loan Program was enacted to provide larger loans to small businesses for plant acquisition, construction or expansion. Such loans create jobs and improve the economic health of communities. Congress should not allow such opportunities to be limited because the SBA has been unable to recover funds on defaulted loans effectively.

In 1996, Congress passed, at my urging, the Small Business Programs Improvement Act, which established a pilot program that allowed approximately 20 CDCs to liquidate loans that they had originated. Reports on this pilot program indicate it has been a success—CDCs are obtaining higher recoveries than the SBA. This bill makes the pilot program permanent and permits CDCs that have the ability to manage loan liquidations to do so. This change in the law is designed to increase the recoveries on defaulted loans thereby decreasing borrower fees. Consequently, more small businesses will have access to 504 loans, which will create more jobs and will help sustain the economic growth this country has been experiencing.

The ''Small Business Reauthorization Act of 1997'' included the creation of the HUBZone Program, which raised the goal to 23% from 20% for prime contracts being awarded by the Federal government to small business. This increase was advocated by the SBA Administrator and was embraced by the Clinton Administration.

It has been brought to the attention of the Committee on Small Business that some Federal agencies may be using bookkeeping ploys to reduce the amount of contract dollars going into the pool of contracts used for calculating the older 20% small business set aside goal. By reducing the overall dollar volume of contracts, the value of contracts counted under the older 20% set aside goal is also reduced. Now that Congress has increased the goal to 23%, I am concerned there may be greater pressure on the agencies to ''juggle the books.''

In order for the Committee on Small Business to conduct its oversight of the small business contract set aside goal, Section 6 of the bill directs the SBA to send a report to the Committee on Small Business each year highlighting any Federal agency that alters its statistical methodology in tracking its efforts to meet the 23% goal. The bill also directs the Administrator of SBA to notify the Committee and the SBA Chief Counsel for Advocacy prior to approving any request from an agency to change how it reports its small business contracting efforts.

Last year, when Congress approved the ''Small Business Reauthorization Act of 1997,'' it included a separate title to improve business opportunities for service-disabled veterans. The Senate and House Committees on Small Business believed strongly that these individuals deserve better support from the Federal agencies than they have received historically. Last year's bill included a provision requiring the SBA to complete a comprehensive report containing the findings and recommendations of the SBA Administrator on the needs of small businesses owned and controlled by service-disabled veterans. Although this report should be received by the Congress no later than the first week of September, SBA's efforts to date to complete this report within the statutory deadline are disappointing.

Section 7 of ''The Small Business Programs Restructuring and Reform Act of 1998'' would go one step further to strengthen the mandate that SBA's programs be more responsive to all veteran small business owners. The bill would direct that veterans receive comprehensive help at SBA. The bill elevates the Office of Veterans Affairs at SBA to the Office of Veterans Business Development, which would be headed by an Associate Administrator, who would report directly to the SBA Administrator.

In addition, the bill would establish an Advisory Committee on Veterans' Business Affairs composed of 15 members. Eight members would be veterans who own small businesses, and seven members will be representatives of national veterans service organizations. Further, the bill would create the position of National Veterans' Business Coordinator within the Service Corps of Retired Executives (SCORE) Program. This new position would work in the SBA headquarters to ensure that SCORE's programs nationwide include entrepreneurial counseling and training for veterans.

Section 7 of the bill would make veteran small business owners eligible to apply for small, start-up loans under SBA's Microloan Program. And the SBA Office of Advocacy would be directed to evaluate annually efforts by Federal agencies, business and industry to help business that are owned and controlled by veterans.

The ''Small Business Programs Restructuring and Reform Act of 1998'' is a sound bill that will help small business owners, particularly those who are struggling or in the business start-up phase to compete more effectively. I urge my colleagues to support this legislation.

Mr. President, I ask unanimous consent the full 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. 2407

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 ''Small Business Programs Restructuring and Reform Act of 1998''.

SEC. 2. WOMEN'S BUSINESS CENTER PROGRAM.

(a) FINDINGS.—Congress finds that—

(1) with small business concerns owned and controlled by women being created at a rapid rate in the United States, there is a need to increase the authorization level for the women's business center program under section 29 of the Small Business Act (15 U.S.C. 656) in order to establish additional women's business center sites throughout the Nation that focus on entrepreneurial training programs for women; and

(2) increased funding for the women's business center program will ensure that—

(A) new women's business center sites can be established to reach women located in geographic areas not presently served by an existing women's business center without jeopardizing the full funding of existing women's business centers for the term prescribed by law; and

(B) the Small Business Administration achieves the goal of establishing at least 1 sustainable women's business center in each State.

(b) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—Section 29(k)(1) of the Small Business Act (15 U.S.C. 656(k)(1)) is amended to read as follows:

''(1) AUTHORIZATION.—There is authorized to be appropriated to carry out this section, $12,000,000 for fiscal year 1999 and each fiscal year thereafter.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take effect on October 1, 1998.

(c) TERMS OF ASSISTANCE.—

(1) IN GENERAL.—Section 308(b) of the Small Business Reauthorization Act of 1997 (15 U.S.C. 656 note) is amended—

(A) by striking ''(b)'' and all that follows through ''paragraph (2), any organization'' and inserting the following:

''(b) APPLICABILITY.—Any organization''; and

(B) by striking paragraph (2).

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take effect as if included in the enactment of the Small Business Reauthorization Act of 1997.

(d) GENERAL ACCOUNTING OFFICE REPORTING REQUIREMENTS.—

(1) BASELINE REPORT.—Not later than October 31, 1999, the Comptroller General of the United States shall—

(A) conduct a review of the administration of the women's business center program under section 29 of the Small Business Act (15 U.S.C. 656) by the Office of Women's Business Ownership of the Small Business Administration, which shall include an analysis of—

(i) the operation of the women's business center program by the Administration;

(ii) the efforts of the Administration to meet the legislative objectives established for the program;

(iii) the oversight role of the Administration of the operations of women's business centers;

(iv) the manner in which the women's business centers operate;

(v) the benefits provided by the women's business centers to small business concerns owned and controlled by women; and

(vi) any other matters that the Comptroller General determines to be appropriate; and

(B) submit to the Committees on Small Business of the Senate and House of Representatives a report describing the results of the review under subparagraph (A).

(2) FOLLOWUP REPORT.—Not later than October 31, 2002, the Comptroller General of the United States shall—

(A) conduct a review of any changes, during the period beginning on the date on which the report is submitted under paragraph (1)(B) and ending on the date on which the report is submitted under subparagraph (B) of this paragraph, in the administration of the women's business center program under section 29 of the Small Business Act (15 U.S.C. 656) by the Office of Women's Business Ownership of the Small Business Administration, which shall include an analysis of any changes during that period in—

(i) the operation of the women's business center program by the Administration;

(ii) the efforts of the Administration to meet the legislative objectives established for the program;

(iii) the oversight role of the Administration of the operations of women's business centers;

(iv) the manner in which the women's business centers operate;

(v) the benefits provided by the women's business centers to small business concerns owned and controlled by women; and

(vi) any other matters that the Comptroller General determines to be appropriate; and

(B) submit to the Committees on Small Business of the Senate and House of Representatives a report describing the results of the review under subparagraph (A).

SEC. 3. SBIR PROGRAM.

(a) ASSISTIVE TECHNOLOGY.—Section 9(c) of the Small Business Act (15 U.S.C. 638(c)) is amended by adding at the end the following: ''In order to carry out the purposes of this section, the Administration shall, to the maximum extent practicable, encourage Federal agencies to fund programs for the research and development of assistive and universally designed technology that is designed to result in the availability of new products for individuals with disabilities (as defined in section 3 of the Americans with Disabilities Act of 1990 (42 U.S.C. 12102)).''.

(b) FEDERAL AGENCY EXPENDITURES FOR THE SBIR PROGRAM.—

(1) REQUIRED EXPENDITURE AMOUNTS; DEFINITION OF EXTRAMURAL BUDGET.—Section 9(f)(1) of the Small Business Act (15 U.S.C. 638(f)(1)) is amended—

(A) by striking subparagraphs (A) through (C) and inserting the following:

''(A) not less than 2.5 percent of that budget in each of fiscal years 1999 and 2000;

''(B) not less than 2.75 percent of that budget in fiscal year 2001;

''(C) not less than 3 percent of that budget in fiscal year 2002;

''(D) not less than 3.25 percent of that budget in fiscal year 2003; and

''(E) not less than 3.5 percent of that budget in each fiscal year thereafter;''; and

(B) by adding at the end the following: ''Notwithstanding any other provision of law, any rule, regulation, or order promulgated by the Director of the Office of Management and Budget relating to the definition of the term 'extramural budget' in subsection (e)(1) shall, except with respect to the Federal agencies specifically identified in that subsection, apply uniformly to all departments and agencies of the Federal Government that are subject to the requirements of this section.''.

(2) LIMITATIONS RELATING TO ADMINISTRATIVE COSTS.—Section 9(f)(2) of the Small Business Act (15 U.S.C. 638(f)(2)(A)) is amended—

(1) in the matter preceding subparagraph (A), by striking ''A Federal agency'' and inserting ''In any fiscal year, a Federal agency''; and

(2) in subparagraph (A)—

(A) by striking ''any of'' and inserting ''more than the lesser of $2,000,000 or 2 percent of''; and

(B) by inserting '', funding program outreach for States receiving 25 or fewer awards in that fiscal year, and funding increased activities to promote commercialization of SBIR awards, of which not less than one-third shall be used to support program outreach'' before the semicolon.

(d) REPEAL OF TERMINATION PROVISION.—Section 9 of the Small Business Act (15 U.S.C. 638) is amended by striking subsection (m) and inserting the following:

''(m) [Reserved].''.

SEC. 4. SBIC PROGRAM.

Section 308(i)(2) of the Small Business Investment Act of 1958 (15 U.S.C. 687(i)(2)) is amended by adding at the end the following: ''In this paragraph, the term 'interest' includes only the maximum mandatory sum, expressed in dollars or as a percentage rate, that is payable with respect to the business loan amount received by the small business concern, and does not include the value, if any, of contingent obligations, including warrants, royalty, or conversion rights, granting the small business investment company an ownership interest in the equity or future revenue of the small business concern receiving the business loan.''.

SEC. 5. CERTIFIED DEVELOPMENT COMPANY PROGRAM.

(a) IN GENERAL.—Title V of the Small Business Investment Act of 1958 (15 U.S.C. 695 et seq.) is amended by adding at the end the following:

''SEC. 510. FORECLOSURE AND LIQUIDATION OF LOANS.

''(a) IN GENERAL.—The Administration shall authorize qualified State and local development companies (as defined in section 503(e)) that meet the requirements of subsection (b) to foreclose and liquidate loans in the portfolios of those companies that are funded with the proceeds of debentures guaranteed by the Administration under section 503.

''(b) REQUIREMENTS.—The requirements of this subsection are that—

''(1) the qualified State or local development company—

''(A) participated in the loan liquidation pilot program established by section 204 of the Small Business Programs Improvement Act of 1996 (15 U.S.C. 695 note), as in effect on the day before the promulgation of final regulations by the Administration implementing this section; or

''(B) is participating in the Accredited Lenders Program under section 507 or the Premier Certified Lenders Program under section 508; or

''(2)(A) during the 3 most recent fiscal years, the qualified State or local development company has made an average of not less than 10 loans per year that are funded with the proceeds of debentures guaranteed under section 503; and

''(B) 1 or more of the employees of the qualified State or local development company have—

''(i) not less than 1 year of experience in administering the liquidation and workout of problem loans secured in a manner substantially similar to loans funded with the proceeds of debentures guaranteed under section 503; or

''(ii) completed a training program on loan liquidation developed by the Administration in conjunction with qualified State and local development companies that meet the requirements of this subsection.

''(c) AUTHORITY OF DEVELOPMENT COMPANIES.—

''(1) IN GENERAL.—Each qualified State or local development company authorized to foreclose and liquidate loans under this section shall, with respect to any loan described in subsection (a) in the portfolio of the development company that is in default—

''(A) perform all liquidation and foreclosure functions, including the purchase of any other indebtedness secured by the property securing the loan, in a reasonable and sound manner and according to commercially accepted practices, pursuant to a liquidation plan, which shall be approved in advance by the Administration in accordance with paragraph (2)(A);

''(B) litigate any matter relating to the performance of the functions described in subparagraph (A), except that the Administration may monitor the conduct of any such litigation to which the qualified State or local development company is a party; and

''(C) take other appropriate actions to mitigate loan losses in lieu of total liquidation or foreclosure, including restructuring the loan, which such actions shall be in accordance with prudent loan servicing practices and pursuant to a workout plan, which shall be approved in advance by the Administration in accordance with paragraph (2)(C).

''(2) ADMINISTRATION APPROVAL.—

''(A) LIQUIDATION PLAN.—In carrying out paragraph (1), a qualified State or local development company shall submit to the Administration a proposed liquidation plan. Any request under this subparagraph shall be approved or denied by the Administration not later than 10 business days after the date on which the request is submitted. If the Administration does not approve or deny a request for approval of a liquidation plan before the expiration of the 10-business day period beginning on the date on which the request is submitted, the request shall be considered to be approved.

''(B) PURCHASE OF INDEBTEDNESS.—In carrying out paragraph (1)(A), a qualified State or local development company shall submit

to the Administration a request for written approval from the Administration before committing the Administration to purchase any other indebtedness secured by the property securing the loan at issue. Any request under this subparagraph shall be approved or denied by the Administration not later than 10 business days after the date on which the request is submitted.

''(C) WORKOUT PLAN.—In carrying out paragraph (1)(C), a qualified State or local development company may submit to the Administration a proposed workout plan. Any request under this subparagraph shall be approved or denied by the Administration not later than 20 business days after the date on which the request is submitted. If the Administration does not approve or deny a request for approval of a workout plan before expiration of the 20-business day period beginning on the date on which the request is submitted, the request shall be considered to be approved.

''(3) CONFLICT OF INTEREST.—A qualified State or local development company that is liquidating or foreclosing a loan under this section shall not take any action that would result in an actual or apparent conflict of interest between the qualified State or local development company, or any employee thereof, and any third party lender, associate of a third party lender, or any other person participating in any manner in the liquidation or foreclosure of the loan.

''(d) SUSPENSION OR REVOCATION OF AUTHORITY.—The authority of a qualified State or local development company to foreclose and liquidate loans under this section may be suspended or revoked by the Administration, if the Administration determines that the qualified State or local development company—

''(1) does not meet the requirements of subsection (b); or

''(2) has failed to comply with any requirement of this section or any applicable rule or regulation of the Administration regarding the foreclosure and liquidation of loans under this section, or has violated any other applicable provision of law.

''(e) REPORT.—

''(1) IN GENERAL.—The Administration shall annually submit to the Committees on Small Business of the House of Representatives and the Senate a report on the results of the delegation of authority to qualified State and local development companies to liquidate and foreclose loans under this section.

''(2) INFORMATION INCLUDED.—Each report under this paragraph shall include information, with respect to each qualified State or local development company authorized to foreclose and liquidate loans under this section, and in the aggregate, relating to—

''(A) the total dollar amount of each loan liquidated and the total cost of each project financed with that loan;

''(B) the total dollar amount guaranteed by the Administration;

''(C) total dollar losses;

''(D) total recoveries both as a percentage of the amount guaranteed and the total cost of the project financed; and

''(E) a comparison between—

''(i) the information described in subparagraphs (A) through (D) with respect to loans foreclosed and liquidated by qualified State and local development companies under this section during the 3-year period preceding the date on which the report is submitted; and

''(ii) the same information with respect to loans foreclosed and liquidated by the Administration during that period.''.

(b) REGULATIONS.—

(1) IN GENERAL.—Not later than 120 days after the date of enactment of this Act, the Administrator of the Small Business Administration shall promulgate such regulations as may be necessary to carry out section 510 of the Small Business Investment Act of 1958, as added by subsection (a) of this section.

(2) ELIMINATION OF PILOT PROGRAM.—Effective on the date on which final regulations are promulgated under paragraph (1), section 204 of the Small Business Programs Improvement Act of 1996 (15 U.S.C. 695 note) is repealed.

SEC. 6. SMALL BUSINESS FEDERAL CONTRACT SET-ASIDES.

Section 15(h) of the Small Business Act (15 U.S.C. 644(h)) is amended—

(1) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively;

(2) by inserting after paragraph (1) the following:

''(2)(A) Not later than 180 days after the last day of each fiscal year, based on the reports submitted under paragraph (1) for that fiscal year, the Administration shall submit to the Committees on Small Business of the House of Representatives and the Senate a report, which shall include—

''(i) the information required by paragraph (3);

''(ii) a detailed description of the procurement data that is included in the reports submitted under paragraph (1) for that fiscal year, which shall identify—

''(I) any data on contracts from Federal agencies that is excluded from those reports, accompanied by an explanation for such exclusion; and

''(II) each Federal agency that has submitted a report that deviates from the requirements of paragraphs (3) and (4), accompanied by an explanation of the reasons for each such deviation;

''(iii) a detailed description of any change in statistical methodology used by any Federal agency that is reflected in any statistic in the report submitted under paragraph (1) for that fiscal year, including any inclusion or exclusion of the value of any contracts or types of contracts in any statistic represented by the Federal agency in the report submitted under paragraph (1) as the total value of contracts or subcontracts awarded by the Federal agency or as the total value of contracts or subcontracts awarded to small business concerns; and

''(iv) with respect to each change in statistical methodology by a Federal agency described in clause (iii), a separate calculation (which shall be provided to the Administration by the Federal agency) of the total value of contracts for that fiscal year, using the statistical methodology used by the Federal agency during each of the 2 preceding fiscal years.

''(B)(i) Not less than 45 days before issuing any waiver or permissive letter allowing any Federal agency or group of agencies to make any change in statistical methodology described in subparagraph (A)(iii), the Administration shall submit to the Committees on Small Business of the House of Representatives and the Senate, and to the Chief Counsel for Advocacy of the Administration, a copy of that waiver or letter.

''(ii) Not later than 30 days after the submission of a waiver or letter under clause (i), the Chief Counsel for Advocacy of the Administration shall submit to the Committees on Small Business of the House of Representatives and the Senate, and to each affected Federal agency, the written comments of the Chief Counsel regarding the appropriateness of the decision of the Administration to issue the waiver or letter.''; and

(3) in paragraph (4), as redesignated, by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (3)''.

SEC. 7. ASSISTANCE FOR VETERANS.

(a) DEFINITIONS.—Section 3 of the Small Business Act (15 U.S.C. 632) is amended by adding at the end the following:

''(q) DEFINITIONS RELATING TO VETERANS.—In this Act:

''(1) SERVICE-DISABLED VETERAN.—The term 'service-disabled veteran' means a veteran with a disability that is service-connected (as defined in section 101(16) of title 38, United States Code).

''(2) SMALL BUSINESS CONCERN OWNED AND CONTROLLED BY SERVICE-DISABLED VETERANS.—The term 'small business concern owned and controlled by service-disabled veterans' means a small business concern—

''(A) not less than 51 percent of which is owned by 1 or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by 1 or more service-disabled veterans; and

''(B) the management and daily business operations of which are controlled by 1 or more service-disabled veterans.

''(3) SMALL BUSINESS CONCERN OWNED AND CONTROLLED BY VETERANS.—The term 'small business concern owned and controlled by veterans' means a small business concern—

''(A) not less than 51 percent of which is owned by 1 or more veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by 1 or more veterans; and

''(B) the management and daily business operations of which are controlled by 1 or more veterans.

''(4) VETERAN.—The term 'veteran' has the meaning given the term in section 101(2) of title 38, United States Code.''.

(b) OFFICE OF VETERANS BUSINESS DEVELOPMENT.—

(1) ASSOCIATE ADMINISTRATOR FOR VETERANS BUSINESS DEVELOPMENT.—Section 4(b)(1) of the Small Business Act (15 U.S.C. 633(b)(1)) is amended—

(A) in the fifth sentence, by striking ''four'' and inserting ''5''; and

(B) by inserting after the fifth sentence the following: ''One shall be the Associate Administrator for Veterans Business Development, who shall administer the Office of Veterans Business Development established under section 32.''.

(2) ESTABLISHMENT OF OFFICE.—The Small Business Act (15 U.S.C. 631 et seq.) is amended—

(A) by redesignating section 32 as section 33; and

(B) by inserting after section 31 the following:

''SEC. 32. VETERANS PROGRAMS.

''(a) OFFICE OF VETERANS BUSINESS DEVELOPMENT.—

''(1) ESTABLISHMENT.—There is established in the Administration an Office of Veterans Business Development, which shall be administered by the Associate Administrator for Veterans Business Development (in this section referred to as the 'Associate Administrator') appointed under section 4(b)(1).

''(2) ASSOCIATE ADMINISTRATOR FOR VETERANS BUSINESS DEVELOPMENT.—The Associate Administrator shall be—

''(A) a career appointee in the competitive service or in the Senior Executive Service; and

''(B) responsible for the formulation and execution of the policies and programs of the Administration that provide assistance to small business concerns owned and controlled by veterans and small business concerns owned and controlled by service-disabled veterans.

''(b) ADVISORY COMMITTEE ON VETERANS BUSINESS AFFAIRS.—

''(1) IN GENERAL.—There is established an advisory committee to be known as the Advisory Committee on Veterans Business Affairs (in this subsection referred to as the 'Committee'), which shall serve as an independent source of advice and policy recommendations to the Administrator (through the Associate Administrator), to Congress, and to the President.

''(2) MEMBERSHIP.—

''(A) IN GENERAL.—The Committee shall be composed of 15 members, each of whom shall be appointed by the Administrator, of whom—

''(i) 8 shall be veterans who are owners of small business concerns; and

''(ii) 7 shall be representatives of national veterans service organizations.

''(B) POLITICAL AFFILIATION.—Not more than 8 members of the Committee shall be of the same political party as the President.

''(C) PROHIBITION ON FEDERAL EMPLOYMENT.—No member of the Committee may be an officer or employee of the Federal Government. If any member of the Committee commences employment as an officer or employee of the Federal Government after the date on which the member is appointed to the Committee, the member may continue to serve as a member of the Committee for not more than 30 days after the date on which the member commences employment as such an officer or employee.

''(D) SERVICE TERM.—Each member of the Committee shall serve for a term of 3 years.

''(E) VACANCIES.—Not later than 30 days after the date on which a vacancy in the membership of the Committee occurs, the vacancy be filled in the same manner as the original appointment.

''(F) CHAIRPERSON.—The Committee shall select a Chairperson from among the members of the Committee. Any vacancy in the office of the Chairperson of the Committee shall be filled by the Committee at the first meeting of the Committee following the date on which the vacancy occurs.

''(G) INITIAL APPOINTMENTS.—Not later than 60 days after the date of enactment of this Act, the Administrator shall appoint the initial members of the Committee.

''(3) DUTIES.—The Committee shall—

''(A) review, coordinate, and monitor plans and programs developed in the public and private sectors, that affect the ability of veteran-owned business enterprises to obtain capital and credit;

''(B) promote and assist in the development of business information and surveys relating to veterans;

''(C) monitor and promote the plans, programs, and operations of the departments and agencies of the Federal Government that may contribute to the establishment and growth of veteran's business enterprises;

''(D) develop and promote new initiatives, policies, programs, and plans designed to foster veteran's business enterprises; and

''(E) advise and assist in the design of a comprehensive plan, which shall be updated annually, for joint public-private sector efforts to facilitate growth and development of veteran's business enterprises.

''(4) POWERS.—

''(A) HEARINGS.—The Committee may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Committee considers advisable to carry out the duties of the Committee under this subsection.

''(B) INFORMATION FROM FEDERAL AGENCIES.—The Committee may secure directly from any department or agency of the Federal Government such information as the Committee considers to be necessary to carry out the duties of the Committee under this subsection. Upon request of the Chairperson of the Committee, the head of such department or agency shall furnish such information to the Committee.

''(C) POSTAL SERVICES.—The Committee may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

''(D) GIFTS.—The Committee may accept, use, and dispose of gifts or donations of services or property.

''(5) MEETINGS.—

''(A) IN GENERAL.—The Committee shall meet not less than biannually at the call of the Chairperson, and otherwise upon the request of the Administrator.

''(B) LOCATION.—Each meeting of the full Committee shall be held at the headquarters of the Administration located in Washington, District of Columbia. The Administrator shall provide suitable meeting facilities and such administrative support as may be necessary for each meeting of the Committee.

''(6) PERSONNEL MATTERS.—

''(A) NO COMPENSATION.—Members of the Committee shall serve without compensation for their services to the Committee.

''(B) TRAVEL EXPENSES.—The members of the Committee shall be reimbursed for travel and subsistence expenses in the same manner and to the same extent as members of advisory boards and committees under section 8(b)(13).

''(c) SCORE PROGRAM.—The Administrator shall enter into a memorandum of understanding with the Service Core of Retired Executives (in this subsection referred to as 'SCORE') participating in the program under section 8(b)(1)(B) for—

''(1) the appointment by SCORE in its national office of a National Veterans Business Coordinator, whose exclusive duties shall be those relating to veterans' business matters, and who shall be responsible for the establishment and administration of a program to provide entrepreneurial counseling and training to veterans through the chapters of SCORE throughout the United States;

''(2) the establishment and maintenance of a toll-free telephone number and an Internet website to provide access for veterans to information about the entrepreneurial services available to veterans through SCORE; and

''(3) the collection of statistics concerning services provided by SCORE to veterans and service-disabled veterans and the inclusion of those statistics in each annual report published by the Administrator under section 4(b)(2)(B).

''(d) ANNUAL REPORT.—The Administrator shall annually submit to the Committees on Small Business of the House of Representative and the Senate a report on the needs of small business concerns owned by controlled by veterans and small business concerns owned and controlled by service-disabled veterans, which shall include—

''(1) the availability of programs of the Administration for and the degree of utilization of those programs by those small business concerns during the preceding 12-month period;

''(2) the percentage and dollar value of Federal contracts awarded to those small business concerns during the preceding 12-month period; and

''(3) proposed methods to improve delivery of all Federal programs and services that could benefit those small business concerns.''.

(c) OFFICE OF ADVOCACY.—Section 202 of Public Law 94–305 (15 U.S.C. 634b) is amended—

(1) in paragraph (10), by striking ''and'' at the end;

(2) in paragraph (11), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(12) evaluate the efforts of each Federal agency and of private industry to assist small business concerns owned and controlled by veterans and small business concerns owned and controlled by service-disabled veterans, and make appropriate recommendations to the Administrator and to Congress in order to promote the establishment and growth of those small business concerns.''.

(d) MICROLOAN PROGRAM.—Section 7(m)(1)(A)(i) of the Small Business Act (15 U.S.C. 636(m)(1)(A)(i)) is amended by striking ''low-income, and'' and inserting ''low-income individuals, veterans,''.●

By Mr. CHAFEE (for himself, Mr. ROCKEFELLER, Mr. DEWINE, Mr. LEVIN, Mr. BOND, Mr. MOYNIHAN, Mr. KERREY, Ms. LANDRIEU, and Mr. DORGAN):

S. 2408. A bill to promote the adoption of children with special needs; to the Committee on Finance.

THE ADOPTION EQUALITY ACT OF 1998

● Mr. CHAFEE. Mr. President, I am pleased today to introduce the Adoption Equality Act of 1998, legislation that will make it easier for children with special needs to find permanent, adoptive homes. I want to extend my sincere thanks to Senator ROCKEFELLER for his commitment to this legislation and to foster and adoptive children generally. Senator ROCKEFELLER joins me as an original cosponsor, as do Senators DEWINE, KERREY, BOND, LEVIN, LANDRIEU, DORGAN and MOYNIHAN.

Nationwide there are 500,000 children in foster care. In Rhode Island there are approximately 1,600 children in foster care. On average, these children will spend more than two years in out-of-home care before they are either returned home to their biological families or freed for adoption.

The majority of the children who have been legally freed for adoption—95 percent—have special-needs, which in the world of child welfare means that they are children who are hard to place. They may be older children, they may be children in sibling groups that the state does not want to separate, they may have physical disabilities or mental or emotional problems, or they may belong to a minority group.

The federal government provides an incentive to families wishing to open their homes to these children by offering some of them a monthly subsidy to help defray the cost of adopting these children. It is expensive to care for children, and even more expensive if the child has special needs. The monthly subsidy, which is less than the monthly payment for the child to be in foster care, is used to defray some of these additional costs.

What makes no sense about the current system is that the federal government only makes these subsidies available to special-needs children who are being adopted whose biological families were poor. If the child is being adopted by a low-income family, but their biological family was not low-income, that child will not receive a federal adoption subsidy.

This system makes no sense to me, and that is why we are introducing the Adoption Equality Act today. This measure would make all special-needs children eligible for a modest federal adoption subsidy, regardless of the income of their biological parents. The income of the prospective adoptive parents would be taken into account when calculating the amount of the subsidy, as it is under current law.

Mr. President, I believe this is a simply issue of fairness to these children and the families who adopt them. We should be doing everything we can to help these children find permanent homes. The Adoption Equality Act builds upon the critical reforms we made last year in the enactment of the Adoption and Safe Families Act. I urge my colleagues to join me in cosponsoring and passing this bill. Thank you Mr. President. I ask unanimous consent that the bill be printed in the RECORD.

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

S. 2408

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 ''Adoption Equality Act of 1998''.

SEC. 2. PROMOTION OF ADOPTION OF CHILDREN WITH SPECIAL NEEDS.

(a) IN GENERAL.—Section 473(a) of the Social Security Act (42 U.S.C. 673(a)) is amended by striking paragraph (2) and inserting the following:

''(2)(A) For purposes of paragraph (1)(B)(ii), a child meets the requirements of this paragraph if such child—

''(i) prior to termination of parental rights and the initiation of adoption proceedings was in the care of a public or licensed private child care agency or Indian tribal organization either pursuant to a voluntary placement agreement (provided the child was in care for not more than 180 days) or as a result of a judicial determination to the effect that continuation in the home would be contrary to the safety and welfare of such child, or was residing in a foster family home or child care institution with the child's minor parent (either pursuant to such a voluntary placement agreement or as a result of such a judicial determination); and

''(ii) has been determined by the State pursuant to subsection (c) to be a child with special needs, which needs shall be considered by the State, together with the circumstances of the adopting parents, in determining the amount of any payments to be made to the adopting parents.

''(B) Notwithstanding any other provision of law, and except as provided in paragraph (7), a child who is not a citizen or resident of the United States and who meets the requirements of subparagraph (A) shall be treated as meeting the requirements of this paragraph for purposes of paragraph (1)(B)(ii).

''(C) A child who meets the requirements of subparagraph (A), who was determined eligible for adoption assistance payments under this part with respect to a prior adoption (or who would have been determined eligible for such payments had the Adoption and Safe Families Act of 1997 been in effect at the time that such determination would have been made), and who is available for adoption because the prior adoption has been dissolved and the parental rights of the adoptive parents have been terminated or because the child's adoptive parents have died, shall be treated as meeting the requirements of this paragraph for purposes of paragraph (1)(B)(ii).''.

(b) EXCEPTION.—Section 473(a) of the Social Security Act (42 U.S.C. 673(a)) is amended by adding at the end the following:

''(7)(A) Notwithstanding any other provision of this subsection, no payment may be made to parents with respect to any child that—

''(i) would be considered a child with special needs under subsection (c);

''(ii) is not a citizen or resident of the United States; and

''(iii) was adopted outside of the United States or was brought into the United States for the purpose of being adopted.

''(B) Subparagraph (A) shall not be construed as prohibiting payments under this part for a child described in subparagraph (A) that is placed in foster care subsequent to the failure, as determined by the State, of the initial adoption of such child by the parents described in such subparagraph.''.

(c) REQUIREMENT FOR USE OF STATE SAVINGS.—Section 473(a) of the Social Security Act (42 U.S.C. 673(a)), as amended by subsection (b), is amended by adding at the end the following:

''(8) A State shall spend an amount equal to the amount of savings (if any) in State expenditures under this part resulting from the application of paragraph (2) on and after the effective date of the amendment to such paragraph made by section 2(a) of the Adoption Equality Act of 1998 to provide to children or families any service (including post-adoption services) that may be provided under this part or part B.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 1998.

SEC. 3. REDUCTIONS IN PAYMENTS FOR ADMINISTRATIVE COSTS.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(1) in subsection (a)(7), by striking ''section 1919(g)(3)(B)'' and inserting ''subsection (x) and section 1919(g)(3)(C)''; and

(2) by adding at the end the following:

''(x) ADJUSTMENTS TO PAYMENTS FOR ADMINISTRATIVE COSTS.—

''(1) REDUCTIONS IN PAYMENTS FOR ADMINISTRATIVE COSTS BASED ON DETERMINATIONS OF AMOUNTS ATTRIBUTABLE TO BENEFITING PROGRAMS.—

''(A) IN GENERAL.—Subject to paragraph (2), effective for each of fiscal years 1999 through 2002, the Secretary shall reduce, for each such fiscal year, the amount paid under subsection (a)(7) to each State by an amount equal to the amount determined for the medicaid program under section 16(k)(2)(B) of the Food Stamp Act of 1977 (7 U.S.C. 2025(k)(2)(B)). The Secretary shall, to the extent practicable, make the reductions required by this paragraph on a quarterly basis.

''(B) APPLICATION.—If the Secretary does not make the determinations required by section 16(k)(2)(B) of the Food Stamp Act of 1977 (7 U.S.C. 2025(k)(2)(B)) by September 30, 1999—

''(i) during the fiscal year in which the determinations are made, the Secretary shall reduce the amount paid under subsection (a)(7) to each State by an amount equal to the sum of the amounts determined for the medicaid program under section 16(k)(2)(B) of the Food Stamp Act of 1977 for fiscal year 1999 through the fiscal year during which the determinations are made; and

''(ii) for each subsequent fiscal year through fiscal year 2002, subparagraph (A) applies.

''(C) APPLICATION OF APPEAL OF DETERMINATIONS.—The provisions of section 16(k)(4) of the Food Stamp Act of 1977 (7 U.S.C. 20205(k)(4)) apply to reductions in payments under this subsection in the same manner as they apply to reductions under section 16(k) of that Act.

''(2) BONUS PAYMENT FOR PROGRAM ALIGNMENT.—

''(A) IN GENERAL.—

''(i) AMOUNT.—In addition to any other payment made under this title to a State for a fiscal year, the Secretary shall pay to each State that satisfies the requirements of clause (ii) a portion of the amount by which—

''(I) any decrease in Federal outlays for amounts paid under subsection (a)(7) with respect to the State for the fiscal year as a result of the application of paragraph (1), as determined by the Congressional Budget Office, exceeds

''(II) any increase in Federal outlays with respect to the State for the fiscal year as a result of the application of section 473(a), as amended by section 2 of the Adoption Equality Act of 1998, as determined by the Congressional Budget Office.

''(ii) REQUIREMENTS.—A State satisfies the requirements of this clause if the Secretary determines that—

''(I) the State's income and resource eligibility rules under section 1931, taking into account the income standards and methodologies applied by the State, are not more restrictive than the income and resource eligibility rules applied by the State for the temporary assistance to needy families program funded under part A of title IV (other than for a welfare-to-work program funded under section 403(a)(5)); and

''(II) the State assures the Secretary that families applying for assistance under the temporary assistance to needy families program funded under part A of title IV (other than families applying solely for assistance under a welfare-to-work program funded under section 403(a)(5)) may apply for medical assistance under the State plan under this title without having to submit a separate application for such medical assistance.

''(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as—

''(i) affecting the application of section 1931;

''(ii) affecting any application requirements established under this title or by regulation promulgated under the authority of this title, including the requirements established under section 1902(a)(8); or

''(iii) conditioning the right of an individual to apply for medical assistance under the State plan under this title upon an application for assistance under any State program funded under part A of title IV.

''(3) ALLOCATION OF ADMINISTRATIVE COSTS.—

''(A) IN GENERAL.—No funds or expenditures described in subparagraph (B) may be used to pay for costs—

''(i) eligible for reimbursement under subsection (a)(7) (or costs that would have been eligible for reimbursement but for this subsection); and

''(ii) allocated for reimbursement to the medicaid program under a plan submitted by a State to the Secretary to allocate administrative costs for public assistance programs.

''(B) FUNDS AND EXPENDITURES.—Subparagraph (A) applies to—

''(i) funds made available to carry out part A of title IV or title XX;

''(ii) expenditures made as qualified State expenditures (as defined in section 409(a)(7)(B);

''(iii) any other Federal funds (except funds provided under subsection (a)(7)); and

''(iv) any other State funds that are—

''(I) expended as a condition of receiving Federal funds; or

''(II) used to match Federal funds under a Federal program other than the medicaid program.''.

(b) COPIES OF REPORT ON REVIEW OF METHODOLOGY USED TO MAKE CERTAIN DETERMINATIONS.—Section 502(b)(2) of the Agricultural Research, Extension, and Education Reform Act of 1998 (Public Law 105–185; 112 Stat. 523) is amended by inserting '', the Committee on Commerce of the House of Representatives, the Committee on Finance of the Senate,'' after ''Representatives''.●

● Mr. ROCKEFELLER. Mr. President, I support the introduction of The Adoption Equality Act of 1998.

I am proud to be a co-sponsor of The Adoption Equality Act of 1998, part of a continuing effort to improve the lives of abused and neglected children in my state of West Virginia and across the nation.

I would like to begin by sharing my special thanks with my colleague and good friend, Senator CHAFEE, not only for his work on this important legislation, but for his ongoing commitment to bringing about meaningful change for America's most vulnerable children. I also want to express my sincere gratitude to the other cosponsors of this bill, Senators DEWINE, KERREY, BOND, LEVIN, LANDRIEU, DORGAN, and MOYNIHAN. I am so pleased to see that the strong and unique bipartisan coalition forged during the adoption debate last fall is continuing the job yet to be done on behalf of abused and neglected children.

Last fall, our bipartisan coalition introduced—and the Senate unanimously passed—The Adoption and Safe Families Act. That legislation, signed into law on November 19, 1997, fundamentally shifted the focus of the American foster system by insisting for the first time that health and safety should be the paramount consideration when a State makes any decision regarding the well-being of an abused and neglected child. That legislation is designed to move children out of foster care and into adoptive homes more quickly than ever before.

I am also proud to report that West Virginia is launching its own special initiative to promote adoption. This June, state officials reported that there were 3003 children in the custody of West Virginia. 870 of these children have adoption as the goal of their permanency plans, and 95% of these children have special needs. The State has committed to hiring additional specialists to provide adoption services and is seeking federal support to enhance these efforts. It is wonderful to know that West Virginia and other states are so enthusiastic about moving forward to promote adoptions and to help children find safe and stable homes.

The Adoption and Safe Families Act took into account the unique circumstances of ''special needs'' children—those children who, for whatever reason, are difficult to place in adoptive homes. States now receive a special bonus for each special needs adoption. Most significantly, the Adoption and Safe Families Act took the first essential step in ensuring ongoing health coverage for all special needs children who are adopted into new families.

While I am satisfied that The Adoption and Safe Families Act will strengthen the American foster care system, I made it clear that it was only the first step in many to make things significantly better for abused and neglected children.

The Adoption Equality Act is an essential second step in this ongoing process. This important legislation will promote and increase adoptions by making all special needs children eligible for Federal adoption subsidies. This bill is designed to ''level the playing field'' by ensuring that all loving adoptive families have the support they need to address the fundamental needs of the children they raise.

Federal adoption subsidies, already authorized under section IV–E of the Social Security Act, usually take the form of monthly payments provided to families who adopt special needs children. These payments provide essential income support to help families finance the daily costs of raising these children and to cover the expense of special services. Federal adoption subsidies play a vital role in the lives of thousands of special needs children. Many families that I have visited in West Virginia and across the country have told me that without this essential support, they would not have been able to afford to take in the children who have become such an important part of their family.

This bill will fix the one remaining barrier that keeps many adoptive families from accessing precious Federal adoption subsidies. Under current law, a special needs child is only eligible for Federal adoption subsidies if his biological family was poor enough to qualify for welfare benefits under the now-defunct Aid to Families with Dependent Children Program (AFDC). If his family doesn't qualify under 1994 AFDC standards, even the hardest to place child cannot receive federal adoption subsidies.

In other words, a special needs child's eligibility for federal adoption subsidies is dependent on the income of the parents that abused or neglected him. This is simply wrong.

The Adoption Equality Act will eliminate this tragic anomaly in Federal law by making all special needs children eligible for Federal adoption subsidies. This is a responsible way to make sure that willing adoptive families have the support that they need to take care of all the needs of their new child, whether those include food and clothing, therapy, tutoring, or a new addition to their home.

Throughout my travels as the Chair of the National Commission on Children and my meetings with families in West Virginia, I have observed a recurring theme. I have come to understand that in many cases, a family wants to adopt a child more than anything. And yet, there is often a barrier that stands in its way. The lack of adequate financial resources is at the top of that list. This legislation help alleviate this unnecessary burden.

In closing, I want to reiterate a point that I made during the debate over the Adoption and Safe Families Act. At the heart of the ongoing discussions about what is the best policy for abused and neglected children, there have been many complex questions raised about how Federal taxpayer dollars should be spent and who is worthy of receiving them. As we struggle with these difficult issues—which often pit social against fiscal responsibility—I keep returning to the same fundamental lesson I have learned from the families I have met: if we cannot build social policy that not only protects our children, but gives them the best possible chance to succeed in life, we have failed to do our job as a government and a society.

The Adoption Equality Act is designed to make sure that all abused and neglected children, even the most vulnerable special needs kids, have this real chance for security and happiness.●

By Mr. DODD (for himself and Mr. BENNETT):

S. 2409. A bill to amend the Internal Revenue Code of 1986 to allow a tax credit for business-provided student education and training; to the Committee on Finance.

BUSINESSES EDUCATING STUDENTS IN TECHNOLOGY (BEST) ACT

● Mr. DODD. Mr. President, today I introduce legislation, along with my distinguished colleague from Utah, Senator BENNETT, to help alleviate a serious shortage of students graduating from our nation's colleges and universities with technology-based education and skills.

Technology is reshaping our world at a rapid pace. Competition to meet the needs, wants, and expectations of consumers has accelerated the rate of technological progress to a level inconceivable even just a few decades ago. Today, technology is playing an increasingly important role in the lives of every American and is a key ingredient to sustaining America's economic growth. It is the wellspring from which new businesses, high-wage jobs, and a rising quality of life will flow in the 21st century.

Today, we are fortunate that our economy is strong. We have created more than 16 million new jobs since 1993. We have the lowest unemployment in 28 years, the smallest welfare rolls in 27 years, and the lowest inflation in 32 years. If we want to build on this progress, we must encourage our people to develop and use emerging technologies.

Technological progress is the single most important determining factor in sustaining growth in our economy. It is estimated that technological innovation has accounted for as much as half

the nation's long-term economic growth over the past 50 years and is expected to account for an even higher percentage in the next 50 years.

And yet, there is mounting evidence that we are not doing enough to help our people make the most of technological change. Our businesses are practically desperate for workers with skills in computers and other technologically advanced systems. More than 350,000 information technology positions are currently unfilled throughout the United States. The number of students graduating from colleges with computer science degrees has declined dramatically. In my home state of Connecticut, public and private colleges combined produced only 299 computer science graduates in 1997, a 50 percent decline from 1987. We are not alone. Nationwide, the number of graduates with bachelor's degrees in computer science dropped 43 percent between 1986 and 1994.

The Department of Commerce estimates that 1.3 million new jobs will be created over the next decade for systems analysts, computer engineers and computer scientists. Yet, at a time when our nation is struggling to fill these positions, our colleges are graduating fewer skilled information technology students.

At large and mid-sized companies there is one vacancy for every 10 information technology jobs, and eight out of 10 companies expect to hire information technology workers in the year ahead. According to the U.S. Bureau of Labor Statistics, this trend will only continue through 2006.

This shortage of skilled and knowledgeable workers is perhaps the most significant threat to our continued economic expansion. Clearly, we must do more as a country to eliminate this shortage.

We need to turn our attention to our work force and focus on it as a critical part of our economic development. We must put more emphasis on human capital, and we need to educate more students in the diverse areas of technology.

In Connecticut, many businesses are taking initiatives to do so. They are establishing scholarships, donating lab equipment, planning curricula, and sending employees into schools to instruct and help prepare students for technology-based jobs.

One Connecticut company, The Pfizer Corporation, recently announced that it will spend $19 million to build an animal vaccine research laboratory at The University of Connecticut. This partnership will not only lead to advancements in gene technology and animal health, but it will also promote joint research projects in which company scientists will work alongside professors and students.

Another example in Connecticut is the support provided to the biotechnology program at Middlesex Community-Technical College by The Bristol Myers Squibb Pharmaceutical Research Institute and the CuraGen Corporation. These companies have established scholarships, donated lab equipment, and encouraged their research scientists to give lectures to the students.

And yet, Mr. President, businesses and academic institutions shouldn't have to tackle alone the challenge of helping students obtain the learning and skills they need to succeed in the coming century. The federal government can and should work with our technology-based businesses and places of learning to encourage innovation and education that will create jobs and prosperity for our people.

That is why I am pleased to introduce legislation today that will encourage businesses to work in and with educational institutions in order to improve technology-based learning—so that more of our students will be able to win the best jobs of the 21st century economy.

This bill will give a tax credit to any business that goes into a university, college, or community-technical school and engages in technology-based educational activities which are directly related to the business of that company.

Businesses could claim a tax credit for 40 percent of these educational expenses, up to a maximum of $100,000 for any one company.

It is my hope, Mr. President, that this tax credit will provide the incentive for more of our nation's companies to play an active role in the education, training, and skill development of our nation's most valuable resource—its students.

If businesses take advantage of this credit, not only will they have a larger pool of skilled workers to draw from, but our nation will have a better-educated population that possesses the knowledge to succeed in the information-based economy of the future.

I urge my colleagues to join me in supporting this legislation. I ask unanimous consent that a copy of this legislation be printed in the RECORD.

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

S. 2409

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 ''Businesses Educating Students in Technology (BEST) Act''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) Technological progress is the single most important determining factor in sustaining growth in the Nation's economy. It is estimated that technological innovation has accounted for as much as half the Nation's long-term economic growth over the past 50 years and will account for an even higher percentage in the next 50 years.

(2) The number of jobs requiring technological expertise is growing rapidly. For example, it is estimated that 1,300,000 new computer engineers, programmers, and systems analysts will be needed over the next decade in the United States economy. Yet, our Nation's computer science programs are only graduating 25,000 students with bachelor's degrees yearly.

(3) There are more than 350,000 information technology positions currently unfilled throughout the United States, and the number of students graduating from colleges with computer science degrees has declined dramatically.

(4) In order to help alleviate the shortage of graduates with technology-based education and skills, businesses in a number of States have formed partnerships with colleges, universities, community-technical schools, and other institutions of higher learning to give lectures, donate equipment, plan curricula, and perform other activities designed to help students acquire the skills and knowledge needed to fill jobs in technology-based industries.

(5) Congress should encourage these partnerships by providing a tax credit to businesses that enter into them. Such a tax credit will help students obtain the knowledge and skills they need to obtain jobs in technology-based industries which are among the best paying jobs being created in the economy. The credit will also assist businesses in their efforts to develop a more highly-skilled, better trained workforce that can fill the technology jobs such businesses are creating.

SEC. 3. ALLOWANCE OF CREDIT FOR BUSINESS-PROVIDED STUDENT EDUCATION AND TRAINING.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business related credits) is amended by adding at the end the following:

''SEC. 45D. BUSINESS-PROVIDED STUDENT EDUCATION AND TRAINING.

''(a) ALLOWANCE OF CREDIT.—For purposes of section 38, the business-provided student education and training credit determined under this section for the taxable year is an amount equal to 40 percent of the qualified student education and training expenditures of the taxpayer for such taxable year.

''(b) DOLLAR LIMITATION.—The credit allowable under subsection (a) for any taxable year shall not exceed $100,000.

''(c) DEFINITIONS.—For purposes of this section—

''(1) QUALIFIED STUDENT EDUCATION AND TRAINING EXPENDITURE.—

''(A) IN GENERAL.—The term 'qualified student education and training expenditure' means—

''(i) any amount paid or incurred by the taxpayer for the qualified student education and training services provided by any employee of the taxpayer, and

''(ii) the basis of the taxpayer in any tangible personal property contributed by the taxpayer and used in connection with the provision of such services.

''(B) EXCLUSION FOR AMOUNTS FUNDED BY GRANTS, ETC.—The term 'qualified student education and training expenditure' shall not include any amount to the extent such amount is funded by any grant, contract, or otherwise by another person (or any governmental entity).

''(2) QUALIFIED STUDENT EDUCATION AND TRAINING SERVICES.—

''(A) IN GENERAL.—The term 'qualified student education and training services' means technology-based education and training of students in any eligible educational institution in employment skills related to the trade or business of the taxpayer.

''(B) ELIGIBLE EDUCATIONAL INSTITUTION.—The term 'eligible educational institution' has the meaning given such term by section 529(e)(5).

''(d) SPECIAL RULES.—For purposes of this section—

''(1) AGGREGATION RULES.—All persons which are treated as a single employer under subsections (a) and (b) of section 52 shall be treated as a single taxpayer.

''(2) PASS-THRU IN THE CASE OF ESTATES AND TRUSTS.—Under regulations prescribed by the Secretary, rules similar to the rules of subsection (d) of section 52 shall apply.

''(3) ALLOCATION IN THE CASE OF PARTNERSHIPS.—In the case of partnerships, the credit shall be allocated among partners under regulations prescribed by the Secretary.

''(f) NO DOUBLE BENEFIT.—No deduction or credit shall be allowed under any other provision of this chapter with respect to any expenditure taken into account in computing the amount of the credit determined under this section.''

(b) CONFORMING AMENDMENTS.—

(1) Section 38(b) of the Internal Revenue Code of 1986 is amended—

(A) by striking out ''plus'' at the end of paragraph (11),

(B) by striking out the period at the end of paragraph (12), and inserting a comma and ''plus'', and

(C) by adding at the end the following:

''(13) the business-provided student education and training credit determined under section 45D.''

(2) The table of sections for subpart D of part IV of subchapter A of chapter 1 of such Code is amended by adding at the end the following:

''Sec. 45D. Business-provided student education and training credit.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998.●

By Mr. GRAHAM (for himself, Mr. MOYNIHAN, and Mr. D'AMATO):

S. 2410. A bill to amend titles XIX and XXI of the Social Security Act to give States the options of providing medical assistance to certain legal immigrant children and to increase allotments to territories under the State Children's Health Insurance Program; to the Committee on Finance.

MEDICAID CHILDREN'S HEALTH IMPROVEMENT AMENDMENTS OF 1998

● Mr. GRAHAM. Mr. President, today, along with Senators MOYNIHAN and D'AMATO, I introduce the Medicaid Children's Health Improvement Amendments of 1998. This legislation, which was introduced in the House of Representatives last week, would attempt to correct a situation currently jeopardizing the health of many of the children living in our territories.

Last year Congress passed what was the single largest investment in health care for children since the passage of Medicaid in 1965.'' As a result, the United States will invest an additional $24 billion in children's health care over the next five years. However, not all of our nation's poor children are celebrating this victory.

In the negotiations over the budget reconciliation, the initial proposal providing 1.5 percent of the funding to our nation's territories, which represented a fair distribution, was reduced to a mere 0.25 percent. The children's health care program ultimately included in the Balanced Budget Act of 1997 provides Puerto Rico with approximately 0.22 percent of the overall national funding for the program and 0.03 percent for Guam, the U.S. Virgin Islands, American Samoa and the Northern Mariana Islands. For Puerto Rico alone this would mean less than $11 million per year for a jurisdiction with close to four million U.S. citizens.

It is absolutely outrageous that the United States would continue to endorse a discriminatory policy that denies equal health care to the children of its territories. If this legislation was enacted most of Guam's 5,000 uninsured children would finally receive the coverage that they rightfully deserve. It would also approximately multiply the number of children covered in the U.S. Virgin Islands by six.

In addition to providing additional funding for the children's health insurance program in our territories, this legislation includes a provision that would grant states the option to provide health care coverage to legal immigrant children who entered the United States on or after August 22, 1996. Welfare reform prohibits states from covering these immigrant children.

As we know, children without health insurance do not get important care for preventable diseases. Many uninsured children are hospitalized for acute asthma attacks that could have been prevented, or suffer from permanent hearing loss from untreated ear infections. Without adequate health care, common illnesses can turn into lifelong crippling diseases, whereas appropriate treatment and care can help children with diseases like diabetes live relatively normal lives. A lack of adequate medical care will also hinder the social and educational development of children, as children who are sick and left untreated are less able to learn.

I hope that with the help of my colleagues in Congress we will be able to rectify the discrimination against the children of our territories and afford them the same treatment as the other children in the nation. They deserve no less. Programs created to protect our nation's children should represent the highest and most pure ideals of our society.

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. 2410

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 ''Medical and Children's Health Improvement Amendments of 1998''.

SEC. 2. STATE OPTION TO COVER LEGAL IMMIGRANT CHILDREN UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) MEDICAID.—Section 1902(a)(10(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(1) by strike ''or'' at the end of subclause (XIII);

(2) by adding ''or'' at the end of subclause (XIV); and

(3) by adding after subclause (XIV) the following new subclause:

''(XV) who are described in section 1905(a)(i) and who would be eligible for medical assistance (or for a greater amount of medical assistance) under the State plan under this title but for the provisions of section 403 or section 421 of Public Law 104–193, but the State may not exercise the option of providing medical assistance under this subclause with respect to a subcategory of individuals described in this subclause;''.

(b) CHILDREN'S HEALTH INSURANCE PROGRAM.—Section 2110(b) of the Social Security Act (42 U.S.C. 1397jj(b)) is amended—

(1) in paragraph (1)(A), by inserting before the semicolon ''(including, at the option of the State, a child described in paragraph (3)(B))''; and

(2) in paragraph (3)—

(A) by striking ''SPECIAL RULE.—'' and inserting ''SPECIAL RULES.—

''(A) HEALTH INSURANCE COVERAGE.—'';

(B) by intending the remainder of the text accordingly; and

(C) by adding at the end the following new subparagraph:

''(B) ELIGIBILITY FOR LEGAL IMMIGRANT CHILDREN.—For purposes of paragraph (1)(A), a child is described in this subparagraph if—

''(i) the child would be determined eligible for child health assistance under this title but for provisions of sections 403 and section 421 of Public Law 104–193; and

''(ii) the State exercises the option to provide medical assistance to the category of individuals described in section 1902(a)(10)(A)(ii)(XV).''.

SEC. 3. INCREASED ALLOTMENTS UNDER CHILDREN'S HEALTH INSURANCE PROGRAM FOR TERRITORIES.

(a) IN GENERAL.—Section 2104(c) of the Social Security Act (42 U.S.C. 1397dd(c)) is amended by adding at the end the following new paragraph:

''(4) ADDITIONAL ALLOTMENT.—

''(A) IN GENERAL.—In addition to the allotment under paragraph (1), the Secretary shall allot each commonwealth and territory described in paragraph (3) the applicable percentage specified in paragraph (2) of the amount appropriated under subparagraph (B).

''(B) APPROPRIATION.—For purposes of providing allotments pursuant to subparagraph (A), there is appropriated, out of any money in the Treasury not otherwise appropriated—

''(i) $34,200,000 for each of fiscal years 1999 through 2001;

''(ii) $25,200,000 for each of fiscal years 2002 through 2004;

''(iii) $32,400,000 for each of fiscal years 2005 and 2006; and

''(iv) $40,000,000 for fiscal year 2007.''.

(b) CONFORMING AMENDMENT.—Section 2104(b)(1) of such Act (42 U.S.C. 1397dd(b)(1)) is amended by inserting ''(determined without regard to paragraph (4) thereof)'' after ''subsection (c)''.●

By Mr. BURNS (for himself and Mr. HOLLINGS):

S. 2412. A bill to create employment opportunities and to promote economic growth establishing a public-private partnership between the United States travel and tourism industry and every level of government to work to make the United States the premiere travel and tourism destination in the world, and for other purposes; to the Committee on Commerce, Science, and Transportation.

THE VISIT USA ACT

● Mr. BURNS. Mr. President, today I introduce legislation to strengthen

America's tourism and travel related industry—the Value In Supporting International Tourism Act of 1998 (Visit USA Act). This legislation is a follow-on to the National Tourism Act, Public Law 104–288, enacted two years ago.

In the National Tourism Act, Congress created the U.S. National Tourism Organization (USNTO) in order to re-establish the United States as the premiere destination for tourists throughout the world. While international travel and tourism remains the United States largest service export, its third largest industry, and a major producer of jobs and tax revenue for federal, state and local governments, our share of the international tourism market is threatened unless action is taken now.

Public Law 104–288 authorized a public-private partnership, including a broad cross-section of the U.S. travel and tourism industry, charged with working with government to (1) promote and increase the U.S. share of the international tourism market, (2) develop and implement a national travel and tourism strategy, (3) advise the President and Congress on how to implement this strategy and on other critical matters affecting the travel and tourism industry, (4) conduct travel and tourism market research, and (5) promote the interests of the U.S. travel and tourism industry at international trade shows. The USNTO was authorized to conduct activities necessary to advance these national interests.

The USNTO was also charged with developing a long-term financing plan for the organization. On January 14, 1998, the Board of the USNTO fulfilled its statutory mandate by submitting a report to Congress outlining, among other things, a long-term marketing plan to promote the United States as the premiere international travel destination. The Board is firmly committed to work with Congress to secure appropriate funding for an international marketing effort.

Private sector and state support for the promotion of the United States as an international tourist destination exceeds $1 billion annually. This support, together with the commitment of the USNTO Board of Directors to use only non-governmental sources of funding for all USNTO general and administrative costs, provides a substantial commitment from the ''private'' side of the partnership and a foundation for a successful public-private partnership.

The Visit USA Act establishes an international visitor assistance task force. This interagency body will support the creation of a toll-free telephone line to assist foreign tourists visiting the United States. It will also work to improve signage at airports and other key travel facilities, and facilitate distribution of multilingual travel and tourism materials. Each of these activities is intended to be conducted at minimal or zero cost to the federal government.

This legislation also requires the Secretary of Commerce to report to Congress on how federal lands are used and on how they may have influenced the tourism market, on any changes in the international tourist commerce, on the impact tourism has on the U.S. economy, and on our balance of trade.

The facts concerning the increasingly competitive international tourism justify this legislative approach. While competition for the international tourism dollar has become one among national governments, the U.S. government is the only major industrialized nation that does not promote its tourism market abroad. Other governments spend millions on tourism marketing. In 1995, for example, Australia spent $88 million, the UK and Spain each spent $79 million, and France spent $73 million to promote tourism.

Tourism is a significant element of the U.S. economy. The industry that depends on spending by foreign tourists is diverse, and includes restaurants, hotels, travel agencies, shops, tour bus services, rental car agencies, theaters, airlines, and theme parks. In particular, small businesses depend on revenues from international tourism.

I encourage all Senators to join in supporting this important effort to strengthen our tourism-related economy. The dividends to be realized as a result of this modest investment will benefit every state and every congressional district.●

● Mr. HOLLINGS. Mr. President, today Senator BURNS and I are introducing a bill, the Visit USA Act, which will further the international standing of the U.S. travel and tourism industry. As co-chairman of the United States Senate Tourism Caucus along with Senator BURNS, I know that the tourism industry is a winner for the United States. The Visit USA Act would improve U.S. international marketing and services to travelers in the United States by: creating a toll-free number for international travelers to call for assistance in their native language; improving signs in transportation facilities; and authorizing appropriations for the marketing program of the U.S. National Tourism Organization (NTO).

Tourism is more than cameras and Bermuda shorts. Travel and tourism is a big business. Last year it produced a record $26 billion trade surplus, and the industry continues to grow. In my state of South Carolina, tourism generates over $6.5 billion and is responsible for 113,000 jobs. Over 46 million international visitors came to the United States and spent over $90 billion in 1997. These visitors generated more than $5 billion in Federal taxes alone. To compete with other nations for a larger share of international tourism over the next decade, we must support an international tourism marketing effort. The Visit USA Act would do just that by providing for international promotion of the United States while making travel to this country simpler and more understandable for our foreign guests.

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

S. 2413. A bill to provide for the development of a management plan for the Woodland Lake Park tract in Apache-Sitgreaves National Forest in the State of Arizona reflecting the current use of the tract as a public park; to the Committee on Energy and Natural Resources.

APACHE-SITGREAVES NATIONAL FOREST LEGISLATION

● Mr. MCCAIN. Mr. President, I am proud to introduce legislation, along with my colleague, Senator JON KYL, that will preserve a valuable tract of park land for future public enjoyment in the Apache-Sitgreaves National Forest in Pinetop-Lakeside, Arizona. This proposal authorizes the U.S. Forest Service to develop a management plan to maintain the current recreational use of 583 acres known as Woodland Lake Park.

Mr. President, I want to laud the cooperation forged between the U.S. Forest Service and the town of Pinetop-Lakeside. The initiative requires the acting supervisor of the Apache-Sitgreaves National Forest, under the direction of the Secretary of Agriculture, to work with the town to ensure Woodland Lake Park remains open and accessible to the public. The parties will have 180 days to draft a management plan for the park.

Although the town of Pinetop-Lakeside seeks to one day acquire Woodland Lake Park, the management of this land by the Forest Service is crucial to preserving this resource in the interim. Federal oversight will ensure that the estimated 50,000 residents every year who take pleasure in the lake and along the beautiful wooded trails will continue to do so for years to come.

I look forward to continued constructive collaboration between the Forest Service and the town of Pinetop-Lakeside. I ask unanimous consent that the legislation be entered into the RECORD.

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. 2413

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

SECTION 1. MANAGEMENT OF WOODLAND LAKE PARK TRACT, APACHE-SITGREAVES NATIONAL FOREST, ARIZONA, FOR RECREATIONAL PURPOSES.

(a) MANAGEMENT PLAN REQUIRED.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Agriculture, acting through the supervisor of Apache-Sitgreaves National Forest in the State of Arizona, shall prepare a management plan for the Woodland Lake Park tract that is designed to ensure that the tract is managed by the Forest Service for recreational purposes consistent with the use of the tract as a public park by the town of Pinetop-Lakeside, Arizona. The forest supervisor shall prepare the management plan in consultation with the town of Pinetop-Lakeside.

(b) PROHIBITION ON CONVEYANCE.—The Secretary of Agriculture may not convey any right, title, or interest of the United States in and to the Woodland Lake Park tract unless the conveyance of the tract—

(1) is made to the town of Pinetop-Lakeside; or

(2) is specifically authorized by a law enacted after the date of the enactment of this Act.

(c) DEFINITION.—The terms ''Woodland Lake Park tract'' and ''tract'' mean the parcel of land in Apache–Sitgreaves National Forest in the State of Arizona that consists of approximately 583 acres and is known as the Woodland Lake Park tract.●

● Mr. KYL. Mr. President, the U.S. Forest Service owns a large parcel of land within the boundaries of the town of Pinetop-Lakeside which has historically been used as a park, not only by the town residents, but also by the thousands of tourists who vacation in this bucolic area of Eastern Arizona each year. The town wants to maintain this land as a park. However, the Forest Service has refused to renew the town's special use permit for the largest section of this park, possibly paving the way for the land to be sold to private investors. The bill that Senator MCCAIN and I are introducing, and Representative HAYWORTH is introducing in the House, prevents the Forest Service from selling the land to any entity other than the town, and requires the Forest Service, in conjunction with the town, to develop a management plan ''designed to ensure that the tract is managed by the Forest Service for recreational purposes.''

Mr. President, the town of Pinetop-Lakeside has been trying to find a way to acquire this parcel from the Forest Service for over 10 years, to no avail. This bill will satisfy the town's goal of preserving this land as a park, while being fair to the American taxpayer. However, the legislation will not solve the problems of communities that seek to acquire Forest Service lands to preserve open space, or to fulfill other essential governmental functions. I intend to continue to seek a long-term solution to those problems.●

By Mr. BURNS.

S. 2414. A bill to establish terms and conditions under which the Secretary of the Interior shall convey leaseholds in certain Properties around Canyon Ferry Reservoir, Montana; to the Committee on Energy and Natural Resources.

CANYON FERRY RESERVOIR LEGISLATION

● Mr. BURNS. Mr. President, today I introduce a companion bill to one recently introduced in the House by Congressman RICK HILL, of Montana. This is a bill that will authorize the Bureau of Reclamation to convey certain properties around Canyon Ferry Reservoir in Montana to leaseholders. This bill has the support of a number of organizations, groups and communities in the area of Canyon Ferry and in Montana in general.

The purpose of my bill today, is to get the ball rolling on this legislation. I am aware that currently there is legislation in the Environment and Public Works Committee of a similar nature. But it appears stalled, and does not address the concerns of a number of the groups and communities in the area around Canyon Ferry. The bills basically address the conveyance of this land in the same way, but it is the disposal of the funds received that changes these two bills. So I come here today to propose this legislation to accelerate the process and get Congress involved and moving on this very issue.

I have made a pledge to the people in this area of Montana that I will do all I can to assist them in getting something done on this bill this session before we leave for the year. These people have attempted to work with the Bureau of Reclamation to clear up a number of issues which have come up over the past five or more years. The result of their work has been continued stalling by the Bureau of Reclamation in working with the citizens. As a result then we have been forced to work on legislation that will remove the stumbling blocks and rectify and clarify the situation.

Senator BAUCUS, Congressman HILL and I have worked for the past year developing legislation to address the concerns of these people. We have come ninety percent of the way and now it is necessary for us to move that extra ten percent and get something done to the benefit of the general public and the citizens of Montana.

Canyon Ferry is a man-made reservoir on the Missouri River in Central Montana right outside of our capital Helena. It is a wonderful area for outdoor recreation and draws people from all over the state and in many cases all across the nation. There are a number of people who have built cabin sites on the lake both for the purpose of weekend living but also there are a number of year around residences.

This legislation will work to continue to provide opportunities for all people to enjoy the splendor of Canyon Ferry. In addition there will be ample opportunity for the surrounding communities to develop new ways for the public to enjoy the lake and the various recreational facilities around the lake. The citizens of Montana expect and deserve an opportunity to enjoy this wonderful area. The funds derived from the conveyance of these properties will allow for the continued construction of facilities that will allow more Montanans a chance to enjoy Canyon Ferry.

I give my pledge to the people of Montana that I will continue to work this issue with the members of the Montana delegation, Senator BAUCUS and Congressman HILL to clear this bill and get something done. I know the majority of people in the area want to see something done, and this is the vehicle to do that. I look forward to working with the Chairman of the Energy and Natural Resources Committee to get this done and out as soon as possible.●

By Mr. SANTORUM:

S. 2415. A bill to amend the Internal Revenue Code of 1986 to reduce the tax on beer to its pre-1991 level; to the Committee on Finance.

REPEALING THE BEER TAX

Mr. SANTORUM. Mr. President, I today introduce legislation pertaining to the federal excise tax on beer.

The federal excise tax on beer was doubled as part of the 1991 Omnibus Budget Reconciliation Act. Today, it remain as the only ''luxury tax'' enacted as part of OBRA '91. While taxes on furs, jewelry, and yachts were repealed through subsequent legislation, the federal beer tax remains in place with continued and far reaching negative effects.

The excise tax on beer is among the more regressive federal taxes. Since the 100 percent tax was levied in 1991, it has cost the industry as many as 50,000 jobs. Beer in particular continues to suffer under a disproportionate burden of taxation. Forty-three percent of the cost of beer is comprised of both state and federal taxes. This legislation seeks to correct this inequity and will restore the level of federal excise tax to the pre-1991 tax rate.

Mr. President, this bill represents companion legislation to H.R. 158, introduced by Representative PHIL ENGLISH. The House bill currently carries 95 cosponsors. I commend this Senate legislation to my colleagues for their consideration.

By Mr. CHAFEE (for himself, Mr. GRAHAM, Mr. LIEBERMAN, Mr. SPECTER, and Mr. BAUCUS):

S. 2416. A bill to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to protect consumers in managed care plans and other health coverage; to the Committee on Finance.

PROMOTING RESPONSIBLE MANAGED CARE ACT OF 1998

● Mr. CHAFEE. Mr. President, today, I am pleased to join with Senators BOB GRAHAM, JOE LIEBERMAN, ARLEN SPECTER and MAX BAUCUS in introducing a bipartisan managed care reform bill—the Promoting Responsible Managed Care Act of 1998.

In November 1997, a number of us formed the bipartisan, bicameral Congressional Task Force on Health Care Quality to better understand the mounting public frustration over managed care. The task force heard from numerous consumer and provider groups, and received presentations from the sponsors of all of the major managed care reform bills now pending in Congress. The bill we are introducing today, the Promoting Responsible Managed Care Act of 1998, has benefited greatly from the efforts of the task force, and we wish to thank all participants, on both sides of the aisle, for their attentiveness and diligence.

This legislation was developed in accordance with the following principles:

Bipartisan legislation which can be enacted this year.

Provides all Americans in privately insured health plans with basic federal protections.

Meaningful enforcement which holds managed care plans accountable, and provides individuals harmed by such plans with just compensation.

Report cards to enable consumers to make informed health care choices based on plan performance.

As my colleagues well know, next month the Senate is headed for a polarized debate on managed care reform, which may well result in gridlock. Each party has put forward a plan which contains features unacceptable to the other side—such as exposing insurers to lawsuits in state court in the case of the Daschle plan, and the broad expansion of medical savings accounts (MSAs) in the case of the Nickles plan.

It is for this very reason that we have put forward a bipartisan plan—one which blends the best features of both the Democratic and Republican plans, but omits the so-called poison pills. When it comes to restoring public confidence in managed care and ensuring a basic floor of federal patient protections, gridlock simply will not be an acceptable outcome.

We believe Congress has the responsibility to step up to the plate in the remaining weeks of this session and to enact legislation which the President can sign into law to address the outstanding concerns Americans have about their managed care. Indeed, despite continuing opposition from the insurance industry to the enactment of any reform legislation, many of the managed care industry's own leaders have privately expressed concern about the future of managed care if legislative action is not taken soon to strengthen public confidence.

In our estimation, given the hardened positions of both parties, the only way Congress can succeed in that endeavor this year is for a bipartisan centrist plan to emerge once it becomes clear that neither the Daschle or Nickles plan has the requisite support to cross the finish line.

What we would like to do now is to take a few minutes to lay out the key components of our proposal. First, I will talk about the scope of the bill—a topic which you will be hearing a lot about in the coming weeks. Then, Senator GRAHAM will outline our patient protection provisions, and Senator LIEBERMAN will discuss the importance of arming consumers with meaningful Report Card information, and a credible enforcement regime to ensure that managed care plans play by the rules.

In 1996, Congress passed significant reforms of the private health insurance marketplace with respect to the issue of portability. The Health Insurance Portability and Accountability Act, also known as the Kassebaum-Kennedy bill, established a federal floor of portability protections for all 161 million privately insured Americans.

We see no reason for narrowing the scope of the patient protections in this next and far more consequential area of reform. Thus, like the Daschle plan and the House-passed GOP bill, the Promoting Responsible Managed Care Act would apply to all privately insured Americans.

This approach preserves state prerogatives to enact more stringent standards, while assuring a minimum floor of federal protections for all Americans in private health plans—whether those plans are regulated at the state or federal level. In contrast, the Senate Republican plan proposes to provide a more limited range of patient protections to a much narrower band of the American population—primarily those 48 million enrollees in self-funded ERISA plans.

While it is true that individuals in these plans have fewer protections than those in state-regulated plans, that alone is insufficient reason for denying these basic quality improvements and safeguards to all 161 million Americans in privately insured managed care plans. Such a bifurcation would, in our judgment, create many unnecessary and inequitable circumstances for consumers, and exacerbate the already unlevel playing field which exists in the health insurance marketplace.

Mr. President, I ask unanimous consent that the bill, a summary of the bill, and excerpts of what organizations are saying about the Promoting Responsible Managed Care Act be printed in the RECORD.

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

S. 2416

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 ''Promoting Responsible Managed Care Act of 1998''.

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

SEC. 2. DEFINITIONS.

(a) INCORPORATION OF GENERAL DEFINITIONS.—The provisions of section 2971 of the Public Health Service Act shall apply for purposes of this section, section 3, and title I in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, for purposes of this section and title I, the term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the Secretary of the Treasury, and the term ''appropriate Secretary'' means the Secretary of Health and Human Services in relation to carrying out title I under sections 2706 and 2751 of the Public Health Service Act, the Secretary of Labor in relation to carrying out title I under section 713 of the Employee Retirement Income Security Act of 1974, and the Secretary of the Treasury in relation to carrying out title I under chapter 100 and section 4980D of the Internal Revenue Code of 1986.

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

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

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

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

(2) CLINICAL PEER.—The term ''clinical peer'' means, with respect to a review or appeal, a physician (allopathic or osteopathic) or other health care professional who holds a non-restricted license in a State and who is appropriately credentialed, licensed, certified, or accredited in the same or similar specialty as manages (or typically manages) the medical condition, procedure, or treatment under review or appeal and includes a pediatric specialist where appropriate; except that only a physician may be a clinical peer with respect to the review or appeal of treatment rendered by a physician.

(3) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional provider of health care services.

(4) NONPARTICIPATING.—The term ''nonparticipating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under a group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(5) PARTICIPATING.—The term ''participating'' mean, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under a group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

SEC. 3. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), title I shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of such title.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in title I shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(3) CONSTRUCTION WITH RESPECT TO TIME PERIODS.—Subject to paragraph (2), nothing in title I shall be construed to prohibit a State from establishing, implementing, or continuing in effect any requirement or standard that uses a shorter period of time, than that provided under such title, for any internal or external appeals process to be used by health insurance issuers.

(b) RULES OF CONSTRUCTION.—Nothing in title I (other than section 128) shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

(c) DEFINITIONS.—For purposes of this section:

(1) STATE LAW.—The term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) INCLUSION OF POLITICAL SUBDIVISIONS OF A STATE.—The term ''State'' also includes any political subdivisions of a State or any agency or instrumentality thereof.

(d) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

(1) IN GENERAL.—Nothing in this Act (or the amendments made thereby) shall be construed to—

(A) restrict or limit the right of group health plans, and of health insurance issuers offering health insurance coverage in connection with group health plans, to include as providers religious nonmedical providers;

(B) require such plans or issuers to—

(i) utilize medically based eligibility standards or criteria in deciding provider status of religious nonmedical providers;

(ii) use medical professionals or criteria to decide patient access to religious nonmedical providers;

(iii) utilize medical professionals or criteria in making decisions in internal or external appeals from decisions denying or limiting coverage for care by religious nonmedical providers; or

(iv) compel a participant or beneficiary to undergo a medical examination or test as a condition of receiving health insurance coverage for treatment by a religious nonmedical provider; or

(C) require such plans or issuers to exclude religious nonmedical providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the provider.

(2) RELIGIOUS NONMEDICAL PROVIDER.—For purposes of this subsection, the term ''religious nonmedical provider'' means a provider who provides no medical care but who provides only religious nonmedical treatment or religious nonmedical nursing care.

SEC. 4. REGULATIONS.

The Secretaries of Health and Human Services, Labor, and the Treasury shall issue such regulations as may be necessary or appropriate to carry out this Act. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this Act.

TITLE I—PROMOTING RESPONSIBLE MANAGED CARE

Subtitle A—Grievance and Appeals

SEC. 101. DEFINITIONS AND GENERAL PROVISIONS RELATING TO GRIEVANCE AND APPEALS.

(a) DEFINITIONS.—In this subtitle:

(1) AUTHORIZED REPRESENTATIVE.—The term ''authorized representative'' means, with respect to a covered individual, an individual who—

(A) is—

(i) any treating health care professional of the covered individual (acting within the scope of the professional's license or certification under applicable State law), or

(ii) any legal representative of the covered individual (or, in the case of a deceased individual, the legal representative of the estate of the individual),

regardless of whether such professional or representative is affiliated with the plan or issuer involved; and

(B) is acting on behalf of the covered individual with the individual's consent.

(2) COVERAGE DETERMINATION.—The term ''coverage determination'' means a determination by a group health plan or a health insurance issuer with respect to any of the following:

(A) A decision whether to pay for emergency services (as defined in section 121(a)(2)(B)).

(B) A decision whether to pay for health care services not described in subparagraph (A) that are furnished by a provider that is a participating health care provider with the plan or issuer.

(C) A decision whether to provide benefits or payment for such benefits.

(D) A decision whether to discontinue a benefit.

(E) A decision resulting from the application of utilization review (as defined in section 102(a)(1)(C)).

Such term includes, pursuant to section 104(d)(2), the failure to provide timely notice under section 104(d).

(3) COVERED INDIVIDUAL.—The term ''covered individual'' means an individual who is a participant or beneficiary in a group health plan or an enrollee in health insurance coverage offered by a health insurance issuer.

(4) GRIEVANCE.—The term ''grievance'' means any complaint or dispute other than one involving a coverage determination.

(5) RECONSIDERATION.—The term ''reconsideration'' is defined in section 105(a)(7).

(6) UTILIZATION REVIEW.—The term ''utilization review'' is defined in section 102(a)(1)(C).

(b) SUMMARY OF RIGHTS OF INDIVIDUALS.—In accordance with the provisions of this subtitle, a covered individual has the following rights with respect to a group health plan and with respect to a health insurance issuer in connection with the provision of health insurance coverage:

(1) The right to have grievances between the covered individual and the plan or issuer heard and resolved as provided in section 103.

(2) The right to a timely coverage determination as provided in section 104.

(3) The right to request expedited treatment of a coverage determination as provided in section 104(c).

(4) If dissatisfied with any part of a coverage determination, the following appeal rights:

(A) The right to a timely reconsideration of an adverse coverage determination as provided in section 105.

(B) The right to request expedited treatment of such a reconsideration as provided in section 105(c).

(C) If, as a result of a reconsideration of the adverse coverage determination, the plan or issuer affirms, in whole or in part, its adverse coverage determination, the right to request and receive a review of, and decision on, such determination by a qualified external appeal entity as provided in section 106.

(c) REQUIREMENTS.—

(1) PROCEDURES.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage shall, with respect to the provision of benefits under such plan or coverage—

(A) establish and maintain—

(i) grievance procedures in accordance with section 103;

(ii) procedures for coverage determinations consistent with section 104; and

(iii) appeals procedures for adverse coverage determinations in accordance with sections 105 and 106; and

(B) provide for utilization review consistent with section 102.

(2) DELEGATION.—A group health plan or a health insurance issuer in connection with the provision of health insurance coverage

that delegates any of its responsibilities under this subtitle to another entity or individual through which the plan or issuer provides health care services shall ultimately be responsible for ensuring that such entity or individual satisfies the relevant requirements of this subtitle.

SEC. 102. UTILIZATION REVIEW ACTIVITIES.

(a) IN GENERAL.—

(1) COMPLIANCE WITH REQUIREMENTS.—

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

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

(C) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms ''utilization review'' and ''utilization review activities'' mean procedures used to monitor or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(2) WRITTEN POLICIES AND CRITERIA.—

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

(B) USE OF WRITTEN CRITERIA.—

(i) IN GENERAL.—Such a program shall utilize written clinical review criteria developed pursuant to the program with the input of appropriate physicians. Such criteria shall include written clinical review criteria described in section 114(b)(4)(B).

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

(3) CONDUCT OF PROGRAM ACTIVITIES.—

(A) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—

(i) IN GENERAL.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions.

(ii) HEALTH CARE PROFESSIONAL DEFINED.—In this subsection, the term ''health care professional'' means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with State law.

(B) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

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

(ii) PEER REVIEW OF SAMPLE OF ADVERSE CLINICAL DETERMINATIONS.—Such a program shall provide that clinical peers (as defined in section 2(c)(2)) shall evaluate the clinical appropriateness of at least a sample of adverse clinical determinations.

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

(I) provides direct or indirect incentives for such persons to make inappropriate review decisions; or

(II) is based, directly or indirectly, on the quantity or type of adverse determinations rendered.

(iv) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who provides health care services to a covered individual to perform utilization review activities in connection with the health care services being provided to the individual. A group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, may not retaliate against a covered individual or health care provider based on such individual's or provider's use of, or participation in, the utilization review program under this section.

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

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

(E) LIMITATION ON INFORMATION REQUESTS.—Such a program shall provide that information shall be required to be provided by health care providers only to the extent it is necessary to perform the utilization review activity involved.

(F) REVIEW OF PRELIMINARY UTILIZATION REVIEW DECISION.—Such a program shall provide that a covered individual who is dissatisfied with a preliminary utilization review decision has the opportunity to discuss the decision with, and have such decision reviewed by, the medical director of the plan or issuer involved (or the director's designee) who has the authority to reverse the decision.

(b) STANDARDS RELATING TO MEDICAL DECISION MAKING.—

(1) IN GENERAL.—In providing for a coverage determination in the process of carrying out utilization review, a group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, may not arbitrarily interfere with or alter the decision of the treating physician if the services are medically necessary or appropriate for treatment or diagnosis to the extent that such treatment or diagnosis is otherwise a covered benefit.

(2) CONSTRUCTION.—Paragraph (1) shall not be construed as prohibiting a plan or issuer from limiting the delivery of services to one or more health care providers within a network of such providers.

(3) NO CHANGE IN COVERAGE.—Paragraph (1) shall not be construed as requiring coverage of particular services the coverage of which is otherwise not covered under the terms of the plan or coverage or from conducting utilization review activities consistent with this section.

(4) MEDICAL NECESSITY OR APPROPRIATENESS DEFINED.—In paragraph (1), the term ''medically necessary or appropriate'' means, with respect to a service or benefit, a service or benefit which is consistent with generally accepted principles of professional medical practice.

SEC. 103. ESTABLISHMENT OF PROCESS FOR GRIEVANCES.

(a) ESTABLISHMENT.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall provide meaningful procedures for timely hearing and resolution of grievances brought by covered individuals regarding any aspect of the plan's or issuer's services, including a decision not to expedite a coverage determination or reconsideration under section 104(c)(4)(B)(ii)(II) or 105(c)(4)(B)(ii)(II).

(b) GUIDELINES.—The grievance procedures required under subsection (a) shall meet all guidelines established by the appropriate Secretary.

(c) DISTINGUISHED FROM COVERAGE DETERMINATIONS AND APPEALS.—The grievance procedures required under subsection (a) shall be separate and distinct from procedures regarding coverage determinations under section 104 and reconsiderations under section 105 and external reviews by a qualified external appeal entity under section 106 (which address appeals of coverage determinations).

SEC. 104. COVERAGE DETERMINATIONS.

(a) REQUIREMENT.—

(1) RESPONSIBILITIES.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain procedures for making timely coverage determinations (in accordance with the requirements of this section) regarding the benefits a covered individual is entitled to receive from the plan or issuer, including the amount of any copayments, deductibles, or other cost sharing applicable to such benefits. Under this section, the plan or issuer shall have a standard procedure for making such determinations, and procedures for expediting such determinations in cases in which application of the standard deadlines could seriously jeopardize the covered individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development.

(2) PARTIES WHO MAY REQUEST COVERAGE DETERMINATIONS.—Any of the following may request a coverage determination relating to a covered individual and are parties to such determination:

(A) The covered individual and an authorized representative of the individual.

(B) A health care provider who has furnished an item or service to the individual and formally agrees to waive any right to payment directly from the individual for that item or service.

(C) Any other provider or entity (other than the group health plan or health insurance issuer) determined by the appropriate Secretary to have an appealable interest in the determination.

(3) EFFECT OF COVERAGE DETERMINATION.—A coverage determination is binding on all parties unless it is reconsidered pursuant to section 105 or reviewed pursuant to section 106.

(b) DETERMINATION BY DEADLINE.—

(1) IN GENERAL.—In the case of a request for a coverage determination, the group health plan or health insurance issuer shall provide notice pursuant to subsection (d) to the person submitting the request of its determination as expeditiously as the health condition of the covered individual involved requires, but in no case later than deadline established under paragraph (2) or, if a request for expedited treatment of a coverage

determination is granted under subsection (c), the deadline established under paragraph (3).

(2) STANDARD DEADLINE.—

(A) IN GENERAL.—The deadline established under this paragraph is, subject to subparagraph (B), 14 calendar days after the date the plan or issuer receives the request for the coverage determination.

(B) EXTENSION.—The plan or issuer may extend the deadline under subparagraph (A) by up to 14 calendar days if—

(i) the covered individual (or an authorized representative of the individual) requests the extension; or

(ii) the plan or issuer justifies to the applicable authority a need for additional information to make the coverage determination and how the delay is in the interest of the covered individual.

(3) EXPEDITED TREATMENT DEADLINE.—

(A) IN GENERAL.—The deadline established under this paragraph is, subject to subparagraphs (B) and (C), 72 hours after the date the plan or issuer receives the request for the expedited treatment under subsection (c).

(B) EXTENSION.—The plan or issuer may extend the deadline under subparagraph (A) by up to 5 calendar days if—

(i) the covered individual (or an authorized representative of the individual) requests the extension; or

(ii) the plan or issuer justifies to the applicable authority a need for additional information to make the coverage determination and how the delay is in the interest of the covered individual.

(C) HOW INFORMATION FROM NONPARTICIPATING PROVIDERS AFFECTS DEADLINES FOR EXPEDITED COVERAGE DETERMINATIONS.—In the case of a group health plan or health insurance issuer that requires medical information from nonparticipating providers in order to make a coverage determination, the deadline specified under subparagraph (A) shall begin when the plan or issuer receives such information. Nonparticipating providers shall make reasonable and diligent efforts to expeditiously gather and forward all necessary information to the plan or issuer in order to receive timely payment.

(c) EXPEDITED TREATMENT.—

(1) REQUEST FOR EXPEDITED TREATMENT.—A covered individual (or an authorized representative of the individual) may request that the plan or issuer expedite a coverage determination involving the issues described in subparagraphs (C), (D), or (E) of section 101(a)(2).

(2) WHO MAY REQUEST.—To request expedited treatment of a coverage determination, a covered individual (or authorized representative of the individual) shall submit an oral or written request directly to the plan or issuer (or, if applicable, to the entity that the plan or issuer has designated as responsible for making the determination).

(3) PROVIDER SUPPORT.—

(A) IN GENERAL.—A physician or other health care provider may provide oral or written support for a request for expedited treatment under this subsection.

(B) PROHIBITION OF PUNITIVE ACTION.—A group health plan and a health insurance issuer in connection with the provision of health insurance coverage shall not take or threaten to take any punitive action against a physician or other health care provider acting on behalf or in support of a covered individual seeking expedited treatment under this subsection.

(4) PROCESSING OF REQUESTS.—A group health plan and a health insurance issuer in connection with the provision of health insurance coverage shall establish and maintain the following procedures for processing requests for expedited treatment of coverage determinations:

(A) An efficient and convenient means for the submission of oral and written requests for expedited treatment. The plan or issuer shall document all oral requests in writing and maintain the documentation in the case file of the covered individual involved.

(B) A means for deciding promptly whether to expedite a determination, based on the following requirements:

(i) For a request made or supported by a physician, the plan or issuer shall expedite the coverage determination if the physician indicates that applying the standard deadline under subsection (b)(2) for making the determination could seriously jeopardize the covered individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development.

(ii) For another request, the plan or issuer shall expedite the coverage determination if the plan or issuer determines that applying such standard deadline for making the determination could seriously jeopardize the covered individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development.

(5) ACTIONS FOLLOWING DENIAL OF REQUEST FOR EXPEDITED TREATMENT.—If a group health plan or a health insurance issuer in connection with the provision of health insurance coverage denies a request for expedited treatment of a coverage determination under this subsection, the plan or issuer shall—

(A) make the coverage determination within the standard deadline otherwise applicable; and

(B) provide the individual submitting the request with—

(i) prompt oral notice of the denial of the request, and

(ii) within 2 business days a written notice that—

(I) explains that the plan or issuer will process the coverage determination request within the standard deadlines;

(II) informs the requester of the right to file a grievance if the requester disagrees with the plan's or issuer's decision not to expedite the determination; and

(III) provides instructions about the grievance process and its timeframes.

(6) ACTION ON ACCEPTED REQUEST FOR EXPEDITED TREATMENT.—If a group health plan or health insurance issuer grants a request for expedited treatment of a coverage determination, the plan or issuer shall make the determination and provide the notice under subsection (d) within the deadlines specified under subsection (b)(3).

(d) NOTICE OF COVERAGE DETERMINATIONS.—

(1) REQUIREMENT.—

(A) IN GENERAL.—A group health plan or health insurance issuer that makes a coverage determination that—

(i) is completely favorable to the covered individual shall provide the party submitting the request for the coverage determination with notice of such determination; or

(ii) is adverse, in whole or in part, to the covered individual shall provide such party with written notice of the determination, including the information described in subparagraph (B).

(B) CONTENT OF WRITTEN NOTICE.—A written notice under subparagraph (A)(ii) shall—

(i) provide the specific reasons for the determination (including, in the case of a determination relating to utilization review, the clinical rationale for the determination) in clear and understandable language;

(ii) include notice of the availability of the clinical review criteria relied upon in making the coverage determination;

(iii) describe the reconsideration and review processes established to carry out sections 105 and 106, including the right to, and conditions for, obtaining expedited consideration of requests for reconsideration or review;and

(iv) comply with any other requirements specified by the appropriate Secretary.

(2) FAILURE TO PROVIDE TIMELY NOTICE.—Any failure of a group health plan or health insurance issuer to provide a covered individual with timely notice of a coverage determination as specified in this section shall constitute an adverse coverage determination and a timely request for a reconsideration with respect to such determination shall be deemed to have been made pursuant to the section 105(a)(2).

(3) PROVISION OF ORAL NOTICE WITH WRITTEN CONFIRMATION IN CASE OF EXPEDITED TREATMENT.—If a group health plan or health insurance issuer grants a request for expedited treatment under subsection (c), the plan or issuer may first provide notice of the coverage determination orally within the deadlines established under subsection (b)(3) and then shall mail written confirmation of the determination within 2 business days of the date of oral notification.

SEC. 105. INTERNAL APPEALS (RECONSIDERATIONS).

(a) REQUIREMENT.—

(1) RESPONSIBILITIES.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain procedures for making timely reconsiderations of coverage determinations in accordance with this section. Under this section, the plan or issuer shall have a standard procedure for making such determinations, and procedures for expediting such determinations in cases in which application of the standard deadlines could seriously jeopardize the covered individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development.

(2) PARTIES WHO MAY REQUEST RECONSIDERATION.—Any party to a coverage determination may request a reconsideration of the determination under this section. Such party shall submit an oral or written request directly with the group health plan or health insurance issuer that made the determination. The party who files a request for reconsideration may withdraw it by filing a written request for withdrawal with the group health plan or health insurance issuer involved.

(3) DEADLINE FOR FILING REQUEST.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a party to a coverage determination shall submit the request for a reconsideration within 60 calendar days from the date of the written notice of the coverage determination.

(B) EXTENDING TIME FOR FILING REQUEST.—Such a party may submit a written request to the plan or issuer to extend the deadline specified in subparagraph (A). If such a party demonstrates in the request for the extension good cause for such extension, the plan or issuer may extend the deadline.

(4) PARTIES TO THE RECONSIDERATION.—

(A) IN GENERAL.—The parties to the reconsideration are the parties to the coverage determination, as described in section 104(a)(2), and any other provider or entity (other than the plan or issuer) whose rights with respect to the coverage determination may be affected by the reconsideration (as determined by the entity that conducts the reconsideration).

(B) OPPORTUNITY TO SUBMIT EVIDENCE.—A group health plan and a health insurance issuer shall provide the parties to the reconsideration with a reasonable opportunity to

present evidence and allegations of fact or law, related to the issue in dispute, in person as well as in writing. The plan or issuer shall inform the parties of the conditions for submitting the evidence, especially any time limitations.

(5) EFFECT OF RECONSIDERATION.—A decision of a plan or issuer after reconsideration is binding on all parties unless it is reviewed pursuant to section 106.

(6) LIMITATION ON CONDUCTING RECONSIDERATION.—In conducting the reconsideration under this subsection, the following rules shall apply:

(A) The person or persons conducting the reconsideration shall not have been involved in making the underlying coverage determination that is the basis for such reconsideration.

(B) If the issuer involved in the reconsideration is the plan's or issuer's denial of coverage based on a lack of medical necessity, a clinical peer (as defined in section 2(c)(2)) shall make the reconsidered determination.

(7) RECONSIDERATION DEFINED.—In this subtitle, the term ''reconsideration'' means a review under this section of a coverage determination that is adverse to the covered individual involved, including a review of the evidence and findings upon which it was based and any other evidence the parties submit or the group health plan or health insurance issuer obtains.

(b) DETERMINATION BY DEADLINE.—

(1) IN GENERAL.—In the case of a request for a reconsideration, the group health plan or health insurance issuer shall provide notice pursuant to subsection (d) to the person submitting the request of its determination as expeditiously as the health condition of the covered individual involved requires, but in no case later than the deadline established under paragraph (2) or, if a request for expedited treatment of a reconsideration is granted under subsection (c), the deadline established under paragraph (3).

(2) STANDARD DEADLINE.—

(A) IN GENERAL.—The deadline established under this paragraph is, subject to subparagraph (B)—

(i) in the case of a reconsideration regarding the coverage of benefits, 30 calendar days after the date the plan or issuer receives the request for the reconsideration, or

(ii) in other cases, 60 days after such date.

(B) EXTENSION.—The plan or issuer may extend the deadline under subparagraph (A) by up to 14 calendar days if—

(i) the covered individual (or an authorized representative of the individual) requests the extension; or

(ii) the plan or issuer justifies to the applicable authority a need for additional information to make the reconsideration and how the delay is in the interest of the covered individual.

(3) EXPEDITED TREATMENT DEADLINE.—

(A) IN GENERAL.—The deadline established under this paragraph is, subject to subparagraphs (B) and (C), 72 hours after the date the plan or issuer receives the request for the expedited treatment under subsection (d).

(B) EXTENSION.—The plan or issuer may extend the deadline under subparagraph (A) by up to 5 calendar days if—

(i) the covered individual (or an authorized representative of the individual) requests the extension; or

(ii) the plan or issuer justifies to the applicable authority a need for additional information to make the reconsideration and how the delay is in the interest of the covered individual.

(C) HOW INFORMATION FROM NONPARTICIPATING PROVIDERS AFFECTS DEADLINES FOR EXPEDITED RECONSIDERATIONS.—In the case of a group health plan or health insurance issuer that requires medical information from nonparticipating providers in order to make a reconsideration, the deadline specified under subparagraph (A) shall begin when the plan or issuer receives such information. Nonparticipating providers shall make reasonable and diligent efforts to expeditiously gather and forward all necessary information to the plan or issuer in order to receive timely payment.

(c) EXPEDITED TREATMENT.—

(1) REQUEST FOR EXPEDITED TREATMENT.—A covered individual (or an authorized representative of the individual) may request that the plan or issuer expedite a reconsideration involving the issues described in subparagraphs (C), (D), or (E) of section 101(a)(2).

(2) WHO MAY REQUEST.—To request expedited treatment of a reconsideration, a covered individual (or an authorized representative of the individual) shall submit an oral or written request directly to the plan or issuer (or, if applicable, to the entity that the plan or issuer has designated as responsible for making the decision relating to the reconsideration).

(3) PROVIDER SUPPORT.—

(A) IN GENERAL.—A physician or other health care provider may provide oral or written support for a request for expedited treatment under this subsection.

(B) PROHIBITION OF PUNITIVE ACTION.—A group health plan and a health insurance issuer in connection with the provision of health insurance coverage shall not take or threaten to take any punitive action against a physician or other health care provider acting on behalf or in support of a covered individual seeking expedited treatment under this subsection.

(4) PROCESSING OF REQUESTS.—A group health plan and a health insurance issuer in connection with the provision of health insurance coverage shall establish and maintain the following procedures for processing requests for expedited treatment of reconsiderations:

(A) An efficient and convenient means for the submission of oral and written requests for expedited treatment. The plan or issuer shall document all oral requests in writing and maintain the documentation in the case file of the covered individual involved.

(B) A means for deciding promptly whether to expedite a reconsideration, based on the following requirements:

(i) For a request made or supported by a physician, the plan or issuer shall expedite the reconsideration if the physician indicates that applying the standard deadline under subsection (b)(2) for making the reconsideration determination could seriously jeopardize the covered individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development.

(ii) For another request, the plan or issuer shall expedite the reconsideration if the plan or issuer determines that applying such standard deadline for making the reconsideration determination could seriously jeopardize the covered individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development.

(5) ACTIONS FOLLOWING DENIAL OF REQUEST FOR EXPEDITED TREATMENT.—If a group health plan or a health insurance issuer in connection with the provision of health insurance coverage denies a request for expedited treatment of a reconsideration under this subsection, the plan or issuer shall—

(A) make the reconsideration determination within the standard deadline otherwise applicable; and

(B) provide the individual submitting the request with—

(i) prompt oral notice of the denial of the request, and

(ii) within 2 business days a written notice that—

(I) explains that the plan or issuer will process the reconsideration request within the standard deadlines;

(II) informs the requester of the right to file a grievance if the requester disagrees with the plan's or issuer's decision not to expedite the reconsideration; and

(III) provides instructions about the grievance process and its timeframes.

(6) ACTION ON ACCEPTED REQUEST FOR EXPEDITED TREATMENT.—If a group health plan or health insurance issuer grants a request for expedited treatment of a reconsideration, the plan or issuer shall make the reconsideration determination and provide the notice under subsection (d) within the deadlines specified under subsection (b)(3).

(d) NOTICE OF DECISION IN RECONSIDERATIONS.—

(1) REQUIREMENT.—

(A) IN GENERAL.—A group health plan or health insurance issuer that makes a decision in the reconsideration that—

(i) is completely favorable to the covered individual shall provide the party submitting the request for the reconsideration with notice of such decision; or

(ii) is adverse, in whole or in part, to the covered individual shall—

(I) provide such party with written notice of the decision, including the information described in subparagraph (B), and

(II) prepare the case file (including such notice) for the covered individual involved, to be available for submission (if requested) under section 106(a).

(B) CONTENT OF WRITTEN NOTICE.—The written notice under subparagraph (A)(ii)(I) shall—

(i) provide the specific reasons for the decision in the reconsideration (including, in the case of a decision relating to utilization review, the clinical rationale for the decision) in clear and understandable language;

(ii) include notice of the availability of the clinical review criteria relied upon in making the decision;

(iii) describe the review processes established to carry out sections 106, including the right to, and conditions for, obtaining expedited consideration of requests for review under such section; and

(iv) comply with any other requirements specified by the appropriate Secretary.

(2) FAILURE TO PROVIDE TIMELY NOTICE.—Any failure of a group health plan or health insurance issuer to provide a covered individual with timely notice of a decision in a reconsideration as specified in this section shall constitute an affirmation of the adverse coverage determination and the plan or issuer shall submit the case file to the qualified external appeal entity under section 106 within 24 hours of expiration of the deadline otherwise applicable.

(3) PROVISION OF ORAL NOTICE WITH WRITTEN CONFIRMATION IN CASE OF EXPEDITED TREATMENT.—If a group health plan or health insurance issuer grants a request for expedited treatment under subsection (c), the plan or issuer may first provide notice of the decision in the reconsideration orally within the deadlines established under subsection (b)(3) and then shall mail written confirmation of the decision within 2 business days of the date of oral notification.

(4) AFFIRMATION OF AN ADVERSE COVERAGE DETERMINATION UNDER EXPEDITED TREATMENT.—If, as a result of its reconsideration, the plan or issuer affirms, in whole or in part, a coverage determination that is adverse to the covered individual and the reconsideration received expedited treatment under subsection (c), the plan or issuer shall

submit the case file (including the written notice of the decision in the reconsideration) to the qualified external appeal entity as expeditiously as the covered individual's health condition requires, but in no case later than within 24 hours of its affirmation. The plan or issuer shall make reasonable and diligent efforts to assist in gathering and forwarding information to the qualified external appeal entity.

(5) NOTIFICATION OF INDIVIDUAL.—If the plan or issuer refers the matter to an qualified external appeal entity under paragraph (2) or (4), it shall concurrently notify the individual (or an authorized representative of the individual) of that action.

SEC. 106. EXTERNAL APPEALS (REVIEWS).

(a) REVIEW BY QUALIFIED EXTERNAL APPEAL ENTITY.—

(1) IN GENERAL.—If a qualified external appeal entity obtains a case file under section 105(d) or under paragraph (2) and determines that—

(A) the individual's appeal is supported by the opinion of the individual's treating physician; or

(B) such appeal is not so supported but—

(i) there is a significant financial amount in controversy (as defined by the Secretary); or

(ii) the appeal involves services for the diagnosis, treatment, or management of an illness, disability, or condition which the entity finds, in accordance with standards established by the entity and approved by the Secretary, constitutes a condition that could seriously jeopardize the covered individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development;

the entity shall review and resolve under this section any remaining issues in dispute.

(2) REQUEST FOR REVIEW.—

(A) IN GENERAL.—A party to a reconsidered determination under section 105 that receives notice of an unfavorable determination under section 105(d) may request a review of such determination by a qualified external appeal entity under this section.

(B) TIME FOR REQUEST.—To request such a review, such party shall submit an oral or written request directly to the plan or issuer (or, if applicable, to the entity that the plan or issuer has designated as responsible for making the determination).

(C) IF REVIEW IS REQUESTED.—If a party provides the plan or issuer (or such an entity) with notice of a request for such review, the plan or issuer (or such entity) shall submit the case file to the qualified external appeal entity as expeditiously as the covered individual's health condition requires, but in no case later than 2 business days from the date the plan or issuer (or entity) receives such request. The plan or issuer (or entity) shall make reasonable and diligent efforts to assist in gathering and forwarding information to the qualified external appeal entity.

(3) NOTICE AND TIMING FOR REVIEW.—The qualified external appeal entity shall establish and apply rules for the timing and content of notices for reviews under this section (including appropriate expedited treatment of reviews under this section) that are similar to the applicable requirements for timing and content of notices in the case of reconsiderations under subsections (b), (c), and (d) of section 105.

(4) PARTIES.—The parties to the review by a qualified external appeal entity under this section shall be the same parties listed in section 105(a)(4) who qualified during the plan's or issuer's reconsideration, with the addition of the plan or issuer.

(b) GENERAL ELEMENTS OF EXTERNAL APPEALS.—

(1) CONTRACT WITH QUALIFIED EXTERNAL APPEAL ENTITY.—

(A) CONTRACT REQUIREMENT.—Subject to subparagraph (B), the external appeal review under this section of a determination of a plan or issuer shall be conducted under a contract between the plan or issuer and 1 or more qualified external appeal entities.

(B) ELIGIBILITY FOR DESIGNATION AS EXTERNAL REVIEW ENTITY.—Entities eligible to conduct reviews brought under this subsection shall include—

(i) any State licensed or credentialed external review entity;

(ii) a State agency established for the purpose of conducting independent external reviews; and

(iii) an independent, external entity that contracts with the appropriate Secretary.

(C) LICENSING AND CREDENTIALING.—

(i) IN GENERAL.—In licensing or credentialing entities described in subparagraph (B)(i), the State agent shall use licensing and certification procedures developed by the State in consultation with the National Association of Insurance Commissioners.

(ii) SPECIAL RULE.—In the case of a State that—

(I) has not established such licensing or credentialing procedures within 24 months of the date of enactment of this Act, the State shall license or credential such entities in accordance with procedures developed by the Secretary; or

(II) refuses to designate such entities, the Secretary shall license or credential such entities.

(D) QUALIFICATIONS.—An entity (which may be a governmental entity) shall meet the following requirements in order to be a qualified external appeal entity:

(i) There is no real or apparent conflict of interest that would impede the entity from conducting external appeal activities independent of the plan or issuer.

(ii) The entity conducts external appeal activities through clinical peers (as defined in section 2(c)(2)).

(iii) The entity has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the plan or issuer on a timely basis consistent with subsection (a)(3).

(iv) The entity meets such other requirements as the appropriate Secretary may impose.

(E) LIMITATION ON PLAN OR ISSUER SELECTION.—If an applicable authority permits more than 1 entity to qualify as a qualified external appeal entity with respect to a group health plan or health insurance issuer and the plan or issuer may select among such qualified entities, the applicable authority—

(i) shall assure that the selection process will not create any incentives for qualified external appeal entities to make a decision in a biased manner; and

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

(F) OTHER TERMS AND CONDITIONS.—The terms and conditions of a contract under this paragraph shall be consistent with the standards the appropriate Secretary shall establish to assure that there is no real or apparent conflict of interest in the conduct of external appeal activities. Such contract shall provide that the direct costs of the process (not including costs of representation of a covered individual or other party) shall be paid by the plan or issuer, and not by the covered individual.

(2) ELEMENTS OF PROCESS.—An external appeal process under this section shall be conducted consistent with standards established by the appropriate Secretary that include at least the following:

(A) FAIR PROCESS; DE NOVO DETERMINATION.—The process shall provide for a fair, de novo determination.

(B) OPPORTUNITY TO SUBMIT EVIDENCE, HAVE REPRESENTATION, AND MAKE ORAL PRESENTATION.—Any party to a review under this section—

(i) may submit and review evidence related to the issues in dispute,

(ii) may use the assistance or representation of 1 or more individuals (any of whom may be an attorney), and

(iii) may make an oral presentation.

(C) PROVISION OF INFORMATION.—The plan or issuer involved shall provide timely access to all its records relating to the matter being reviewed under this section and to all provisions of the plan or health insurance coverage (including any coverage manual) relating to the matter.

(3) ADMISSIBLE EVIDENCE.—In addition to personal health and medical information supplied with respect to an individual whose claim for benefits has been appealed and the opinion of the individual's treating physician or health care professional, an external appeals entity shall take into consideration the following evidence:

(A) The results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals.

(B) The results of professional consensus conferences conducted or financed in whole or in part by one or more government agencies.

(C) Practice and treatment guidelines prepared or financed in whole or in part by government agencies.

(D) Government-issued coverage and treatment policies.

(E) To the extent that the entity determines it to be free of any conflict of interest—

(i) the opinions of individuals who are qualified as experts in one or more fields of health care which are directly related to the matters under appeal, and

(ii) the results of peer reviews conducted by the plan or issuer involved.

(c) NOTICE OF DETERMINATION BY EXTERNAL APPEAL ENTITY.—

(1) RESPONSIBILITY FOR THE NOTICE.—After the qualified external appeal entity has reviewed and resolved the determination that has been appealed, such entity shall mail a notice of its final decision to the parties.

(2) CONTENT OF THE NOTICE.—The notice described in paragraph (1) shall—

(A) describe the specific reasons for the entity's decisions; and

(B) comply with any other requirements specified by the appropriate Secretary.

(d) EFFECT OF DETERMINATION.—A final decision by the qualified external appeal entity after a review of the determination that has been appealed is final and binding on the group health plan or the health insurance issuer.

Subtitle B—Consumer Information

SEC. 111. HEALTH PLAN INFORMATION.

(a) DISCLOSURE REQUIREMENT.—

(1) GROUP HEALTH PLANS.—A group health plan shall—

(A) provide to participants and beneficiaries at the time of initial coverage under the plan (or the effective date of this section, in the case of individuals who are participants or beneficiaries as of such date), at least annually thereafter, and at the beginning of any open enrollment period provided under the plan, the information described in subsection (b) in printed form;

(B) provide to participants and beneficiaries information in printed form on material changes in the information described in paragraphs (1), (2)(A), (2)(B), (3)(A), (6),

and (7) of subsection (b), or a change in the health insurance issuer through which coverage is provided, within a reasonable period of (as specified by the Secretary, but not later than 30 days after) the effective date of the changes; and

(C) upon request, make available to participants and beneficiaries, the applicable authority, and prospective participants and beneficiaries, the information described in subsections (b) and (c) in printed form.

(2) HEALTH INSURANCE ISSUERS.—A health insurance issuer in connection with the provision of health insurance coverage shall—

(A) provide to individuals enrolled under such coverage at the time of enrollment, and at least annually thereafter, (and to plan administrators of group health plans in connection with which such coverage is offered) the information described in subsection (b) in printed form;

(B) provide to enrollees and such plan administrators information in printed form on material changes in the information described in paragraphs (1), (2)(A), (2)(B), (3)(A), (6), and (7) of subsection (b), or a change in the health insurance issuer through which coverage is provided, within a reasonable period of (as specified by the Secretary, but later than 30 days after) the effective date of the changes; and

(C) upon request, make available to the applicable authority, to individuals who are prospective enrollees, to plan administrators of group health plans that may obtain such coverage, and to the public the information described in subsections (b) and (c) in printed form.

(3) EXEMPTION AUTHORITY.—Upon application of one or more group health plans or health insurance issuers, the appropriate Secretary, under procedures established by such Secretary, may grant an exemption to one or more plans or issuers from compliance with one or more of the requirements of paragraph (1) or (2). Such an exemption may be granted for plans and issuers as a class with similar characteristics, such as private fee-for-service plans described in section 1859(b)(2) of the Social Security Act.

(4) ESTABLISHMENT OF INTERNET SITE.—The appropriate Secretaries shall provide for the establishment of 1 or more sites on the Internet to provide technical support and information concerning the rights of participants, beneficiaries, and enrollees under this title.

(b) INFORMATION PROVIDED.—The information described in this subsection with respect to a group health plan or health insurance coverage offered by a health insurance issuer includes the following:

(1) SERVICE AREA.—The service area of the plan or issuer.

(2) BENEFITS.—Benefits offered under the plan or coverage, including—

(A) covered benefits, including benefits for preventive services, benefit limits, and coverage exclusions, any optional supplemental benefits under the plan or coverage and the terms and conditions (including premiums or cost-sharing) for such supplemental benefits, and any out-of-area coverage;

(B) cost sharing, such as premiums, deductibles, coinsurance, and copayment amounts, including any liability for balance billing, any maximum limitations on out of pocket expenses, and the maximum out of pocket costs for services that are provided by nonparticipating providers or that are furnished without meeting the applicable utilization review requirements;

(C) the extent to which benefits may be obtained from nonparticipating providers, and any supplemental premium or cost-sharing in so obtaining such benefits;

(D) the extent to which a participant, beneficiary, or enrollee may select from among participating providers and the types of providers participating in the plan or issuer network;

(E) process for determining experimental coverage or coverage in cases of investigational treatments and clinical trials; and

(F) use of a prescription drug formulary.

(3) ACCESS.—A description of the following:

(A) The number, mix, and distribution of health care providers under the plan or coverage.

(B) The procedures for participants, beneficiaries, and enrollees to select, access, and change participating primary and specialty providers.

(C) The rights and procedures for obtaining referrals (including standing referrals) to participating and nonparticipating providers.

(D) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 122(a)(2)(B).

(E) How the plan or issuer addresses the needs of participants, beneficiaries, and enrollees and others who do not speak English or who have other special communications needs in accessing providers under the plan or coverage, including the provision of information described in this subsection and subsection (c) to such individuals, including the provision of information in a language other than English if 5 percent of the number of participants, beneficiaries, and enrollees communicate in that language instead of English, and including the availability of interpreters, audio tapes, and information in braille to meet the needs of people with special communications needs.

(4) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan or issuer.

(5) EMERGENCY COVERAGE.—Coverage of emergency services, including—

(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

(B) the process and procedures of the plan or issuer for obtaining emergency services; and

(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(6) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in noncoverage or nonpayment.

(7) GRIEVANCE AND APPEALS PROCEDURES.—All appeal or grievance rights and procedures under the plan or coverage, including the method for filing grievances and the time frames and circumstances for acting on grievances and appeals, the name, address, and telephone number of the applicable authority with respect to the plan or issuer, and the availability of assistance through an ombudsman to individuals in relation to group health plans and health insurance coverage.

(8) QUALITY ASSURANCE.—A summary description of the data on quality indicators and measures submitted under section 112(a) for the plan or issuer, including a summary description of the data on process and outcome satisfaction of participants, beneficiaries, and enrollees (including data on individual voluntary disenrollment and grievances and appeals) described in section 112(b)(3)(D), and notice that information comparing such indicators and measures for different plans and issuers is available through the Agency for Health Care Policy and Research.

(9) SUMMARY OF PROVIDER FINANCIAL INCENTIVES.—A summary description of the information on the types of financial payment incentives (described in section 1852(j)(4) of the Social Security Act) provided by the plan or issuer under the coverage.

(10) INFORMATION ON ISSUER.—Notice of appropriate mailing addresses and telephone numbers to be used by participants, beneficiaries, and enrollees in seeking information or authorization for treatment.

(11) INFORMATION ON LICENSURE.—Information on the licensure, certification, or accreditation status of the plan or issuer.

(12) AVAILABILITY OF TECHNICAL SUPPORT AND INFORMATION.—Notice that technical support and information concerning the rights of participants, beneficiaries, and enrollees under this title are available from the Secretary of Labor (in the case of group health plans) or the Secretary of Health and Human Services (in the case of health insurance issuers), including the telephone numbers and mailing address of the regional offices of the appropriate Secretary and the Internet address to obtain such information and support.

(13) ADVANCE DIRECTIVES AND ORGAN DONATION DECISIONS.—Information regarding the use of advance directives and organ donation decisions under the plan or coverage.

(14) PARTICIPATING PROVIDER LIST.—A list of current participating health care providers for the relevant geographic area, including the name, address and telephone number of each provider.

(15) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request and how and where (such as the telephone number and Internet website) such information may be obtained.

(c) INFORMATION MADE AVAILABLE UPON REQUEST.—The information described in this subsection is the following:

(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 102(a), including under any drug formulary program under section 123(b).

(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and internal and external appeals and on the disposition in the aggregate of such matters, including information on the reasons for the disposition of external appeal cases.

(3) METHOD OF COMPENSATION.—A summary description as to the method of compensation of participating health care professionals and health care facilities, including information on the types of financial payment incentives (described in section 1852(j)(4) of the Social Security Act) provided by the plan or issuer under the coverage and on the proportion of participating health care professionals who are compensated under each type of incentive under the plan or coverage.

(4) CONFIDENTIALITY POLICIES AND PROCEDURES.—A description of the policies and procedures established to carry out section 112.

(5) FORMULARY RESTRICTIONS.—A description of the nature of any drug formula restrictions, including the specific prescription medications included in any formulary and any provisions for obtaining off-formulary medications.

(6) ADDITIONAL INFORMATION ON PARTICIPATING PROVIDERS.—For each current participating health care provider described in subsection (b)(14)—

(A) the licensure or accreditation status of the provider;

(B) to the extent possible, an indication of whether the provider is available to accept new patients;

(C) in the case of medical personnel, the education, training, speciality qualifications or certification, speciality focus, affiliation

arrangements, and specialty board certification (if any) of the provider; and

(D) any measures of consumer satisfaction and quality indicators for the provider.

(7) PERCENTAGE OF PREMIUMS USED FOR BENEFITS (LOSS-RATIOS).—In the case of health insurance coverage only (and not with respect to group health plans that do not provide coverage through health insurance coverage), a description of the overall loss-ratio for the coverage (as defined in accordance with rules established or recognized by the Secretary of Health and Human Services).

(8) QUALITY INFORMATION DEVELOPED.—Quality information on processes and outcomes developed as part of an accreditation or licensure process for the plan or issuer to the extent the information is publicly available.

(d) FORM OF DISCLOSURE.—

(1) UNIFORMITY.—Information required to be disclosed under this section shall be provided in accordance with uniform, national reporting standards specified by the Secretary, after consultation with applicable State authorities, so that prospective enrollees may compare the attributes of different issuers and coverage offered within an area within a type of coverage. Such information shall be provided in an accessible format that is understandable to the average participant, beneficiary, or enrollee involved.

(2) INFORMATION INTO HANDBOOK.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from making the information under subsections (b) and (c) available to participants, beneficiaries, and enrollees through an enrollee handbook or similar publication.

(3) UPDATING PARTICIPATING PROVIDER INFORMATION.—The information on participating health care providers described in subsections (b)(14) and (c)(6) shall be updated within such reasonable period as determined appropriate by the Secretary. A group health plan or health insurance issuer shall be considered to have complied with the provisions of such subsection if the plan or issuer provides the directory or listing of participating providers to participants and beneficiaries or enrollees once a year and such directory or listing is updated within such a reasonable period to reflect any material changes in participating providers. Nothing in this section shall prevent a plan or issuer from changing or updating other information made available under this section.

(4) RULE OF MAILING TO LAST ADDRESS.—For purposes of this section, a plan or issuer, in reliance on records maintained by the plan or issuer, shall be deemed to have met the requirements of this section with respect to the disclosure of information to a participant, beneficiary, or enrollee if the plan or issuer transmits the information requested to the participant, beneficiary, or enrollee at the address contained in such records with respect to such participant, beneficiary, or enrollee.

(e) ENROLLEE ASSISTANCE.—

(1) IN GENERAL.—Each State that obtains a grant under paragraph (3) shall provide for creation and operation of a Health Insurance Ombudsman through a contract with a not-for-profit organization that operates independent of group health plans and health insurance issuers. Such Ombudsman shall be responsible for at least the following:

(A) To provide consumers in the State with information about health insurance coverage options or coverage options offered within group health plan.

(B) To provide counseling and assistance to enrollees dissatisfied with their treatment by health insurance issuers and group health plans in regard to such coverage or plans and with respect to grievances and appeals regarding determinations under such coverage or plans.

(2) FEDERAL ROLE.—In the case of any State that does not provide for such an Ombudsman under paragraph (1), the Secretary may provide for the creation and operation of a Health Insurance Ombudsman through a contract with a not-for-profit organization that operates independent of group health plans and health insurance issuers and that is to provide consumers in the State with information about health insurance coverage options or coverage options offered within group health plans.

(3) ELIGIBILITY.—To be eligible to serve as a Health Insurance Ombudsman under this section, a not-for-profit organization shall provide assurances that—

(A) the organization has no real or perceived conflict of interest in providing advice and assistance to consumers regarding health insurance coverage, and

(B) the organization is independent of health insurance issuers, health care providers, health care payors, and regulators of health care or health insurance.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Health and Human Services such amounts as may be necessary to provide for grants to States for contracts for Health Insurance Ombudsmen under paragraph (1) or contracts for such Ombudsmen under paragraph (2).

(5) CONSTRUCTION.—Nothing in this section shall be construed to prevent the use of other forms of enrollee assistance.

(f) CONSTRUCTION.—Nothing in this section shall be construed as requiring public disclosure of individual contracts or financial arrangements between a group health plan or health insurance issuer and any provider.

SEC. 112. HEALTH CARE QUALITY INFORMATION.

(a) COLLECTION AND SUBMISSION OF INFORMATION ON QUALITY INDICATORS AND MEASURES.—

(1) IN GENERAL.—A group health plan and a health insurance issuer that offers health insurance coverage shall collect and submit to the Director for the Agency for Health Care Policy and Research (in this section referred to as the ''Director'') aggregate data on quality indicators and measures (as defined in subsection (g)) that includes the minimum uniform data set specified under subsection (b). Such data shall not include patient identifiers.

(2) DATA SAMPLING METHODS.—The Director shall develop data sampling methods for the collection of data under this subsection.

(3) EXEMPTION AUTHORITY.—The provisions of section 111(a)(3) shall apply to the requirements of paragraph (1) in the same manner as they apply to the requirements referred to in such section.

(b) MINIMUM UNIFORM DATA SET.—

(1) IN GENERAL.—The Secretary shall specify (and may from time to time update) by rule the data required to be included in the minimum uniform data set under subsection (a) and the standard format for such data.

(2) DESIGN.—Such specification shall—

(A) take into consideration the different populations served (such as children and individuals with disabilities);

(B) be consistent where appropriate with requirements applicable to Medicare+Choice health plans under 1851(d)(4)(D) of the Social Security Act;

(C) take into consideration such differences in the delivery system among group health plans and health insurance issuers as the Secretary deems appropriate;

(D) be consistent with standards adopted to carry out part C of title XI of the Social Security Act; and

(E) be consistent where feasible with existing health plan quality indicators and measures used by employers and purchasers.

(3) MINIMUM DATA.—The data in such set shall include, to the extent determined feasible by the appropriate Secretary, at least—

(A) data on process measures of clinical performance for health care services provided by health care professionals and facilities;

(B) data on outcomes measures of morbidity and mortality including to the extent feasible and appropriate data for pediatric and gender-specific measures; and

(C) data on data on satisfaction of such individuals, including data on voluntary disenrollment and grievances.

The minimum data set under this paragraph shall be established by the appropriate Secretaries using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

(c) DISSEMINATION OF INFORMATION.—

(1) IN GENERAL.—The Director shall publicly disseminate (through printed media and the Internet) information on the aggregate data submitted under this section.

(2) FORMATS.—The information shall be disseminated in a manner that provides for a comparison of health care quality among different group health plans and health insurance issuers, with appropriate differentiation by delivery system. In disseminating the information, the Director may reference an appropriate benchmark (or benchmarks) for performance with respect to specific quality indicators and measures (or groups of such measures).

(d) HEALTH CARE QUALITY RESEARCH AND INFORMATION.—The Secretary of Health and Human Services, acting through the Director, shall conduct and support research demonstration projects, evaluations, and the dissemination of information with respect to measurement, status, improvement, and presentation of quality indicators and measures and other health care quality information.

(e) NATIONAL REPORTS ON HEALTH CARE QUALITY.—

(1) REPORT ON NATIONAL GOALS.—Not later than 18 months after the date of enactment of this Act, and every 2 years thereafter, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress and the President a report that—

(A) establishes national goals for the improvement of the quality of health care; and

(B) contains recommendations for achieving the national goals established under paragraph (1).

(2) REPORT ON HEALTH RELATED TOPICS.—Not later than 30 months after the date of enactment of this Act and every 2 years thereafter, such Secretary shall prepare and submit to Congress and the President a report that addresses at least 1 of the following (or a related matter):

(A) The availability, applicability, and appropriateness of information to consumers regarding the quality of their health care.

(B) The state of information systems and data collecting capabilities for measuring and reporting on quality indicators.

(C) The impact of quality measurement on access to and the cost of medical care.

(D) Barriers to continuous quality improvement in medical care.

(E) The state of health care quality measurement research and development.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $25,000,000 for each fiscal year (beginning with fiscal year 1999) to carry out this section. Any such amounts appropriated for a fiscal year shall remain available, without fiscal year limitation, until expended.

(g) QUALITY INDICATORS AND MEASURES DEFINED.—For purposes of this section, the term ''quality indicators and measures'' means structural characteristics, patient-encounter data, and the subsequent health status change of a patient as a result of health care services provided by health care professionals and facilities.

SEC. 113. CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.

A group health plan or a health insurance issuer shall establish procedures with respect to medical records or other health information maintained regarding participants, beneficiaries, and enrollees to safeguard the privacy of any individually identifiable information about them.

SEC. 114. QUALITY ASSURANCE.

(a) REQUIREMENT.—A group health plan, and a health insurance issuer that offers health insurance coverage, shall establish and maintain an ongoing, internal quality assurance and continuous quality improvement program that meets the requirements of subsection (b).

(b) PROGRAM REQUIREMENTS.—The requirements of this subsection for a quality improvement program of a plan or issuer are as follows:

(1) ADMINISTRATION.—The plan or issuer has an identifiable unit with responsibility for administration of the program.

(2) WRITTEN PLAN.—The plan or issuer has a written plan for the program that is updated annually and that specifies at least the following:

(A) The activities to be conducted.

(B) The organizational structure.

(C) The duties of the medical director.

(D) Criteria and procedures for the assessment of quality.

(3) SYSTEMATIC REVIEW.—The program provides for systematic review of the type of health services provided, consistency of services provided with good medical practice, and patient outcomes.

(4) QUALITY CRITERIA.—The program—

(A) uses criteria that are based on performance and patient outcomes where feasible and appropriate;

(B) includes criteria that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate;

(C) includes methods for informing covered individuals of the benefit of preventive care and what specific benefits with respect to preventive care are covered under the plan or coverage; and

(D) makes available to the public a description of the criteria used under subparagraph (A).

(5) SYSTEM FOR IDENTIFYING.—The program has procedures for identifying possible quality concerns by providers and enrollees and for remedial actions to correct quality problems, including written procedures for responding to concerns and taking appropriate corrective action.

(6) DATA ANALYSIS.—The program provides, using data that include the data collected under section 112, for an analysis of the plan's or issuer's performance on quality measures.

(7) DRUG UTILIZATION REVIEW.—The program provides for a drug utilization review program which—

(A) encourages appropriate use of prescription drugs by participants, beneficiaries, and enrollees and providers, and

(B) takes appropriate action to reduce the incidence of improper drug use and adverse drug reactions and interactions.

(c) DEEMING.—For purposes of subsection (a), the requirements of—

(1) subsection (b) (other than paragraph (5)) are deemed to be met with respect to a health insurance issuer that is a qualified health maintenance organization (as defined in section 1310(c) of the Public Health Service Act); or

(2) subsection (b) are deemed to be met with respect to a health insurance issuer that is accredited by a national accreditation organization that the Secretary certifies as applying, as a condition of certification, standards at least a stringent as those required for a quality improvement program under subsection (b).

(d) VARIATION PERMITTED.—The Secretary may provide for variations in the application of the requirements of this section to group health plans and health insurance issuers based upon differences in the delivery system among such plans and issuers as the Secretary deems appropriate.

(e) CONSULTATION IN MEDICAL POLICIES.—A group health plan, and health insurance issuer that offers health insurance coverage, shall consult with participating physicians (if any) regarding the plan's or issuer's medical policy, quality, and medical management procedures.

Subtitle C—Patient Protection Standards

SEC. 121. EMERGENCY SERVICES.

(a) COVERAGE OF EMERGENCY SERVICES.—

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

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

(B) whether or not the health care provider furnishing such services is a participating provider with respect to such services;

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

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

(ii) the plan or issuer pays an amount that is not less than the amount paid to a participating health care provider for the same services; and

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

(2) DEFINITIONS.—In this section:

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

(B) EMERGENCY SERVICES.—The term ''emergency services'' means—

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

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

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—In the case of services (other than emergency services) for which benefits are available under a group health plan, or under health insurance coverage offered by a health insurance issuer, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant, beneficiary, or enrollee other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) if the services are maintenance care or post-stabilization care covered under the guidelines established under section 1852(d)(2) of the Social Security Act (relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after an enrollee has been determined to be stable), in accordance with regulations established to carry out such section.

SEC. 122. ENROLLEE CHOICE OF HEALTH PROFESSIONALS AND PROVIDERS.

(a) CHOICE OF PERSONAL HEALTH PROFESSIONAL.—

(1) PRIMARY CARE.—A group health plan, and a health insurance issuer that offers health insurance coverage, shall permit each participant, beneficiary, and enrollee—

(A) to receive primary care from any participating primary care provider who is available to accept such individual, and

(B) in the case of a participant, beneficiary, or enrollee who has a child who is also covered under the plan or coverage, to designate a participating physician who specializes in pediatrics as the child's primary care provider.

(2) SPECIALISTS.—

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

(B) LIMITATION.—Subparagraph (A) shall not apply to specialty care if the plan or issuer clearly informs participants, beneficiaries, and enrollees of the limitations on choice of participating providers with respect to such care.

(b) SPECIALIZED SERVICES.—

(1) OBSTETRICAL AND GYNECOLOGICAL CARE.—

(A) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for a participant, beneficiary, or enrollee to designate a participating primary care provider, and an individual who is female has not designated a participating physician specializing in obstetrics and gynecology as a primary care provider, the plan or issuer—

(i) may not require authorization or a referral by the individual's primary care provider or otherwise for coverage of routine gynecological care (such as preventive women's health examinations) and pregnancy-related services provided by a participating health care professional who specializes in obstetrics and gynecology to the extent such care is otherwise covered, and

(ii) may treat the ordering of other gynecological care by such a participating physician as the authorization of the primary care provider with respect to such care under the plan or coverage.

(B) CONSTRUCTION.—Nothing in subparagraph (A)(ii) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological care so ordered.

(2) SPECIALTY CARE.—

(A) SPECIALTY CARE FOR COVERED SERVICES.—

(i) IN GENERAL.—If—

(I) an individual is a participant or beneficiary under a group health plan or an enrollee who is covered under health insurance coverage offered by a health insurance issuer,

(II) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist, and

(III) benefits for such treatment are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease.

(ii) SPECIALIST DEFINED.—For purposes of this paragraph, the term ''specialist'' means, with respect to a condition, a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

(iii) CARE UNDER REFERRAL.—A group health plan or health insurance issuer may require that the care provided to an individual pursuant to such referral under clause (i) be—

(I) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

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

Nothing in this paragraph shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(iv) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under clause (i) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have an appropriate specialist that is available and accessible to treat the individual's condition and that is a participating provider with respect to such treatment.

(v) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to clause (i), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

(B) SPECIALISTS AS PRIMARY CARE PROVIDERS.—

(i) IN GENERAL.—A group health plan, or a health insurance issuer, in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition (as defined in clause (iii)) may receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care. If such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

(ii) TREATMENT AS PRIMARY CARE PROVIDER.—Such specialist shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan (referred to in subparagraph (A)(iii)(I)).

(iii) ONGOING SPECIAL CONDITION DEFINED.—In this subparagraph, the term ''special condition'' means a condition or disease that—

(I) is life-threatening, degenerative, or disabling, and

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

(iv) TERMS OF REFERRAL.—The provisions of clauses (iii) through (v) of subparagraph (A) apply with respect to referrals under clause (i) of this subparagraph in the same manner as they apply to referrals under subparagraph (A)(i).

(C) STANDING REFERRALS.—

(i) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist.

(ii) TERMS OF REFERRAL.—The provisions of clauses (iii) through (v) of subparagraph (A) apply with respect to referrals under clause (i) of this subparagraph in the same manner as they apply to referrals under subparagraph (A)(i).

(c) CONTINUITY OF CARE.—

(1) IN GENERAL.—

(A) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, and a health care provider is terminated (as defined in subparagraph (C)), 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, beneficiary, or enrollee in the plan or coverage is undergoing a course of treatment from the provider at the time of such termination, the plan or issuer shall—

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

(ii) subject to paragraph (3), permit the individual to continue or be covered with respect to the course of treatment with the provider during a transitional period (provided under paragraph (2)) if the plan or issuer is notified orally or in writing of the facts and circumstances concerning the course of treatment.

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

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

(2) TRANSITIONAL PERIOD.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) through (D), the transitional period under this subsection shall extend for at least 90 days from the date of the notice described in paragraph (1)(A)(i) of the provider's termination.

(B) INSTITUTIONAL CARE.—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.

(C) PREGNANCY.—If—

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

(ii) the provider was treating the pregnancy before 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.

(D) TERMINAL ILLNESS.—If—

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

(ii) 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, but in no case is the transitional period required to extend for longer than 180 days.

(3) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under paragraph (1)(A)(ii) upon the provider agreeing to the following terms and conditions:

(A) The provider agrees to accept reimbursement from the plan or issuer 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 paragraph (1)(B), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) 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 paragraph (1)(A) had not been terminated.

(B) The provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under subparagraph (A) and to provide to such plan or issuer necessary medical information related to the care provided.

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

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

(d) PROTECTION AGAINST INVOLUNTARY DISENROLLMENT BASED ON CERTAIN CONDITIONS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer in connection with the provision of health insurance coverage may not disenroll an individual under the plan or coverage because the individual's behavior is considered disruptive, unruly, abusive, or uncooperative to the extent that the individual's continued enrollment under the coverage seriously impairs the plan's or issuer's ability to furnish covered services if the circumstances for the individual's behavior is directly related to diminished mental capacity, severe and persistent mental illness, or a serious childhood mental and emotional disorder.

(2) EXCEPTION.—Paragraph (1) shall not apply if the behavior engaged in directly threatens bodily injury to any person.

(e) GENERAL ACCESS.—

(1) IN GENERAL.—Each group health plan, and each health insurance issuer offering health insurance coverage, that provides benefits, in whole or in part, through participating health care providers shall have (in relation to the coverage) a sufficient number, distribution, and variety of qualified participating health care providers to ensure that all covered health care services, including specialty services, will be available and accessible in a timely manner to all participants, beneficiaries, and enrollees under the plan or coverage.

(2) TREATMENT OF CERTAIN PROVIDERS.—The qualified health care providers under paragraph (1) may include Federally qualified health centers, rural health clinics, migrant health centers, high-volume, disproportionate share hospitals, and other essential community providers located in the service area of the plan or issuer and shall include such providers if necessary to meet the standards established to carry out such subsection.

SEC. 123. ACCESS TO APPROVED SERVICES.

(a) COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.—

(1) COVERAGE.—

(A) IN GENERAL.—If a group health plan, or health insurance issuer that is providing health insurance coverage, provides coverage to a qualified individual (as defined in paragraph (2)), the plan or issuer—

(i) may not deny the individual participation in the clinical trial referred to in paragraph (2)(B);

(ii) subject to paragraph (3), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(iii) may not discriminate against the individual on the basis of the enrollee's participation in such trial.

(B) EXCLUSION OF CERTAIN COSTS.—For purposes of subparagraph (A)(ii), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

(C) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in subparagraph (A) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(2) QUALIFIED INDIVIDUAL DEFINED.—For purposes of paragraph (1), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan, or who is an enrollee under health insurance coverage, and who meets the following conditions:

(A)(i) The individual has a life-threatening or serious illness for which no standard treatment is effective.

(ii) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

(iii) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

(B) Either—

(i) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in subparagraph (A); or

(ii) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in subparagraph (A).

(3) PAYMENT.—

(A) IN GENERAL.—Under this subsection a group health plan or health insurance issuer shall provide for payment for routine patient costs described in paragraph (1)(A) but is not required to pay for costs of items and services that are reasonably expected (as determined by the Secretary) to be paid for by the sponsors of an approved clinical trial.

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

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

(ii) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable services under subparagraph (A).

(4) APPROVED CLINICAL TRIAL DEFINED.—

(A) IN GENERAL.—In this subsection, the term ''approved clinical trial'' means a clinical research study or clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

(i) The National Institutes of Health.

(ii) A cooperative group or center of the National Institutes of Health.

(iii) Either of the following if the conditions described in subparagraph (B) are met:

(I) The Department of Veterans Affairs.

(II) The Department of Defense.

(B) CONDITIONS FOR DEPARTMENTS.—The conditions described in this subparagraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

(i) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

(ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(5) CONSTRUCTION.—Nothing in this subsection shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

(b) ACCESS TO PRESCRIPTION DRUGS.—

(1) IN GENERAL.—If a group health plan, or health insurance issuer that offers health insurance coverage, provides benefits with respect to prescription drugs but the coverage limits such benefits to drugs included in a formulary, the plan or issuer shall—

(A) ensure participation of participating physicians and pharmacists in the development of the formulary; and

(B) disclose to providers and, disclose upon request under section 111(c)(5) to participants, beneficiaries, and enrollees, the nature of the formulary restrictions; and

(C) consistent with the standards for a utilization review program under section 102(a), provide for exceptions from the formulary limitation when a non-formulary alternative is medically indicated.

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a group health plan (or health insurance issuer in connection with health insurance coverage) to provide any coverage of prescription drugs or as preventing such a plan or issuer from negotiating higher cost-sharing in the case a non-formulary alternative is provided under paragraph (1)(C).

SEC. 124. NONDISCRIMINATION IN DELIVERY OF SERVICES.

(a) APPLICATION TO DELIVERY OF SERVICES.—Subject to subsection (b), a group health plan, and health insurance issuer in relation to health insurance coverage, may not discriminate against a participant, beneficiary, or enrollee in the delivery of health care services consistent with the benefits covered under the plan or coverage or as required by law based on race, color, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed as relating to the eligibility to be covered, or the offering (or guaranteeing the offer) of coverage, under a plan or health insurance coverage, the application of any pre-existing condition exclusion consistent with applicable law, or premiums charged under such plan or coverage. To the extent that health care providers are permitted under State and Federal law to prioritize the admission or treatment of patients based on such patients' individual religious affiliation, group health plans and health insurance issuers may reflect those priorities in referring patients to such providers.

SEC. 125. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) IN GENERAL.—An organization on behalf of a group health plan (as described in subsection (a)(2)) or a health insurance issuer shall not penalize (financially or otherwise) a health care professional for advocating on behalf of his or her patient or for providing information or referral for medical care (as defined in section 2791(a)(2) of the Public Health Service Act) consistent with the health care needs of the patient and with the code of ethical conduct, professional responsibility, conscience, medical knowledge, and license of the health care professional.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed as requiring a health insurance issuer or a group health plan to pay for medical care not otherwise paid for or covered by the plan provided by nonparticipating health care professionals, except in those instances and to the extent that the issuer or plan would normally pay for such medical care.

(c) ASSISTANCE AND SUPPORT.—A group health plan or a health insurance issuer shall not prohibit or otherwise restrict a health care professional from providing letters of support to, or in any way assisting, enrollees who are appealing a denial, termination, or reduction of service in accordance with the procedures under subtitle A.

SEC. 126. PROVIDER INCENTIVE PLANS.

(a) PROHIBITION OF TRANSFER OF INDEMNIFICATION.—

(1) IN GENERAL.—No contract or agreement between a group health plan or health insurance issuer (or any agent acting on behalf of such a plan or issuer) and a health care provider shall contain any provision purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions, or omissions of the plan, issuer, or agent (as opposed to the provider).

(2) NULLIFICATION.—Any contract or agreement provision described in paragraph (1) shall be null and void.

(b) PROHIBITION OF IMPROPER PHYSICIAN INCENTIVE PLANS.—

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

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

SEC. 127. PROVIDER PARTICIPATION.

(a) IN GENERAL.—A group health plan and a health insurance issuer that offers health insurance coverage shall, if it provides benefits through participating health care professionals, have a written process for the selection of participating health care professionals under the plan or coverage. Such process shall include—

(1) minimum professional requirements;

(2) providing notice of the rules regarding participation;

(3) providing written notice of participation decisions that are adverse to professionals; and

(4) providing a process within the plan or issuer for appealing such adverse decisions, including the presentation of information and views of the professional regarding such decision.

(b) VERIFICATION OF BACKGROUND.—Such process shall include verification of a health care provider's license and a history of suspension or revocation.

(c) RESTRICTION.—Such process shall not use a high-risk patient base or location of a provider in an area with residents with poorer health status as a basis for excluding providers from participation.

(d) GENERAL NONDISCRIMINATION.—

(1) IN GENERAL.—Subject to paragraph (2), such process shall not discriminate with respect to selection of a health care professional to be a participating health care provider, or with respect to the terms and conditions of such participation, based on the professional's race, color, religion, sex, national origin, age, sexual orientation, or disability (consistent with the Americans with Disabilities Act of 1990).

(2) RULES.—The appropriate Secretary may establish such definitions, rules, and exceptions as may be appropriate to carry out paragraph (1), taking into account comparable definitions, rules, and exceptions in effect under employment-based nondiscrimination laws and regulations that relate to each of the particular bases for discrimination described in such paragraph.

SEC. 128. REQUIRED COVERAGE FOR APPROPRIATE HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER; REQUIRED COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.

(a) COVERAGE OF INPATIENT CARE FOR SURGICAL TREATMENT OF BREAST CANCER.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the 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 generally accepted principles of professional medical practice, in consultation with the patient, to be medically necessary or 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 necessary or appropriate.

(b) COVERAGE OF RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES.—A group health plan, and a health insurance issuer providing health insurance coverage, 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 or enrollee upon enrollment and annually thereafter.

(c) 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 or health insurance 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 or health insurance coverage, except that the provision of such inpatient stay benefits shall not be contingent upon such notification.

(d) PROHIBITIONS.—A group health plan and a health insurance issuer offering health insurance coverage may not—

(1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan or coverage, 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, beneficiary, or enrollee 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, beneficiary, or enrollee in a manner inconsistent with this section; and

(5) subject to subsection (e)(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.

(e) RULES OF CONSTRUCTION.—

(1) IN GENERAL.—Nothing in this section shall be construed to require a patient who is a participant, beneficiary, or enrollee—

(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 health insurance coverage, 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 from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

Subtitle D—Enhanced Enforcement Authority

SEC. 141. INVESTIGATIONS AND REPORTING AUTHORITY, INJUNCTIVE RELIEF AUTHORITY, AND INCREASED CIVIL MONEY PENALTY AUTHORITY FOR SECRETARY OF HEALTH AND HUMAN SERVICES FOR VIOLATIONS OF PATIENT PROTECTION STANDARDS.

(a) INVESTIGATIONS AND REPORTING AUTHORITY.—

(1) IN GENERAL.—For purposes of carrying out sections 2722(b) and 2761(b) of the Public Health Service Act with respect to enforcement of the provisions of sections 2706 and 2752, respectively, of such Act (as added by title II of this Act)—

(A) the Secretary of Health and Human Services shall have the same authorities with respect to compelling health insurance issuers to produce information and to conducting investigations in cases of violations of such provisions as the Secretary of Labor has under section 504 of the Employee Retirement Income Security Act of 1974 with respect to violations of title I of such Act; and

(B) section 504(c) of the Employee Retirement Income Security Act of 1974 shall apply to investigations conducted under paragraph (1) in the same manner as it applies to investigations conducted under title I of such Act.

(2) REPORTING AUTHORITY.—In exercising authority under paragraph (1), the Secretary may require—

(A) States that have indicated an intention to assume authority under section 2722(a)(1) or 2761(a) of the Public Health Service Act to report to the Secretary on enforcement efforts undertaken to assure compliance with the requirements of sections 2706 and 2752, respectively, of such Act; and

(B) health insurance issuers to submit reports to assure compliance with such requirements.

(b) AUTHORITY FOR INJUNCTIVE RELIEF.—In addition to the authority referred to in subsection (a), the Secretary of Health and Human Services has the same authority with respect to enforcement of the provisions of this title as the Secretary of Labor has under subsection (a)(5) of section 502 of the Employee Retirement Income Security Act of 1974 (as applied without regard to subsection (b) of that section) and the related provisions of part 5 of subtitle B of title I of

such Act with respect to enforcement of such title I of such Act.

(c) INCREASE IN CIVIL MONEY PENALTIES.—

(1) IN GENERAL.—In the case of a civil money penalty that may be imposed under section 2722(b)(2) or 2761(b) of the Public Health Service Act with respect to a failure to meet the provisions of sections 2706 and 2752, respectively, of such Act, the maximum amount of penalty otherwise provided under section 2722(b)(2)(C)(i) of such Act may, notwithstanding the amounts specified in such section, and subject to paragraph (2), be up to the greatest of the following:

(A) FAILURES INVOLVING UNREASONABLE DENIAL OR DELAY IN BENEFITS IMPACTING ON LIFE OR HEALTH.—In the case of a failure that results in an unreasonable denial or delay in benefits that has seriously jeopardized (or has substantial likelihood of seriously jeopardizing) the individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development, the greater of the following:—

(i) PATTERN OR PRACTICE FAILURE.—If the failure reflects a pattern or practice of wrongful conduct, $250,000, plus the amount (if any) determined under paragraph (2).

(ii) OTHER FAILURES.—In the case of a failure that does not reflect a pattern or practice of wrongful conduct, $50,000 for each individual involved, plus the amount (if any) determined under paragraph (2).

(B) OTHER FAILURES.—In the case of a failure not described in subparagraph (A), the greater of the following:

(i) PATTERN AND PRACTICE FAILURES.—In the case of a failure that reflects a pattern or practice of wrongful conduct $50,000, plus the amount (if any) determined under paragraph (2).

(ii) OTHER FAILURES.—In the case of a failure that does not reflect a pattern or practice of wrongful conduct, $10,000 for each individual involved, plus the amount (if any) determined under paragraph (2).

(2) CONTINUING FAILURE WITHOUT CORRECTION.—In the case of a failure which is not corrected within the first week beginning with the date on which the failure is established, the maximum amount of the penalty under paragraph (1) shall be increased by $10,000 for each full succeeding week in which the failure is not so corrected.

(d) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other amounts authorized to be appropriated, there are authorized to be appropriated to the Secretary of Health and Human Services such sums as may be necessary to carry out this section.

SEC. 142. AUTHORITY FOR SECRETARY OF LABOR TO IMPOSE CIVIL PENALTIES FOR VIOLATIONS OF PATIENT PROTECTION STANDARDS.

(a) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)) is amended by redesignating paragraphs (6) and (7) as paragraphs (7) and (8), respectively, and by inserting after paragraph (5) the following new paragraph:

''(6)(A) The Secretary may assess a civil penalty against a person acting in the capacity of a fiduciary of a group health plan (as defined in 733(a)) so as to cause a violation of section 713.

''(B) Subject to subparagraph (C), the maximum amount which may be assessed under subparagraph (A) is the greatest of the following:

''(i) In the case of a failure that results in an unreasonable denial or delay in benefits that seriously jeopardized (or has substantial likelihood of seriously jeopardizing) the individual's life, health, or ability to regain or maintain maximum function or (in the case of a child under the age of 6) development, the greater of the following:—

''(I) If the failure reflects a pattern or practice of wrongful conduct, $250,000, plus the amount (if any) determined under subparagraph (C).

''(II) In the case of a failure that does not reflect a pattern or practice of wrongful conduct, $50,000 for each individual involved, plus the amount (if any) determined under subparagraph (C).

''(ii) In the case of a failure not described in clause (i), the greater of the following:

''(I) In the case of a failure that reflects a pattern or practice of wrongful conduct $50,000, plus the amount (if any) determined under subparagraph (C).

''(II) In the case of a failure that does not reflect a pattern or practice of wrongful conduct, $10,000 for each individual involved, plus the amount (if any) determined under subparagraph (C).

''(C) In the case of a failure which is not corrected within the first week beginning with the date on which the failure is established, the maximum amount of the penalty under subparagraph (B) shall be increased by $10,000 for each full succeeding week in which the failure is not so corrected.''.

(b) CONFORMING AMENDMENT.—Section 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is amended by striking ''paragraph (2), (4), (5), or (6)'' and inserting ''paragraph (2), (4), (5), (6), or (7)''.

(c) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other amounts authorized to be appropriated, there are authorized to be appropriated to the Secretary of Labor such sums as may be necessary to carry out the amendments made by this section.

TITLE II—PATIENT PROTECTION STANDARDS UNDER PUBLIC HEALTH SERVICE ACT

SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2706. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title I of the Promoting Responsible Managed Care Act of 1998, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2706)'' after ''requirements of such subparts''.

(c) REFERENCE TO ENHANCED ENFORCEMENT AUTHORITY.—For provisions providing for enhanced authority to enforce the patient protection requirements of title I under the Public Health Service Act, see section 141.

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2751 the following new section:

''SEC. 2752. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under title I of the Promoting Responsible Managed Care Act of 1998 with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such title as if such section applied to such issuer and such issuer were a group health plan.''.

TITLE III—PATIENT PROTECTION STANDARDS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 301. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 713. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Promoting Responsible Managed Care Act of 1998 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

''(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of title I of the Promoting Responsible Managed Care Act of 1998 with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) Section 121 (relating to access to emergency care).

''(B) Section 122 (relating to choice of providers).

''(C) Section 122(b) (relating to specialized services).

''(D) Section 122(c)(1)(A) (relating to continuity in case of termination of provider contract) and section 122(c)(1)(B) (relating to continuity in case of termination of issuer contract), but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(E) Section 123(a) (relating to coverage for individuals participating in approved clinical trials.)

''(F) Section 123(b) (relating to access to needed prescription drugs).

''(G) Section 122(e) (relating to adequacy of provider network).

''(H) Subtitle B (relating to consumer information).

''(2) INFORMATION.—With respect to information required to be provided or made available under section 111 of such Act, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer's failure to provide or make available the information), if the issuer is obligated to provide and make

available (or provides and makes available) such information.

''(3) GRIEVANCE AND INTERNAL APPEALS.—With respect to the grievance system and internal appeals process required to be established under sections 102 and 103 of such Act, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such system and process (and is not liable for the issuer's failure to provide for such system and process), if the issuer is obligated to provide for (and provides for) such system and process.

''(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 106 of such Act, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

''(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any of the following sections of such Act, the group health plan shall not be liable for such violation unless the plan caused such violation:

''(A) Section 124 (relating to nondiscrimination in delivery of services).

''(B) Section 125 (relating to prohibition of interference with certain medical communications).

''(C) Section 126 (relating to provider incentive plans).

''(D) Section 102(b) (relating to providing medically necessary care).

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

(b) SATISFACTION OF ERISA CLAIMS PROCEDURE REQUIREMENT.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting ''(a)'' after ''SEC. 503.'' and by adding at the end the following new subsection:

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subtitle D (and section 113) of title I of the Promoting Responsible Managed Care Act of 1998 in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 713''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 712 the following new item:

''Sec. 713. Patient protection standards.''.

(3) Section 502(b)(3) of such Act (29 U.S.C. 1132(b)(3)) is amended by inserting ''(other than section 144(b))'' after ''part 7''.

(d) REFERENCE TO ENHANCED ENFORCEMENT AUTHORITY.—For provisions providing for enhanced authority to enforce the patient protection requirements of title I under the Employee Retirement Income Security Act of 1974, see section 142.

SEC. 302. ENFORCEMENT FOR ECONOMIC LOSS CAUSED BY COVERAGE DETERMINATIONS.

(a) IN GENERAL.—Section 502(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 142(a) of this Act, is amended by redesignating paragraphs (7) and (8) as paragraphs (8) and (9), respectively, and by inserting after paragraph (6) the following new paragraph:

''(7)(A) In any case in which—

''(i) a coverage determination (as defined in section 101(a)(2) of the Promoting Responsible Managed Care Act of 1998) under a group health plan (as defined in section 503(b)(8)) is not made on a timely basis or is made on such a basis but is not made in accordance with the terms of the plan, this title, or title I of such Act, and

''(ii) a participant or beneficiary suffers injury (including loss of life, health, or the ability to regain or maintain maximum function or (in the case of a child under the age of 6) development) as a result of such coverage determination,

any person or persons who are responsible under the terms of the plan for the making of such coverage determination are liable to the aggrieved participant or beneficiary for the amount of the economic loss suffered by the participant or beneficiary caused by such coverage determination. Any question of fact in any cause of action under this paragraph shall be based on the preponderance of the evidence after de novo review.

''(B) For purposes of subparagraph (A), the term 'economic loss' means any pecuniary loss (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities) caused by the coverage determination. Such term does not include punitive damages or damages for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

''(C) Nothing in this paragraph shall be construed as requiring exhaustion of administrative process in the case of severe bodily injury or death.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to coverage determinations made on or after the date of the enactment of this Act.

TITLE IV—PATIENT PROTECTION STANDARDS UNDER THE INTERNAL REVENUE CODE OF 1986.

SEC. 401. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (as amended by section 1531(a) of the Taxpayer Relief Act of 1997) is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Standard relating to patient protection standards.''; and

(2) by inserting after section 9812 the following:

''SEC. 9813. STANDARD RELATING TO PATIENT PROTECTION STANDARDS.

''A group health plan shall comply with the requirements of title I of the Promoting Responsible Managed Care Act of 1998 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section.''.

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 501. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 1999 (in this section referred to as the ''general effective date'') and also shall apply to portions of plan years occurring on and after such date.

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreement relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) the general effective date.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this Act shall not be treated as a termination of such collective bargaining agreement.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by section 202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

SEC. 502. COORDINATION IN IMPLEMENTATION.

Section 104(1) of Health Insurance Portability and Accountability Act of 1996 is amended by striking ''this subtitle (and the amendments made by this subtitle and section 401)'' and inserting ''the provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts A and C of title XXVII of the Public Health Service Act, chapter 100 of the Internal Revenue Code of 1986, and title I of the Promoting Responsible Managed Care Act of 1998''.

PROMOTING RESPONSIBLE MANAGED CARE ACT OF 1998

PRINCIPLES

Today, a majority of the U.S. population is enrolled in some form of managed care—a system which has enabled employers, insurers and taxpayers to achieve significant savings in the delivery of health care services. However, there is growing anxiety among many Americans that insurance health plan accountants—not doctors—are determining what services and treatments they receive. Congress has an opportunity to enact legislation this year which will ensure that patients receive the benefits and services to which they are entitled, without compromising the savings and coordination of care that can be achieved through managed care. However, to ensure the most effective result, legislation must embody the following principles:

It must be bipartisan and balanced.

It must offer all 161 million privately insured Americans—not just those in self-funded ERISA plans—a floor of basic federal patient protections.

It must establish credible federal enforcement remedies to ensure that managed care plans play by the rules and that individuals harmed by such entities are justly compensated.

It should encourage managed care plans to compete on the basis of quality—not just price. ''Report card'' information will provide consumers with the information they need to make informed choices based on plan performance.

SUMMARY

''The Promoting Responsible Managed Care Act of 1998'' blends the best features of both the Democratic and Republican plans.

The legislation would restore public confidence in managed care through a comprehensive set of policy changes that would apply to all private health plans in the country. These include strengthened federal enforcement to ensure managed care plans play by the rules; compensation for individuals harmed by the decisions of managed care plans; an independent external system for processing complaints and appealing adverse decisions; information requirements to allow competition based on quality; and, a reasonable set of patient protection standards to ensure patients have access to appropriate medical care.

Scope of protection

Basic protections for all privately insured Americans.—All private insurance plans would be required to meet basic federal patient protections regardless of whether they are regulated at the state or federal level. This approach follows the blueprint established with the enactment of the Health Insurance Portability and Accountability Act of 1996, which allows states to build upon a basic framework of federal protections.

Enforcement and compensation

Strengthened federal enforcement to ensure managed care plans play by the rules.—To ensure compliance with the bill's provisions, current federal law would be strengthened by giving the Secretaries of Labor and Health & Human Services enhanced authorities to enjoin managed care plans from denying medically necessary care and to levy fines (up to $50,000 for individual cases and up to $250,000 for a pattern of wrongful conduct). This provision would ensure that enforcement of federal law is not dependent upon individuals bringing court cases to enforce plan compliance. Rather, it provides for real federal enforcement of new federal protections.

Compensation for individuals harmed by the decisions of managed care plans.—All privately insured individuals would have access to federal courts for economic loss resulting from injury caused by the improper denial of care by managed care plans. Economic loss would be defined as any pecuniary loss caused by the decision of the managed care plan, and would include lost earnings or other benefits related to employment, medical expenses, and business or employment opportunities. Awards for economic loss would be uncapped and attorneys fees could be awarded at the discretion of the court.

Coverage determination, grievance and appeals

Coverage determination based on medical necessity.—When making determinations whether to provide a benefit (or where or how that benefit should be provided) health plans would be prohibited from arbitrarily interfering with the decision of the treating physician if the services are medically necessary and a covered benefit. Medically necessary services would be defined by the treating physician in accordance with generally accepted principles of professional medical practice—not as defined by the plan. Plans would be required to make coverage determinations in a timely manner, and have a process for making expedited determinations.

Internal appeals.—Patients would be assured the right to appeal the following: failure to cover emergency services, the denial, reduction or termination of benefits, or any decision regarding the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings. The plan would be required to have a timely internal review system, using health care professionals independent of the case at hand, and procedures for expediting decisions in cases in which the standard timeline could seriously jeopardize the covered individual's life, health, ability to regain or maintain maximum function, or (in the case of a child under the age of 6) development.

External appeals.—Individuals would be assured access to an external, independent appeals process for cases of sufficient seriousness or which exceed a certain monetary threshold that were not resolved to the patient's satisfaction through the internal appeals process. The external appeal entity would have the authority to decide whether a particular plan decision is in fact externally appealable, not the plan. A reasonable medical practice standard would be established against which to measure plan conduct, and the range of evidence that is permissible in an external review would include valid studies that have been carried out by entities without a conflict of interest. The external appeal process would require a fair, ''de novo'' determination, the plan would pay the costs of the process, and any decision would be binding on the plan.

Consumer information

Comparative information.—Consumers would be given uniform comparative information on quality measures in order to make informed choices. Data would include: patient satisfaction, delivery of health care services such as immunizations, and resulting changes in beneficiary health. Variations would be allowed based on plan type.

Plan information.—Patients would be provided with information on benefits, cost-sharing, access to services, grievance and appeals, etc. A grant program would be authorized to provide enrollees with information about their coverage options, and with grievance and appeals processes.

Confidentiality of enrollee records.—Plans would be required to have procedures to safeguard the privacy of individually identifiable information.

Quality assurance.—Plans would be required to establish an internal quality assurance program. Accredited plans would be deemed to have met this requirement, and variations would be allowed based on plan type.

Patient protection standards

Emergency services.—Coverage of emergency services would be based upon the ''prudent layperson'' standard, and, importantly, would include reimbursement for post-stabilization and maintenance care. Prior authorization of services would be prohibited.

Enrollee choice of health professionals and providers.—Patients would be assured that plans would:

allow women to obtain obstetrical/gynecological services without a referral from a primary care provider;

allow plan enrollees to choose pediatricians as the primary care provider for their children;

have a sufficient number, distribution and variety of providers;

allow enrollees to choose any provider within the plan's network, who is available to accept such individual (unless the plan informs enrollee of limitations on choice);

provide access to specialists, pursuant to a treatment plan;

in the case of a contract termination, allow continuation of care for a set period of time for chronic and terminal illnesses, pregnancies, and institutional care.

Access to approved services.—Plans would be required to cover routine patient costs incurred through participation in an approved clinical trial. In addition, they would be required to use plan physicians and pharmacists in development of formularies, disclose formulary restrictions, and provide an exception process for non-formulary treatments when medically necessary.

Nondiscrimination in delivery of services.—Discrimination on the basis of race, religion, sex, disability and other characteristics would be prohibited.

Prohibition of interference with certain medical communications.—Plans would be prohibited from using ''gag rules'' to restrict physicians from discussing health status and legal treatment options with patients.

Provider incentive plans.—Plans would be barred from using financial incentives as an inducement to physicians for reducing or limiting the provision of medically necessary services.

Provider participation.—Plans would be required to provide a written description of their physician and provider selection procedures. This process would include a verification of a health care provider's license, and plans would be barred from discriminating against providers based on race, religion and other characteristics.

Appropriate standards of care for mastectomy patients.—Plans would be required to cover the length of hospital stay for a mastectomy, lumpectomy or lymph node dissection that is determined by the physician to be appropriate for the patient and consistent with generally accepted principles of professional medical practice. Plans covering mastectomies would also be required to cover breast reconstructive surgery.

WHAT ORGANIZATIONS ARE SAYING ABOUT THE PROMOTING RESPONSIBLE MANAGED CARE ACT OF 1998

National Association of Children's Hospitals, Inc.: ''As you have recognized, children have health and developmental needs that are markedly different than the needs of the adult population and require pediatric expertise to understand, diagnose, and treat health problems correctly. . . . Again, we applaud you for your important and bipartisan efforts to address children's unique health care needs as part of your legislation. . . .''

National Mental Health Association: ''On behalf of the National Mental Health Association and its 330 affiliates nationwide, I am writing to express strong support for the Promoting Responsible Managed Care Act of 1998. . . . NMHA was particularly gratified to learn that you included language in your important compromise legislation which guarantees access to psychotropic medications. . . . Finally—alone among all the managed care bills introduced in this session of Congress—your legislation prohibits the involuntary disenrollment of adults with severe and persistent mental illnesses and children with serious mental and emotional disturbances.''

American Academy of Pediatrics: ''Children are not little adults. Their care should be provided by physician specialists who are appropriately educated in the unique physical and developmental issues surrounding the care of infants, children, adolescents, and young adults. We are particularly pleased that you recognize this and have included access to appropriate pediatric specialists, as well as other protections for children, as key provisions of your legislation.''

National Alliance for the Mentally Ill: ''Thank you for your efforts on behalf of people with severe mental illnesses. Your bipartisan approach to this difficult issue is an important step forward in placing the interests of consumers and families ahead of politics. NAMI looks forward to working with you to ensure passage of meaningful managed care consumer protection legislation in 1998.''

American Cancer Society: ''. . . I commend you on your bipartisan effort to craft patient

protection legislation that meets the needs of cancer patients under managed care. . . . Your legislation grants patients access to specialists, ensures continuity of care . . . and permits for specialists to serve as the primary care physician for a patient who is undergoing treatment for a serious or life-threatening illness. Most critically, your bill promotes access to clinical trials for patients for whom standard care has not proven most effective.''

American Protestant Health Alliance: ''Your proposal strikes a balance which is most appropriate. As each of us is aware, often we have missed the opportunity to enact health policy changes, only to return later and achieve fewer gains than we might have earlier. It would be tragic if we allowed this year's opportunity to escape our grasp. We are pleased to stand with you in support of your proposal.''

American College of Physicians/American Society of Internal Medicine: ''We believe your bill contains necessary patient protections, as well as provisions designed to foster quality improvement, and therefore has the potential to improve the quality of care patients receive. The College is particularly pleased that your proposal covers all Americans, rather than only those individuals who are insured by large employers under ERISA.''

National Association of Public Hospitals & Health Systems: ''This legislation provides consumers with the information to make informed decisions about their managed care plans, offers consumers protections from disincentives to provide care, and provides consumers with meaningful claims review, appeals and grievance procedures. We applaud your leadership in this area and we look forward to working with you to shape final legislation.''

Mental Health Liaison Group (a coalition of 19 national groups): ''By establishing a clear grievance and appeals process, assuring access to mental health specialists, and assuring the availability of emergency services, your bill begins to establish the consumer protections necessary for the delivery of quality mental health care to every American.''

Council of Jewish Federations: ''Your provisions on continuity of care also provide landmark protections for consumers in our community and in the broader community as well. Overall, your legislation provides important safeguards for consumers and providers that are involved in managed care.''

Families USA: ''We are pleased that your bill . . . would establish many protections important to consumers, such as access to specialists, prescription drugs and consumer assistance. In addition, your external appeals language addresses many consumer concerns in this area.''

National Association of Chain Drug Stores: ''. . . we applaud your efforts . . . in crafting a bipartisan managed care proposal. . . . Your bill, ''Promoting Responsible Managed Care Act'' takes a realistic step in improving the health care system for all Americans.''

Catholic Health Association: ''The Catholic Health Association of the United States (CHA) applauds your bipartisan leadership in Congress to help enact legislation this year protecting consumers who receive health care through managed care plans. The Chafee-Graham-Lieberman bill is a sound piece of legislation.''

National Association of Community Health Centers: ''We appreciate the bipartisan efforts you have undertaken to correct the deficiencies in the managed care system. . . . We applaud your inclusion of standards for the determination of medical necessity (Section 102) that are based on generally accepted principles of medical practice. . . . We also appreciate your inclusion of federally qualified health centers (FQHCs) as providers that may be included in the network.''●

● Mr. GRAHAM. Mr. President, I want to commend Senator CHAFEE, Senator LIEBERMAN, Senator SPECTER, and Senator BAUCUS for your outstanding leadership on an issue of vital importance to the country—protecting patients from abuses by managed care organizations.

Mr. President, what looms before the Senate is ominous. If nothing changes, when we return in September, we appear destined to be witnesses to the Senate's version of a massive train wreck in the form of managed care debate.

The Republican train and the Democratic train are racing toward each other with ever-increasing speed and hostility, neither side willing to apply the brakes and switch tracks—neither side mindful of the havoc the wreck could cause.

If we don't switch tracks, the wreck is inevitable. And the casualties will not be either political party. Instead, they will be the American public, who have asked us to provide them with basic federal protections.

My colleagues and I are simply not willing to sacrifice the opportunity to pass meaningful managed care reform this year for the opportunity to score political points.

Over the past few years, it has become increasingly clear that the American people are anxious about their health security as a consequence of managed care. Even managed care plans are nervous about the possibility of declining enrollment due to an increasing lack of consumer confidence.

Our bill seeks to leave the decision-making to doctors and their patients, and to ensure that patients get what they are paying for with their hard-earned dollars.

Our goal is to hold insurance companies accountable for the benefits and services they claim to be delivering. Patients want the right to see a specialist when they need one; our bill assures that. Patients want assurances they will get the medicines their doctors say they need, not just what's on a plan's formulary; our bill assures that. Patients want to know that plans are not providing financial incentives to their doctors to withhold medically necessary treatment; our bill assures that. Parents want to know that a pediatrician is available to serve as their child's primary care provider; our bill assures that.

Women want to know that they can see their ob/gyn without first getting permission from the plan's gatekeeper; our plan assures that.

However, having said all of that, it is vitally important to look at the fine print when comparing the patient protections contained in each of these proposals because, as the saying goes, the Devil is in the details.

For example, all of the plans would require insurers to pay for emergency services. However, the GOP plan lacks a critical protection which was enacted into law for Medicare and Medicaid beneficiaries as part of the Balanced Budget Act of 1997—reimbursement for post-stabilization care.

Each bill contains an external appeals process to allow patients to appeal denials or limitations of care to an independent entity. However, the Republican proposal would prevent any complaint for a service valued at less than $1,000.00 from being referred to an external appeals body. Picture the situation where a woman is denied a mammogram which, had it been done, would have resulted in early detection of breast cancer and you begin to understand why this provision is problematic.

In closing while the idea of playing the blame game up to the fall elections might be appealing to some, we are asking our colleagues, through this legislation, to take another course of action—to pass meaningful and effective patient protections for 161 million Americans this year.●

● Mr. LIEBERMAN. Mr. President, I am delighted to join Senators CHAFEE, GRAHAM, SPECTER, and BAUCUS to introduce the Promoting Responsible Managed Care Act of 1998. Our bill is a bipartisan effort that we believe can be enacted this year.

Our effort is modest in authorship because we have chosen to draw from both Republican and Democratic bills, but bold in goal. We aim to bring protections to 161 million Americans without delay before this Congress adjourns. Included in those bold protections are new rights of access to specialists, access to independent grievance and appeals, quality report cards, and compensation if a plan's actions result in their injury. Excluded are those provisions, even some with appeal, that are likely to prevent any Congressional action on patients' rights this year.

Over the last decade we have crossed over a turbulent river of change in health care. The raging cost escalation of the 80's and 90's buffeted families and tore away an ever increasing share of their paycheck to pay for health insurance coverage. Some couldn't afford the price, and lost their hold on health care—for themselves and their families.

Today, the on flowing health care costs have slowed, but left behind permanent changes in the health care shoreline. We have a tool that has dammed up health care costs—managed care. Yet, after more than a decade of cost increases, we have over forty-one million uninsured among us that can't afford coverage. We need to be mindful of these uninsured and the millions close to losing their insurance whenever we intervene in the health care market in ways that raise costs.

Managed care has calmed the rise in medical costs that buffeted us so badly and brought double-digit inflation under control. The average rate of increase of costs of medical plans

dropped 10 percent between 1991 and 1996. Without managed care, costs would be higher, millions more would be uninsured, and wages and salaries would be lower.

Today over 75 percent of Americans who receive their health coverage through their employer are in some form of managed care. Consumers no longer have a family doctor—they have a gatekeeper. They don't pick a physician—they (or in most cases, their employer) pick a network. A family's access to care, to drugs, to specialists all can be limited by the managed care organization.

Now that cost increases have slowed, it is also time to focus on health care quality. Many people are nervous about the quality of their managed care plans. They are concerned that the success of managed care in containing costs, has come at the expense of health care quality.

People want to know that they can get health care for their children from pediatricians, go see a specialist if their condition warrants some special attention, even go the emergency room if they feel that it is necessary.

They want to know that they aren't going to be locked out of medical care by an unresponsive managed care bureaucracy, vainly calling an unanswered phone to get approval for necessary medical care.

The entry of managed care into the health care marketplace has created competition that has lowered prices, enabling better access for millions to health care. But we also need to introduce competition over quality into this marketplace.

Our bill covers all 161 million Americans who are privately-insured. It includes patient protection standards to protect patient's access to the physician of their choice including women's access to obstetrical/gynecological specialists, a childs to a pediatrician, and other patients to specialists such as oncologists pursuant to a treatment plan.

It protects continuity of care, so that patients can continue to see their physician through an illness or pregnancy despite changes in the managed care network.

Plans would be prohibited from using ''gag rules'' to restrict physicians communication with their patients.

Visits to emergency rooms would be covered based on the ''prudent layperson'' standard and would include reimbursement for post stabilization and maintenance care.

Most important, we have included strong enforcement to protect these rights and protect the health and lives of all 161 privately insured Americans.

We have four important enforcement rights. We give consumers the right to obtain performance information so they don't get trapped in a bad health plan in the first place, establish a new grievance and appeals process so that consumers have a speedy process and fair setting to seek needed healthcare, give the U.S. Department of Labor and Health and Human Services the right to place heavy fines on health plans that don't protect patients, and finally, if all three fail, give the patient new rights to sue for compensation in federal courts if all the new protections fail and they are injured as the result of a decision by their managed care plan.

Our first enforcement tool is to empower consumer choice based on accurate, comparable information with information about their health care options. Millions of American healthcare consumers can get more information about the quality of a toaster oven or a candy bar than about their health plan. Report cards on health care quality should be the rule not the exception. Consumers who choose between plans, employers who purchase them, and plans and providers who compete for business will all drive up quality if report cards on their performance become the rule not the exception.

Some of the large employers in my state joined together years ago to hold health plans accountable. These companies stood up to say before they would even offer a health plan to their employees, that plan would have to agree to provide their record of performance and outcome on critical services such as breast cancer screening, prenatal care, asthma and diabetic treatment.

Workers at these companies now choose the plan with the best performance for them. All workers in America should have that right. It drives up quality and drives down bad managed care plans.

We require that all health plans be held accountable by reporting how well they are doing in providing the services that keep people healthy. We allow the Secretary to develop requirements that will work for different types of insurance, but get critical quality information to workers and purchasers. Although Senator NICKLES' bill includes voluminous information requirements, nowhere does he ask for the most critical information—how good a job is a health plan doing in keeping members of that plan healthy and alive.

Our second enforcement tool gives consumers in a health plan the right to appeal a denial of coverage to a independent, external panel of fair-minded experts under specific, quick deadlines.

When consumers need health care services, delays and indecision can be critical. The appeals process protects patients health by getting decisions made quickly and services provided before their medical condition worsens. No longer will consumers and their doctors spend months or even years fighting through a morass of managed care bureaucrats none of whom seem accountable, and all of whom add their own dollop of delay to a final decision.

We have adopted the ''gold standard'' set by the Medicare program which guarantees an answer in 72 hours or less for urgent care, and in less than one month for even the most routine decisions. Consumers have full rights to appeal any denial of care—both internally and to an external body for a completely independent review.

Third, we fix ERISA—a law that was enacted in 1974—so that it no longer blunts enforcement of patient protections. Under current law there are no meaningful enforcement remedies available to Americans who get their insurance through their employers. The U.S. Departments of Labor and Health and Human Services can do little to carry out their enforcement responsibilities. Individuals can not seek compensation when their health care plan makes a decision that injures them. A person, grievously harmed by their plan, can only sue for the cost of the benefit wrongly denied. For example, under current ERISA law, a mother on death's bed with cancer wrongly denied. For example, under current ERISA law, a mother on death's bed with cancer because she didn't get a mammogram would only be able to sue her health plan for the cost of the mammogram.

The Democrats have chosen to address this problem by allowing participants in ERISA plans to seek redress, including uncapped punitive damages, in state courts, an absolute nonstarter with the Republicans. The Republican plan simply extends the enforcement mechanism provided under current law, which is to say the cost of the benefit denied, and have thrown in a small additional fine of $100 a day in cases where a health plan refuses to comply with the decision of the external appeal entity. $100 is a cruel compensation for a family that has lost a breadwinner through the botched denial of coverage of a managed care plan.

We believe it is vitally important for Congress to step up to the plate with a real federal patient rights enforcement. In order to ensure that plans abide by the new patient protections in our bill, we give new civil money penalty and injunctive relief authority to the Secretaries of Health and Human Services and Labor. Plans that violate the law can be compelled to pay for it—up to $250,000.

Finally, there will be those tragic instances where our broad, new protections fail. A person is injured despite their new rights and powers and the managed care organization is at fault. Under our plan, people can take their plan to court, and sue that plan for the full amount of any damages equal to their economic loss plus attorney's fees. The injured person can get back the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities, caused by the coverage determination of the managed care plan. For the injured person and their family, the dollars probably can never compensate for the loss of health, but we think that it is critical that at least their

economic losses by paid when a plan causes the injury.

That is our plan, a stronghold of patient rights protected by four well-buttressed walls of individual and government enforcement. We have given patients the strongest tools at our disposal—information, appeal rights, agency enforcement, and access to the courts. Our proposal has these strengths, but not the baggage of provisions that partisans of either party I fear may use to prevent congressional action. I urge the passage of the Promoting Responsible Managed Care Act of 1998 so that 161 million Americans can receive its protections without delay.●

● Mr. BAUCUS. Mr. President, I rise today to join Senators CHAFEE, GRAHAM, LIEBERMAN, and SPECTER in introducing the Promoting Responsible Managed Care Act of 1998. This bill will provide needed protections for all patients, while omitting the most polarizing aspects of the two major managed care bills designed by Republican and Democratic leaders. This bill seeks to establish a middle ground so that patients can be guaranteed quality health care this year.

Mr. President, this legislation provides improved quality health care for all 161 million Americans enrolled in private health insurance plans, including managed care plans. The measure will protect the doctor-patient relationship, make information readily available, create quality standards, insure a timely appeals process, and provide patients with better access to care.

By offering report cards on health plans, patients will be given the opportunity to make informed choices when selecting a health plan. This bill will also guarantee patients access to their specialists, and ensure that people have needed emergency treatment available wherever they are. Patients will not just receive stabilization in the emergency room, but will be guaranteed care afterwards as well.

The bipartisan bill gives women direct access to obstetrician-gynecologists, and children direct access to pediatricians. Prescription drugs which doctors deem necessary to patient care, whether on provider formulary lists or not, will now be made available. Routine costs associated with plan-approved clinical trials will also be guaranteed. Gag clauses, which undermine the patient-doctor relationship by penalizing doctors for referring patients to specialists or discussing costly medical procedures, will be prohibited.

Mr. President, under the bipartisan bill, independent parties would be given the authority to rule on managed care denials through an appeals process, guaranteeing that each patient has a chance to appeal HMO decisions. Enforcement laws will help guarantee these provisions. This legislation will allow the Department of Health and Human Services and the Department of Labor to levy civil monetary penalties to managed care plans which do not abide by the bill's provisions. Also, self and fully-insured patients will be granted access to federal courts to claim compensatory damages.

Mr. President, in health care, quality patient care should be the bottom line. I believe that the bottom line is achieved by Democratic plan. But with a Democratic plan that is unlikely to pass in this Republican-controlled Senate, and a Republican measure which would likely be vetoed by the president, this proposal stands as a fresh start to significant managed care reform. This bipartisan and balanced measure will ensure that quality care prevails over political differences, and I urge the Senate to pass it.●

By Mr. SESSIONS:

S. 2417. A bill to provide for allowable catch quota for red snapper in the Gulf of Mexico, and for other purposes; to the Committee on Commerce, Science, and Transportation.

NATIONAL MARINE FISHERIES LEGISLATION

● Mr. SESSIONS. Mr. President, I rise today to introduce legislation, which I have drafted to address a matter which is of growing concern in my state. In particular, my constituents who live and work in the coastal communities of Alabama have voiced serious and legitimate concerns about the validity of recently issued National Marine Fisheries Service regulations which threaten to reduce the total allowable catch of red snapper in the Gulf of Mexico this year. The red snapper stock in the Gulf of Mexico is a very important economic asset for my state and, in fact, serves as a major economic linchpin for many of these coastal communities. I believe that my bill presents a reasonable solution to ensuring the long-term viability of the snapper stocks while also ensuring continuity and economic stability for individuals and communities who are so reliant on the income that commercial and recreational snapper fishing provides. Additionally, I feel that this bill could provide relief for persons in the shrimp industry, who feel that they have been unduly and unfairly burdened by NMFS regulatory requirements. Mr. President, I would also like to stress that this bill would assist all Gulf Coast communities that rely on the red snapper as an asset and I would hope that my colleagues who are hearing the same concerns from their constituencies will join with me in support of this bill.

Mr. President, I will have more to say about this bill in the future. For the sake of brevity, however, I would simply like to highlight some of the features in my legislation. To begin with, it maintains a total allowable catch of 9,120,000 pounds for each calendar year 1998 through 2001 which is to be allocated according to the current 51% commercial and 49% recreational split. The intent of this language is to provide certainty to our coastal communities by establishing a total allowable catch quota for this time period which cannot be lowered. The bill also provides that release of this quota cannot be conditioned upon the performance of bycatch reduction devices over the 1998–2001 time period. Additionally, the legislation maintains the current minimum size limits, and maintains the National Marine Fisheries Service's recently established 4 bag limit. My bill also requires the Secretary of Commerce to immediately review existing turtle excluder devices to see if they can be certified as bycatch reduction devices in the hopes that, if they can be so certified, shrimpers will be spared the cutting of an additional hole in their nets. Finally, my bill will also require a future study of bycatch reduction efficiency to be undertaken by the Secretary so that snapper management techniques can be based on accurate, and scientifically sound, understanding of the role that bycatch reduction devices can play in our efforts to continue to strengthen the replenishing snapper stocks. In my view, this bill adds clarity and stability to a situation that has been needlessly complicated over the past several years, and will allow both the regulators and the regulated community an opportunity to ''catch their breath'' as we determine the proper steps to take in resolving this ongoing debate.●

By Mr. JEFFORDS (for himself, Mr. LEAHY, and Mr. WARNER):

S. 2418. A bill to establish rural opportunity communities, and for other purposes; to the Committee on Finance.

RURAL OPPORTUNITIES EMPOWERMENT ACT OF 1998

● Mr. JEFFORDS. Mr. President, today with my friend and colleague, Senator LEAHY, I introduce the Rural Opportunities Empowerment Act of 1998—a bipartisan bill that will do a great deal to assist urban and rural areas develop communities in economic need.

The legislation will do a number of things. It builds off the Taxpayer Relief Act of 1997, which authorized 20 rural and urban Empowerment Zones, and creates new opportunities for those communities desperately in need of federal assistance, but unable to access those funds.

Our legislation will help scores of communities across the country seeking to improve their local economy through desperately needed federal funds. Within our legislation, monies are provided for the 20 Empowerment Zones authorized last year. Also, new grants are created for communities that are not able or eligible to compete for the EZ Round II competition this fall. Additional points will be given to those Enterprise Communities who have met a high standard of performance and who are seeking to be designated as an Empowerment Zone. Finally, a small amount of money will be provided to the Secretary to reward so-called ''Top Performers,'' and allow

them to be able to continue their operations so additional goals of their strategic plan are met.

Mr. President, the Department of Housing and Urban Development (HUD) and the U.S. Department of Agriculture's (USDA) Empowerment Zones and Enterprise Communities provide critical resources for those rural and urban areas in economic distress. Many of these communities intend to apply for a Round II Empowerment Zone designation. Vermont's old North End in Burlington, for example, has met numerous milestones in their strategic plan by successfully leveraging additional monies from the private sources. If Congress does not pass this legislation there will be no funding. Burlington's application for an Empowerment Zone designation under Round II this fall will be useless.

Providing rehabilitation and tax breaks to businesses who are interested in investing in a depressed area has been an impressive success in Burlington and elsewhere and my legislation will not only allow Burlington to compete for Empowerment Zone status in Round II, but it will also require HUD to disseminate best EC practices to other ECs around the country who may not be performing as impressively. This legislation is not only good for rural and urban communities, it is good government.

I ask my colleagues to work with me and with Senator LEAHY to ensure that this legislation is passed in the short time we have left in the 105th Congress. I will be working with the Finance Committee to ensure that this Congress does not forget those communities who look toward the federal government to provide incentives for the private sector to invest in economically depressed areas.●

● Mr. LEAHY. Mr. President, I am pleased to join Senator JEFFORDS today in introducing the Rural Opportunity Communities Act of 1998. This bill will greatly enhance the Empowerment Zone program by providing incentives to reward well performing Empowerment Zones and Enterprise Communities. The bill will also offer communities which face significant economic problems, but do not fit the strict definitions of the Empowerment Zone program with an alternative built on the same long-term, comprehensive, community-based planning.

In 1995 the first round of Empowerment Zones and Enterprise Communities were designated. Those communities have well demonstrated the potential of the program to revitalize inner-city neighborhoods and poverty stricken rural areas. In Burlington's Old North End, Vermont's only Enterprise Community, the benefits of this program have been tremendous. What was once a decaying section of the city is now a vital neighborhood. Equally important, the ''New North End'' has become an integral part of the city through the network of organizations and community members that pulled together to develop a plan to revitalize the area.

A new round of Empowerment Zone awards will allow additional communities to benefit from the program. This bill further enhances the Empowerment Zone program by recognizing those communities which have made the most progress in implementing their ten year plans and improving their neighborhoods. These model Empowerment Zones and Enterprise Communities will be eligible to compete for special incentive grants so that the successful programs they have initiated can continue to flourish. The success of well-performing Enterprise Communities will also be recognized by giving them additional points on their applications for empowerment zone status.

FInally, the bill establishes a special demonstration program, the Rural Opportunity Communities. This demonstration is designed to test the Empowerment Zone model of long-term, community based planning, with communities which are facing economic problems different from those defined by the Empowerment Zone program. Among other factors, the ROC demonstration will recognize the very real problem of under-employment, a significant problem in Vermont. The northeastern corner of Vermont, known as the Northeast Kingdom, is regularly responsible for one of the highest unemployment rates in the state. This is a very rural area where many families also hold down multiple jobs to make ends meet.

Last year I worked to bring together a group of economic development organizations and local officials to take a broader look at the problems facing the region, and work to find a common approach to addressing those problems. Since that time this group, known as the Northeast Kingdom Enterprise Collaborative, has continued to grow and has begun to lay the groundwork for a long-term plan for the three-county area. The ROC demonstration will offer a perfect opportunity for areas like the Northeast Kingdom, that are interested in pursuing this Empowerment Zone model, to gain access to the resources they need.

By Mr. D'AMATO:

S. 2419. A bill to amend the Public Utility Regulatory Policies Act of 1978 to protect the nation's electricity ratepayers by ensuring that rates charged by qualifying small power producers and qualifying cogenerators do not exceed the incremental cost to the purchasing utility of alternative electric energy at the time of delivery, and for other purposes; to the Committee on Energy and Natural Resources.

THE ELECTRIC POWER CONSUMER RATE RELIEF ACT OF 1998

Mr. D'AMATO. Mr. President, I ask unanimous consent that the text of the bill, S. 2419, be printed in the RECORD.

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

S. 2419

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 ''Electric Power Consumer Rate Relief Act of 1998''.

SEC. 2. FINDINGS.

Congress finds that—

(1) certain courts have found that States are preempted under the Public Utility Regulatory Policies Act of 1978 from engaging in certain ratepayer protection activities critical to ensuring reasonable rates for in-State ratepayers;

(2) those courts have found that, although States have the authority initially to establish rates charged by qualifying small power producers and qualifying cogenerators to local electric utilities, that such States thereafter are preempted by that Act from ensuring over time that rates—

(A) are just and reasonable to the retail electric consumers of purchasing electric utilities and are in the public interest; and

(B) do not exceed the incremental cost to such purchasing electric utilities of alternative electric energy at the time of delivery;

(3) other courts have found that States are preempted from monitoring effectively the operating and efficiency performance of in-State cogeneration and small power production facilities for the purpose of determining whether such facilities meet Federal Energy Regulatory Commission standards for qualifying cogenerators; and

(4) that Act should be amended to clarify the intent of Congress that States have the authority—

(A) to ensure that rates charged by qualifying small power producers andqualifying cogenerators to purchasing electric utilities—

(i) are just and reasonable to the electric consumers of such purchasing electric utilities and in the public interest; and

(ii) do not exceed the incremental cost to such purchasing electric utilities of alternative electric energy at the time of delivery; and

(B) to establish effective programs for monitoring the operating and efficiency performance of in-State cogeneration and small power production facilities for the purpose of determining whether such facilities meet Federal Energy Regulatory Commission standards for qualifying cogenerators.

SEC. 3. IMPLEMENTATION OF RULES.

Section 210(f)(1) of the Public Utility Regulatory Policies Act of 1978 (16 U.S.C. 824a–3(f)(1)) is amended—

(1) by striking ''(1) Beginning'' and inserting the following:

''(1) BY STATE REGULATORY AUTHORITIES.—

''(A) IN GENERAL.—Beginning''; and

(2) by adding at the end the following:

''(B) REQUIREMENTS.—Notwithstanding any other provision of this section, a State regulatory authority may ensure that rates charged by qualifying small power producers and qualifying cogenerators—

''(i) are just and reasonable to the electric consumers of the purchasing electric utility and in the public interest; and

''(ii) do not exceed the incremental cost at the time of delivery to the purchasing utility of alternative electric energy and capacity.

''(C) MONITORING.—A State regulatory authority may establish programs for monitoring the operating and efficiency performance of in-State cogeneration and small power production facilities for the purpose of determining whether the facilities meet standards established by the Commission for qualifying facilities.

''(D) AMENDMENT OF CONTRACT.—A State regulatory authority may require that any

contract entered into before the date of enactment of this paragraph be amended to conform to any requirements imposed under subparagraph (B).''.

By Mr. HARKIN (for himself, Mr. HATCH, Mr. DASCHLE, Mr. CRAIG, Ms. MILKULSKI, Mr. D'AMATO, Ms. MOSELEY-BRAUN, Mr. GRASSLEY and Mr. WELLSTONE):

S. 2420. A bill to establish within the National Institutes of Health an agency to be known as the National Center for Complementary and Alternative Medicine; to the Committee on Labor and Human Resources.

CENTER FOR COMPLEMENTARY AND ALTERNATIVE LEGISLATION

● Mr. HARKIN. Mr. President, today I am introducing a bill, cosponsored by Senators DASCHLE, HATCH, GRASSLEY, D'AMATO, WELLSTONE, MIKULSKI, CRAIG, and MOSELEY-BRAUN to improve and expand rigorous scientific review of alternative and complementary therapies. This bill will elevate the NIH's Office of Alternative Medicine to Center status. It would be renamed the ''National Center for Complementary and Alternative Medicine.''

Mr. President, the American public supports this bill. Increasingly, Americans are turning to complementary and alternative medicine. According to a recent study by Harvard University researchers, fully one third of Americans regularly use complementary and alternative medicine. This same study found that in 1990, American consumers spent more than $14 billion on these practices. In that year there were 425 million visits to complementary and alternative practitioners—more than those to conventional primary care practitioners!

These practices, which range from acupuncture, to chiropractic care, to naturopathic, herbal and homeopathic remedies, are not simply complementary and alternative, but are integral to how millions of Americans manage their health and treat their illnesses. Yet there is little scientific research being done to investigate and validate these therapies.

We must reexamine our spending priorities. Approximately 90 million Americans suffer from chronic illnesses which cost society roughly $659 billion in health care expenditures, lost productivity and premature death. According to the Centers for Disease Control, we spend $28.6 billion Medicare dollars on diabetes alone—a disease which can be treated effectively with low-cost alternative therapies. A Robert Wood Johnson Foundation study recently published in the Journal of the American Medical Association (JAMA) revealed that the current health care delivery system is not meeting the needs of the chronically ill in the United States. The study also concluded that such trends reveal skyrocketing costs, increasing numbers of people in need and a dysfunctional system of care. Alternative medical therapies could offer a cost-saving alternative to this trend.

We are in an era when we must take a closer look at ways to provide cost-effective, preventive health care, and as we do so, Congress must act to strengthen the mission of the Office of Alternative Medicine in finding safe and effective treatments and preventive methods for chronic conditions. Patients throughout our nation are suffering because there is a lack of available information on alternative medicine.

In 1992, after finding that the National Institutes of Health (NIH) was largely ignoring this increasingly important area, at my urging Congress passed legislation creating the Office of Alternative Medicine (OAM) within NIH. At that time, Congress charged OAM with assuring objective, rigorous scientific review of alternative therapies. They were to investigate and validate therapies so that consumers would be better informed as to what treatments work and what treatments don't.

It is now clear that without greater authority to initiate research projects and assure unbiased and rigorous peer review, alternative therapies will not be adequately reviewed. The main problem is that the Office has no authority to directly provide research funding to any medical professional seeking to study the safety and effectiveness of alternative treatments. And unlike all other major organizations within NIH, the OAM has no autonomy to oversee its mission and goals. Because the Office must work through other Institutes to carry out research projects, promising projects are blocked and considerable time and resources are wasted.

The bill we are introducing would increase the status and authority of the Office of Alternative Medicine by creating in its place a National Center for Complementary and Alternative Medicine at NIH. The principal change in authority is granting the Center the ability to directly fund research proposals and other projects. This will not only assure that alternative therapies receive the review they need and deserve, it will improve efficiency by eliminating unnecessary bureaucratic steps required by the current set up.

Our bill also addresses another shortcoming of the NIH's current handling of alternative medicine research. The hallmark of rigorous scientific review at NIH is the peer review process. However, when it comes to alternative and complementary therapies, there is no true peer review. There are no complementary or alternative medicine specialists on NIH peer review panels. That means, for example, that when a research proposal comes in on chiropractic care, it often is reviewed by peer review panels that include no chiropractors. Rather, these proposals may be reviewed by scientists who have little or no experience in or knowledge about chiropractic care.

This has three negative results. First, these projects are not being reviewed by individuals with expertise in the fields contemplated by the research. This reduces the scientific quality of the review process. Second, because those reviewing these proposals have no expertise in this area, they may be less likely to support their approval. And, third, because those seeking NIH support of alternative medicine research know that their proposals will not receive true peer review, they may hesitate to apply, thereby reducing the number and quality of research proposals. Our proposal corrects this problem by requiring that projects are reviewed by scientists with expertise in the particular area of complementary and alternative medicine proposed to be studied.

The federal government and state-of-the-art science must begin to catch up with the public's increasing demand for information and answers regarding alternative and complementary health care. The time is now. I urge you and my colleagues to support this important bill that will improve the quality of health care for Americans.●

By Mr. CONRAD:

S. 2421. A bill to provide for the permanent extension of income averaging for farmers; to the Committee on Finance.

PERMANENT EXTENSION OF INCOME AVERAGING FOR FARMERS

Mr. CONRAD. Mr. President, I am taking the floor today to introduce a bill which will respond to a critical problem faced by farmers. This proposal would amend the provision in the Taxpayer Relief Act of 1997 the temporarily reinstated income averaging for farmers.

When income averaging was eliminated as part of the Tax Reform Act of 1986, Congress acted primarily on the assumption that fewer tax brackets and dramatically lower marginal tax rates would substantially reduce the number of taxpayers whose fluctuating incomes could subject them to higher progressive rates. Congress was also concerned that income averaging, as it existed at that time, was effectively targeted on taxpayers who actually experienced wildly fluctuating incomes.

Today, it is hard to imagine a group of taxpayers whose incomes fluctuate more wildly than farmers. There is no place where that kind of fluctuation is more vividly demonstrated than in my own state of North Dakota. In 1996, North Dakota farm income came in at $764 million. A year later, it was $15 million. That is a 98 percent decrease, Mr. President! Fluctuations just don't come much wilder than that.

Reflecting on the situation, I think Congress made a mistake eliminating income averaging altogether in 1986—at least with respect to farmers. Fluctuating income is a fact of life in agriculture, and to the extent that the Internal Revenue Code can respond to that reality, it should do so.

The change we made in 1997 was a good one, but it did not go far enough to help many farmers who desperately need it. That reinstatement of income averaging for farmers should have made farmers' incomes in 1997 eligible for averaging and the reinstatement should have been permanent. The bill I introduce today does both.

This bill will provide modest, but much needed, assistance to farmers who were devastated in 1997, and provide it in a way that is consistent with the approach Congress took in the Taxpayer Relief Act last year.

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. 2421

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

SECTION 1. PERMANENT EXTENSION OF INCOME AVERAGING FOR FARMERS.

Section 933(c) of the Taxpayer Relief Act of 1997 is amended by striking ''after December 31, 1997, and before January 1, 2001'' and inserting ''after December 31, 1996''.

By Mr. MACK (for himself, Mr. D'AMATO, Mr. COVERDELL, Mr. MCCONNELL, Mr. MURKOWSKI, Mr. GORTON, and Mr. NICKLES):

S. 2422. A bill to provide incentives for states to establish and administer periodic teacher testing and merit pay programs for elementary school and secondary teachers; to the Committee on Labor and Human Resources.

MEASURE TO ENCOURAGE RESULTS IN TEACHING ACT OF 1998

Mr. MACK. Mr. President, I rise today to introduce legislation with my friend and colleague, Senator D'AMATO, to ensure that every classroom in America is staffed with a competent, qualified and caring teacher. During the past several months, Congress has debated a number of initiatives to further this goal, including an amendment that Senator D'AMATO and I introduced and passed as part of the Education Savings Accounts package. Our amendment passed with bipartisan support, and we are here today to pursue this legislation in light of the President's veto of the ESA bill.

As early as the 1890s, the United States was the world's premiere industrial power, boasting a manufacturing sector roughly equal to that of Great Britain, Germany and France combined. While relatively new, this industrial order grew at a remarkable pace, leading many to concur with Teddy Roosevelt's prediction that the Twentieth Century would be ''America's Century.''

As we stand at the edge of a new millennium, another economic revolution in underway. But unlike the industrial revolution of one hundred years ago, this new revolution is defined not by large factories and natural resources, but by something a little less tangible and a little more human. I believe the 21st Century will be known as the ''Century of Knowledge,'' where ingenuity and innovation will prove to be the most critical of resources. Now, if our children are to be prepared for the challenges ahead, educational excellence must become our first order of business.

The President has placed education near the top of his domestic agenda. I am pleased that he, too, recognizes the importance of providing our children with an education second to none. This is an area where we can easily agree. However, I am discouraged that none of his proposals confronts the most basic, the most important, and the most neglected aspect of public education: the quality of instruction in the classroom. It cannot be overstated that the best teachers produce the best students. Unless the quality of teaching improves, all other very worthwhile reforms, from smaller classes and higher salaries to newer buildings and computers in the classroom—are meaningless.

Good teachers are the backbone to a good education. Every student in America has a fundamental right to be taught by a skilled and well-prepared teacher. Teachers make all the difference in the learning process. America's classrooms are staffed with many dedicated, knowledgeable, and hard-working teachers. Studies show again and again that teacher expertise is one of the most important factors in determining student achievement.

Nevertheless, the case for sweeping reform is not difficult to make. The United States already spends more money per pupil than virtually any industrialized democracy in the world. Nonetheless, our children frequently score near the bottom in international exams in science and math. If the teacher-student relationship—which in my opinion is the most basic building-block in the educational process—is defective, no amount of resources will be able to turn bad schools into good schools. Throwing more money at the problem is no longer the answer. Again, real reforms are needed.

Mr. President, real education reform begins in America's classrooms. Any reform must include measures to ensure that teachers are qualified to teach the subjects they are teaching. To my dismay, I have learned that all across the country, many teachers are being assigned to teach classes for which they have no formal training. Consider these statistics:

One out of five English classes were taught by teachers who did not have at least a minor in English, literature, communications, speech, journalism, English education, or reading education.

One out of four mathematics classes were taught by teachers without at least a minor in mathematics or mathematics education.

Nearly 4 out of 10 life science or biology classes were taught by teachers without at least a minor in biology or life science.

More than half of physical science classes were taught by teachers without at least a minor in physics, chemistry, geology or earth science.

More than half of history or world civilization classes were taught by teachers who did not have at least a minor in history.

Students in schools with the highest minority enrollments have less than a 50% chance of getting a science or mathematics teacher who holds a license and a degree in the field he or she teaches.

Our schools and classrooms should be staffed with teachers who have the appropriate training and background. One way to determine this would be to test teachers on their knowledge of the subject areas they teach.

Teacher testing is an important first step toward upgrading the quality of classroom instruction. Testing would identify teachers who are not making the grade, and would enable principals to help weaker teachers improve. Much has been made about social promotion, where students are often pushed on to the next grade with his or her peers despite the fact that the student has not met the criteria needed to advance. In my opinion, teachers face social promotion too. They are kept on staff regardless of performance. That is wrong. States should measure the expertise of their teachers through periodic teacher testing.

Common sense also dictates that we should not concentrate all our attention on underperforming teachers. We must also recognize that there are many great teachers who are successfully challenging their students on a daily basis. Today, our public schools compensate teachers based almost solely on seniority, not on their performance inside the classroom. Merit-pay would differentiate between teachers who are hard-working and inspiring, and those who fall short.

The legislation we are introducing today, known as the MERIT ACT—which stands for Measures to Enhance Results in Teaching—is the same legislation that passed the Senate during debate on the Education Savings Accounts bill. It rewards states that test its teachers on their subject matter knowledge, and pays its teachers based on merit.

Here is how it works: we will make half of any additional funding over the FY 1999 level for the Eisenhower Professional Development Program available to states that periodically test elementary and secondary school teachers, and reward teachers based on merit and proven performance. There will be NO reduction in current funding to states under this program based on this legislation. As funding increases for this program, so will the amount each state receives. Incentives will and should be provided to those states that take the initiative to establish teacher testing and merit pay programs.

Again, I want to emphasize that all current money being spent on this program is unaffected by this legislation.

Only additional money will be used as an incentive for states to enact teacher testing and merit pay programs.

Finally, this amendment enables states to also use federal education money to establish and administer teacher testing and merit pay programs. This broad approach will enable states to staff their schools with the best and most qualified teachers, thereby enhancing learning for all students. In turn, teachers can be certain that all of their energy, dedication and expertise will be rewarded. And it can be done without placing new mandates on states or increasing the federal bureaucracy.

Mr. President, as I pointed out earlier, the Senate has already debated this innovative approach when we considered the Education Savings Accounts bill. I was impressed that we passed the amendment with bipartisan support by a vote of 63–35, and that it was included in the Conference report sent to the President for his signature. I was disappointed, however, when the President vetoed that important legislation on July 22, 1998, despite his own earlier involvement in developing a teacher testing program in his home state of Arkansas while he was Governor.

As Governor, Bill Clinton enthusiastically supported teacher testing, and while Governor of South Carolina, Secretary of Education Richard Riley advocated a merit-pay plan. In fact, then-Governor Clinton in 1984 said that he was more convinced than ever that competency tests were needed to take inventory of teacher' basic skills. He said, ''Teachers who don't pass the test shouldn't be in the classroom''. Since coming to Washington, however, neither the President nor Secretary Riley has tried to do for the children of America what they as Governors fought to do for the children of their own states. Our nation's children deserve better.

While Bill Clinton let an opportunity for true reform pass him by, I am encouraged by the recent action taken by the American Federation of Teachers. They, too, recognize that true reform begins in the classroom and that teacher quality must be at the heart of that reform. They recently passed a resolution affirming the need for improved teacher quality, which also states that they will take a more active role in reviewing teacher performance and dismissing teachers that cannot be helped. This same proposal was rejected two years ago by the Federation's membership. Again, I am encouraged by this change of heart. I am hopeful that we can work together with the AFT and any other organization interested in moving forward to improve teacher quality. While we may not agree on every approach, I would like to commence an ongoing dialogue on this important issue.

Mr. President, I must also point out how timely this legislation is in light of the recent reports out of the state of Massachusetts, which tested prospective teachers with a tenth-grade level exam. Sadly, 60 percent of those taking the test failed. It's unfortunate that the poor results of the test overshadow the positive contributions teachers make day in and day out to challenge the imagination of their students. That's why it's important to help teachers become the best they can be and to reward the outstanding teachers who are making a difference in the lives of our youth. Our children deserve nothing less. That's what this legislation does.

The President's lack of support for merit pay and teacher testing has only temporarily set back the call for excellence in education. But I will continue to press forward with plans to ensure that our classrooms are led by capable teachers, and I will continue the fight to give dedicated professionals who teach our children a personal stake in the quality of the instruction they provide. If we accomplish these reforms, and place the interests of students above the preservation of the status quo, then the extraordinary dynamism of the American people will continue, and the 21st Century will, once again, be the ''American Century''.

I hope there will again be broad, bipartisan support for this important initiative.

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:

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

SECTION 1. SHORT TITLE; FINDINGS; AND PURPOSES.

(a) SHORT TITLE.—This Act may be cited as the ''Measures to Encourage Results in Teaching Act of 1998''.

(b) FINDINGS.—Congress makes the following findings:

(1) All students deserve to be taught by well-educated, competent, and qualified teachers.

(2) More than ever before, education has and will continue to become the ticket not only to economic success but to basic survival. Students will not succeed in meeting the demands of a knowledge-based, 21st century society and economy if the students do not encounter more challenging work in school. For future generations to have the opportunities to achieve success the future generations will need to have an education and a teacher workforce second to none.

(3) No other intervention can make the difference that a knowledgeable, skillful teacher can make in the learning process. At the same time, nothing can fully compensate for weak teaching that, despite good intentions, can result from a teacher's lack of opportunity to acquire the knowledge and skill needed to help students master the curriculum.

(4) The Federal Government established the Dwight D. Eisenhower Professional Development Program in 1985 to ensure that teachers and other educational staff have access to sustained and high-quality professional development. This ongoing development must include the ability to demonstrate and judge the performance of teachers and other instructional staff.

(5) States should evaluate their teachers on the basis of demonstrated ability, including tests of subject matter knowledge, teaching knowledge, and teaching skill. States should develop a test for their teachers and other instructional staff with respect to the subjects taught by the teachers and staff, and should administer the test every 3 to 5 years.

(6) Evaluating and rewarding teachers with a compensation system that supports teachers who become increasingly expert in a subject area, are proficient in meeting the needs of students and schools, and demonstrate high levels of performance measured against professional teaching standards, will encourage teachers to continue to learn needed skills and broaden teachers' expertise, thereby enhancing education for all students.

(c) PURPOSES.—The purposes of this Act are as follows:

(1) To provide incentives for States to establish and administer periodic teacher testing and merit pay programs for elementary school and secondary school teachers.

(2) To encourage States to establish merit pay programs that have a significant impact on teacher salary scales.

(3) To encourage programs that recognize and reward the best teachers, and encourage those teachers that need to do better.

SEC. 2. STATE INCENTIVES FOR TEACHER TESTING AND MERIT PAY.

(a) AMENDMENTS.—Title II of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6601 et seq.) is amended—

(1) by redesignating part D as part E;

(2) by redesignating sections 2401 and 2402 as sections 2501 and 2502, respectively; and

(3) by inserting after part C the following:

''PART D—STATE INCENTIVES FOR TEACHER TESTING AND MERIT PAY

''SEC. 2401. STATE INCENTIVES FOR TEACHER TESTING AND MERIT PAY.

''(a) STATE AWARDS.—Notwithstanding any other provision of this title, from funds described in subsection (b) that are made available for a fiscal year, the Secretary shall make an award to each State that—

''(1) administers a test to each elementary school and secondary school teacher in the State, with respect to the subjects taught by the teacher, every 3 to 5 years; and

''(2) has an elementary school and secondary school teacher compensation system that is based on merit.

''(b) AVAILABLE FUNDING.—The amount of funds referred to in subsection (a) that are available to carry out this section for a fiscal year is 50 percent of the amount of funds appropriated to carry out this title that are in excess of the amount so appropriated for fiscal year 1999, except that no funds shall be available to carry out this section for any fiscal year for which—

''(1) the amount appropriated to carry out this title exceeds $600,000,000; or

''(2) each of the several States is eligible to receive an award under this section.

''(c) AWARD AMOUNT.—A State shall receive an award under this section in an amount that bears the same relation to the total amount available for awards under this section for a fiscal year as the number of States that are eligible to receive such an award for the fiscal year bears to the total number of all States so eligible for the fiscal year.

''(d) USE OF FUNDS.—Funds provided under this section may be used by States to carry out the activities described in section 2207.

''(e) DEFINITION OF STATE.—For the purpose of this section, the term 'State' means each of the 50 States and the District of Columbia.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on October 1, 1999.

SEC. 3. TEACHER TESTING AND MERIT PAY.

(a) IN GENERAL.—Notwithstanding any other provision of law, a State may use Federal education funds—

(1) to carry out a test of each elementary school or secondary school teacher in the State with respect to the subjects taught by the teacher; or

(2) to establish a merit pay program for the teachers.

(b) DEFINITIONS.—In this section, the terms ''elementary school'' and ''secondary school'' have the meanings given the terms in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801).

Mr. D'AMATO. Mr. President, I rise with my friend and colleague, Senator MACK, to introduce the MERIT Act. The MERIT Act seeks to reward those teachers who provide, day in and day out, magic in the classrooms, to reward them with a salary to match their importance. We should develop a methodology of rewarding those truly outstanding teachers and seeing to it that we keep them, retain them. Truly outstanding teachers are the unsung heroes of our communities. Unfortunately, however, great education does not take place for every child in every classroom, and that is sad. But it is something we can strive for and work to change.

The bill that Senator MACK and I introduce comes on the heels of receiving some discouraging news, news from Massachusetts where a test of prospective teachers was given and nearly 60 percent of them failed. It was a test at the eighth-grade level. I firmly believe that most New York teachers are very good. But, nonetheless, I must ask the question, Why not have the best? Why not reach out to them? Why not attract them?

The Massachusetts test was a good idea, but we should also give periodic competency tests to teachers who are already in the system. Most teachers are very dedicated and highly competent, but some are not. Some teachers who are highly skilled in one or two subject areas may be forced to teach other subjects in which they lack the competence. When that happens, our children are the ones who suffer.

Another desperately needed reform is merit pay for outstanding teachers. We must reward the best teachers. In most of our Nation's schools there is no financial incentive for the truly outstanding teachers. Great teachers, who help our children achieve educational excellence, should be rewarded.

The measure introduced today by Senator MACK and myself, the MERIT Act, is the same measure that passed the Senate on April 21 by a vote of 63 to 35. This legislation provides incentives for States to establish periodic teacher assessments and merit rewards. Incentives are provided through the Eisenhower Professional Development Program. The measure sets aside 50 percent of the funds appropriated over the fiscal year 1999 levels in the program, and then distributes them to States that have established teacher testing and merit pay. Last year, fiscal year 1998, Congress appropriated $335 million for this program to subsidize training for teachers. That is an increase of $25 million from the year before. Should we not be able to use this program to ensure that teachers are actually improving their teaching skills, as well as substantive knowledge? Teacher testing will help accomplish that goal.

But let me be clear. As the Eisenhower Professional Development Program funding increases, so will each State and local government's share, with 50 percent of the increase reserved for those States that put in place a mechanism by which to periodically measure the ability, knowledge, and skills of teachers, and implement a pay scale to reward those determined and dedicated teachers. When we look at reforming our public schools, one thing must always be kept foremost in our efforts, and that is, we must put our children first. Our children are the best and the brightest. They are our most precious resource.

So, when it comes to recruiting and retaining the best young professionals, I believe, in order to do that, we are going to have to pay them adequately. We are going to have to reward their accomplishments and see to it that the truly outstanding are rewarded with merit pay so we can assure our children get that opportunity. I hope our colleagues will join in this effort to improve America's schools and help prepare our children for the 21st century.

By Mr. ABRAHAM:

S. 2423. A bill to improve the accuracy of the budget and revenue estimates of the Congressional Budget Office by creating an independent CBO Economic Council and requiring full disclosures of the methodology and assumptions used by CBO in producing the estimates; to the Committee on the Budget and the Committee on Governmental Affairs, jointly, pursuant to the order of August 4, 1977, that if one Committee reports, the other Committee have thirty days to report or be discharged.

THE CONGRESSIONAL BUDGET OFFICE IMPROVEMENT ACT OF 1998

● Mr. ABRAHAM. Mr. President, I introduce legislation to improve the accuracy of Congressional Budget Office estimates.

Congress places enormous demands on the professionals working in the CBO. Day after day, year after year these dedicated men and women are asked to provide estimates and projections on which legislators rely in carrying out their public responsibilities. Their hard work and professionalism are well known and they deserve our gratitude for the excellent job they do.

However, Mr. President, CBO estimates and projections are only as good as the assumptions on which they are based. No matter how dedicated and hard-working they are, they are limited by the tools at their disposal. And recent experience shows that those tools require improvement.

Mr. President, there was a great deal of surprise, both in this Chamber and across the country, when the CBO released its latest estimates regarding federal budget surpluses. In January of this year the CBO had projected a $5 billion deficit for 1998, with surpluses of $127 billion for the period 1998–2003 and $655 billion for the period 1998–2008. But in its July budget update, the CBO projected a $63 billion surplus for 1998, a $583 billion surplus for the period 1998–2003, and a $1,611 billion surplus for the period 1998–2008.

Those are massive discrepancies, Mr. President, and they have a significant impact on our ability to legislate. Coming so late in the session, these new estimates are not as helpful as they could have been in helping shape our fiscal policies. What they mean, in essence, is that Congress has been determining its budgets and appropriations with inaccurate revenue estimates.

What is more, Mr. President, it does not appear that the accuracy of CBO projections will improve without Congressional action. Current CBO policy calls for basing estimates on the assumption that federal revenues will grow more slowly than Gross Domestic Product. This despite the long-standing trend of revenues outpacing GDP. Thus we can look forward to revenue estimates in the future that remain significantly lower than actual revenues.

Without accurate revenue estimates, Mr. President, we cannot properly address tax reform and general fiscal policy. Indeed, without knowing the level of federal revenues with a significant degree of accuracy we cannot properly and responsibly budget for the federal government. We must establish a fair and accurate mechanism for estimating federal revenue.

That is why I am introducing the CBO Improvement Act. This legislation is based on a bill introduced in the 102nd Congress by Representatives NEWT GINGRICH, DICK ARMEY and Robert Michel. It would provide CBO with the expert, hands-on oversight necessary to improve the accuracy of its estimates.

To begin with, Mr. President, this legislation would establish a Congressional Budget Board to provide general oversight of CBO operations, oversee studies and publications that may be necessary in addition to those CBO is required by law to produce, and provide guidance to the CBO Director in the formulation and implementation of procedures and policies. This board would be made up of 6 members each from the Senate and the House of Representatives, half from each party.

In addition to its oversight function, the Board will establish an Economic Advisory Council. This Council will evaluate CBO research for the Board. It will be composed of 12 members, each