

1998; to the Committee on Governmental Affairs.

EC-922. A communication from the Secretary of Energy, transmitting, pursuant to law, the Department's report under the Inspector General Act for the period from April 1, 1998 through September 30, 1998; to the Committee on Governmental Affairs.

EC-923. A communication from the Secretary of Commerce, transmitting, pursuant to law, the Department's report under the Inspector General Act for the period from April 1, 1998 through September 30, 1998; to the Committee on Governmental Affairs.

EC-924. A communication from the Interim District of Columbia Auditor, transmitting, pursuant to law, a report entitled "Statutory Audit of Advisory Neighborhood Commission 2C for the Period October 1, 1995 through December 31, 1997"; to the Committee on Governmental Affairs.

EC-925. A communication from the Executive Director of the Committee for Purchase From People who are Blind or Severely Disabled, transmitting, pursuant to law, a list of additions to and deletions from the Committee's Procurement List dated December 22, 1998; to the Committee on Governmental Affairs.

EXECUTIVE REPORTS OF COMMITTEE

The following executive reports of committees were submitted:

By Mr. ROTH, from the Committee on Finance:

Susan G. Esserman, of Maryland, to be Deputy United States Trade Representative, with the rank of Ambassador.

Timothy F. Geithner, of New York, to be an Under Secretary of the Treasury.

Gary Gensler, of Maryland, to be an Under Secretary of the Treasury.

Edwin M. Truman, of Maryland, to be a Deputy Under Secretary of the Treasury.

David C. Williams, of Maryland, to be Inspector General for Tax Administration, Department of the Treasury. (New Position)

(The above nominations were reported with the recommendation that they be confirmed, subject to the nominees' commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

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

By Mr. WYDEN (for himself and Mr. SMITH of Oregon):

S. 294. A bill to direct the Secretary of the Army to develop and implement a comprehensive program for fish screens and passage devices; to the Committee on Environment and Public Works.

By Mr. LUGAR:

S. 295. A bill to amend part S of title I of the Omnibus Crime Control and Safe Streets Act of 1968 to permit the use of certain amounts for assistance to jail-based substance treatment programs, and for other purposes; to the Committee on the Judiciary.

By Mr. FRIST (for himself, Mr. ROCKEFELLER, Mr. DOMENICI, Mr. LIEBERMAN, Mr. GRAMM, Mr. BINGAMAN, Mr. BURNS, Mr. BREAUX, Mrs. HUTCHISON, Mr. CLELAND, Mr. THOMP-

SON, Mr. KERRY, Mr. DEWINE, Mr. KERREY, Mr. ABRAHAM, Mr. AKAKA, Mr. ALLARD, Mrs. BOXER, Mr. ROBERTS, and Mr. ROBB):

S. 296. A bill to provide for continuation of the Federal research investment in a fiscally sustainable way, and for other purposes; to the Committee on Commerce, Science, and Transportation.

By Mr. SHELBY:

S. 297. A bill to amend title 37, United States Code, to authorize members of the uniformed services to participate in the Thrift Savings Plan, and for other purposes; to the Committee on Governmental Affairs.

S. 298. A bill to amend the Federal Election Campaign Act of 1971 (2 U.S.C. 431 et seq.) to clarify that donations of hard and soft money by foreign nationals are prohibited; to the Committee on Rules and Administration.

By Mr. MCCAIN (for himself, Mr. INOUE, and Mr. CONRAD):

S. 299. A bill to elevate the position of Director of the Indian Health Service within the Department of Health and Human Services to Assistant Secretary for Indian Health, and for other purposes; to the Committee on Indian Affairs.

By Mr. LOTT (for himself, Mr. NICKLES,

Ms. COLLINS, Mr. FRIST, Mr. GRAMM, Mr. HAGEL, Mr. JEFFORDS, Mr. ROTH, Mr. SANTORUM, Mr. MACK, Mr. CRAIG, Mr. COVERDELL, Mr. MCCONNELL, Mr. ABRAHAM, Mr. ALLARD, Mr. ASHCROFT, Mr. BENNETT, Mr. BOND, Mr. BROWNBACK, Mr. BUNNING, Mr. BURNS, Mr. CAMPBELL, Mr. COCHRAN, Mr. DEWINE, Mr. DOMENICI, Mr. ENZI, Mr. GORTON, Mr. GRAMS, Mr. GRASSLEY, Mr. GREGG, Mr. HATCH, Mr. HELMS, Mr. HUTCHINSON, Mrs. HUTCHISON, Mr. INHOFE, Mr. LUGAR, Mr. MCCAIN, Mr. MURKOWSKI, Mr. ROBERTS, Mr. SESSIONS, Mr. SHELBY, Mr. SMITH of New Hampshire, Mr. SMITH of Oregon, Ms. SNOWE, Mr. STEVENS, Mr. THOMAS, Mr. THOMPSON, Mr. THURMOND, Mr. VOINOVICH, and Mr. WARNER):

S. 300. A bill to improve access and choice of patients to quality, affordable health care; to the Committee on Health, Education, Labor, and Pensions.

By Mr. CAMPBELL:

S. 301. A bill to amend title 39, United States Code, relating to mailability, false representations, civil penalties, and for other purposes; to the Committee on Governmental Affairs.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

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

By Mr. ROBB (for himself and Mr. CAMPBELL):

S. Res. 29. A resolution to designate the week of May 2, 1999, as "National Correctional Officers and Employees Week"; to the Committee on the Judiciary.

By Mr. DEWINE (for himself, Mr. GRAHAM, Mr. HELMS, and Mr. COVERDELL):

S. Con. Res. 3. A concurrent resolution condemning the irregular interruption of the democratic political institutional process in Haiti; to the Committee on Foreign Relations.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. WYDEN (for himself and Mr. SMITH of Oregon):

S. 294. A bill to direct the Secretary of the Army to develop and implement a comprehensive program for fish screens and passage devices; to the Committee on Environment and Public Works.

WATER DIVERSION PROTECTION AND FISHERIES ENHANCEMENT PROGRAM

• Mr. WYDEN. Mr. President, the legislation I introduce today will help the people of the Pacific Northwest address one of the most important natural resource issues in the region: the restoration of our majestic salmon runs. This bill will lend a much-needed hand to Oregonians and other Northwesters who have been working together to find common sense solutions to preserve this precious natural resource.

As many people know, any effort to recover these salmon runs must be both creative and comprehensive, due to the complex nature of the salmon life cycle. Salmon are hatched in fresh water, migrate down streams and rivers to the sea to grow and mature, and then return to the streams of their birth to spawn. This complex life cycle exposes the fish to many hazards which threaten their survival. If we are to achieve our goal of restoring salmon runs to healthy levels, we must identify and address the various causes of salmon mortality.

One of the hazards facing salmon and other fish is the diversion of water from streams and rivers to irrigate agricultural crops. Migrating juvenile fish, including endangered salmon and bull trout, are killed when they are diverted from rivers and streams along with water used for irrigation.

The common-sense solution to this pervasive problem is to safely screen the points of water diversion: to allow water through while keeping fish out. Despite existing State and Federal programs to assist with the installation of fish screens, unscreened diversions continue to be a significant problem for endangered fish in the Pacific Northwest.

My home state of Oregon has identified fish mortality caused by water diversions as a priority problem. One of Oregon's primary goals relating to salmon restoration is to encourage the installation of fish screens and passage devices for water diversions on streams and rivers. Oregon has developed a cooperative program to assist in screening smaller diversions used on family farms. However, the State cannot afford to provide similar assistance for larger sized diversions. That's where the Federal government can help.

This bill gives the U.S. Army Corps of Engineers new authority to help irrigators make their water systems safer for fish. Participation by irrigators in the program will be voluntary and will require a sharing of the cost.

I believe this legislation will be very effective because irrigators from Oregon and the other Northwest states have told me they want to make their water systems more fish-friendly, but

they need help to do so. This bill will give them the help they need and will greatly benefit the current efforts of local irrigation districts and watershed councils to conserve and protect our fish runs.

I am pleased that this legislation is cosponsored by Senator GORDON SMITH and has support from all the Northwest irrigation groups and literally dozens of Northwest and national conservation and sport fishing groups, including National Audubon Society, Natural Resources Defense Council, Oregon Trout, Trout Unlimited, American Rivers, Pacific Coast Federation of Fishermen's Associations, and Northwest Sportfishing Industries Association.

Despite our best efforts to restore these salmon runs, they continue to decline year after year. We need a fresh approach to this problem—one that involves the participation of the local folks who are affected by conservation efforts. This bill takes that approach.

Of course, a fish screen program alone is not the missing clue to solve our salmon problem. But this program, along with others like the Clean Water bill I introduced last session with Senator BURNS are pieces of the complete puzzle.

Ultimately, it will take the integrated efforts of all interests in our region to recover our salmon successfully. State, Tribal and local governments, local watershed councils, private landowners and the Federal government will all need to work together. Initiatives like this fish screen bill will help forge the partnerships upon which successful salmon recovery will be based. I urge your support for this legislation, so that the people of the Pacific Northwest can continue their important work to restore this precious natural resource. ●

By Mr. LUGAR:

S. 295. A bill to amend part S of title I of the Omnibus Crime Control and Safe Streets Act of 1968 to permit the use of certain amounts for assistance to jail-based substance treatment programs, and for other purposes; to the Committee on the Judiciary.

JAIL-BASED SUBSTANCE ABUSE TREATMENT PROGRAM

● Mr. LUGAR. Mr. President, I rise today to offer legislation amending the Residential Substance Abuse Treatment program, known as R-SAT, to enable jurisdictions below the state level to realize greater benefits from the program. The R-SAT program allows the Attorney General to make grants for the establishment of treatment programs within local correctional facilities, but only a few jurisdictions have been able to take advantage of these grants.

The legislation I am offering today will solve this problem by establishing a separate Jail-Based Substance Abuse Treatment Program, or J-SAT. Under this new program, states will be explicitly authorized to devote up to ten percent of the funds they receive under R-SAT to qualifying J-SAT programs.

This legislation will provide matching funds to jail-based treatment programs that meet several criteria. First, the program must be at least three months in length. This is the minimum amount of time for a treatment program to have the desired effect. To qualify for funding, a program must also have been in existence for at least two years. This criterion is intended to ensure that jurisdictions which have already demonstrated a commitment to treatment programs at the local level receive first priority for funding. It also ensures that scarce treatment resources are allocated to programs with a demonstrable track record of success. The third criterion for programs seeking J-SAT funding is that the treatment regimen must include regular drug testing. This is necessary to ensure that some objective measure of the program's success is available. Grant recipients are also encouraged to provide the widest range of aftercare services possible, including job training, education and self-help programs. These steps are necessary to leverage the resources devoted to solving the problem of substance abuse, and to give individuals involved in treatment the best possible chance for successful rehabilitation.

I am offering this legislation because substance abuse and problems arising from it are putting a severe strain on the resources of local jurisdictions throughout the nation. This is not a minor problem. The Office of National Drug Control Policy indicates that approximately three-fourths of prison inmates—and over half of those in jails or on probation—are substance abusers, yet only a small percentage of inmates participate in treatment programs while they are incarcerated. The time during which drug-using offenders are in custody or under post-release correctional supervision presents a unique opportunity to reduce drug use and crime through effective drug testing and treatment programs.

Research indicates that programs like J-SAT can help to reduce the strain on our communities by cutting drug use in half; by reducing other criminal activity like shoplifting, assault, and drug sales by up to 80 percent; and by reducing arrests for all crimes by up to 64 percent.

I would also note that jail-based treatment programs are cost effective. In 1994, the American Correctional Association estimated the annual cost of incarceration at \$18,330. The Office of National Drug Control Policy states that treatment while in prison and under post-incarceration supervision can reduce recidivism by roughly 50 percent. Thus, for every \$1,800 the government invests in treatment, it saves more than \$9,000. Former Assistant Health Secretary Philip Lee has estimated that every dollar invested in treatment can save \$7 in societal and medical costs.

For these reasons, I ask my colleagues to support the Jail-Based Sub-

stance Abuse Treatment legislation I am introducing today. I also 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. 295

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

SECTION 1. JAIL-BASED SUBSTANCE ABUSE TREATMENT PROGRAMS.

(a) IN GENERAL.—Part S of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796ff et seq.) is amended by adding at the end the following:

“SEC. 1906. JAIL-BASED SUBSTANCE ABUSE TREATMENT.

“(a) DEFINITIONS.—In this section—

“(1) the term ‘jail-based substance abuse treatment program’ means a course of individual and group activities, lasting for a period of not less than 3 months, in an area of a correctional facility set apart from the general population of the correctional facility, if those activities are—

“(A) directed at the substance abuse problems of prisoners; and

“(B) intended to develop the cognitive, behavioral, social, vocational, and other skills of prisoners in order to address the substance abuse and related problems of prisoners; and

“(2) the term ‘local correctional facility’ means any correctional facility operated by a unit of local government.

“(b) AUTHORIZATION.—

“(1) IN GENERAL.—Not less than 10 percent of the total amount made available to a State under section 1904(a) for any fiscal year may be used by the State to make grants to local correctional facilities in the State for the purpose of assisting jail-based substance abuse treatment programs established by those local correctional facilities.

“(2) FEDERAL SHARE.—The Federal share of a grant made by a State under this section to a local correctional facility may not exceed 75 percent of the total cost of the jail-based substance abuse treatment program described in the application submitted under subsection (c) for the fiscal year for which the program receives assistance under this section.

“(c) APPLICATIONS.—

“(1) IN GENERAL.—To be eligible to receive a grant from a State under this section for a jail-based substance abuse treatment program, the chief executive of a local correctional facility shall submit to the State, in such form and containing such information as the State may reasonably require, an application that meets the requirements of paragraph (2).

“(2) APPLICATION REQUIREMENTS.—Each application submitted under paragraph (1) shall include—

“(A) with respect to the jail-based substance abuse treatment program for which assistance is sought, a description of the program and a written certification that—

“(i) the program has been in effect for not less than 2 consecutive years before the date on which the application is submitted; and

“(ii) the local correctional facility will—

“(I) coordinate the design and implementation of the program between local correctional facility representatives and the appropriate State and local alcohol and substance abuse agencies;

“(II) implement (or continue to require) urinalysis or other proven reliable forms of substance abuse testing of individuals participating in the program, including the testing of individuals released from the jail-based substance abuse treatment program

who remain in the custody of the local correctional facility; and

“(III) carry out the program in accordance with guidelines, which shall be established by the State, in order to guarantee each participant in the program access to consistent, continual care if transferred to a different local correctional facility within the State;

“(B) written assurances that Federal funds received by the local correctional facility from the State under this section will be used to supplement, and not to supplant, non-Federal funds that would otherwise be available for jail-based substance abuse treatment programs assisted with amounts made available to the local correctional facility under this section; and

“(C) a description of the manner in which amounts received by the local correctional facility from the State under this section will be coordinated with Federal assistance for substance abuse treatment and aftercare services provided to the local correctional facility by the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.

“(d) REVIEW OF APPLICATIONS.—

“(1) IN GENERAL.—Upon receipt of an application under subsection (c), the State shall—

“(A) review the application to ensure that the application, and the jail-based residential substance abuse treatment program for which a grant under this section is sought, meet the requirements of this section; and

“(B) if so, make an affirmative finding in writing that the jail-based substance abuse treatment program for which assistance is sought meets the requirements of this section.

“(2) APPROVAL.—Based on the review conducted under paragraph (1), not later than 90 days after the date on which an application is submitted under subsection (c), the State shall—

“(A) approve the application, disapprove the application, or request a continued evaluation of the application for an additional period of 90 days; and

“(B) notify the applicant of the action taken under subparagraph (A) and, with respect to any denial of an application under subparagraph (A), afford the applicant an opportunity for reconsideration.

“(3) ELIGIBILITY FOR PREFERENCE WITH AFTERCARE COMPONENT.—

“(A) IN GENERAL.—In making grants under this section, a State shall give preference to applications from local correctional facilities that ensure that each participant in the jail-based substance abuse treatment program for which a grant under this section is sought, is required to participate in an aftercare services program that meets the requirements of subparagraph (B), for a period of not less than 1 year following the earlier of—

“(i) the date on which the participant completes the jail-based substance abuse treatment program; or

“(ii) the date on which the participant is released from the correctional facility at the end of the participant's sentence or is released on parole.

“(B) AFTERCARE SERVICES PROGRAM REQUIREMENTS.—For purposes of subparagraph (A), an aftercare services program meets the requirements of this paragraph if the program—

“(i) in selecting individuals for participation in the program, gives priority to individuals who have completed a jail-based substance abuse treatment program;

“(ii) requires each participant in the program to submit to periodic substance abuse testing; and

“(iii) involves the coordination between the jail-based substance abuse treatment program and other human service and reha-

bilitation programs that may assist in the rehabilitation of program participants, such as—

“(I) educational and job training programs;

“(II) parole supervision programs;

“(III) half-way house programs; and

“(IV) participation in self-help and peer group programs; and

“(iv) assists in placing jail-based substance abuse treatment program participants with appropriate community substance abuse treatment facilities upon release from the correctional facility at the end of a sentence or on parole.

“(e) COORDINATION AND CONSULTATION.—

“(1) COORDINATION.—Each State that makes 1 or more grants under this section in any fiscal year shall, to the maximum extent practicable, implement a statewide communications network with the capacity to track the participants in jail-based substance abuse treatment programs established by local correctional facilities in the State as those participants move between local correctional facilities within the State.

“(2) CONSULTATION.—Each State described in paragraph (1) shall consult with the Attorney General and the Secretary of Health and Human Services to ensure that each jail-based substance abuse treatment program assisted with a grant made by the State under this section incorporates applicable components of comprehensive approaches, including relapse prevention and aftercare services.

“(f) USE OF GRANT AMOUNTS.—

“(1) IN GENERAL.—Each local correctional facility that receives a grant under this section shall use the grant amount solely for the purpose of carrying out the jail-based substance abuse treatment program described in the application submitted under subsection (c).

“(2) ADMINISTRATION.—Each local correctional facility that receives a grant under this section shall carry out all activities relating to the administration of the grant amount, including reviewing the manner in which the amount is expended, processing, monitoring the progress of the program assisted, financial reporting, technical assistance, grant adjustments, accounting, auditing, and fund disbursement.

“(3) RESTRICTION.—A local correctional facility may not use any amount of a grant under this section for land acquisition or a construction project.

“(g) REPORTING REQUIREMENT; PERFORMANCE REVIEW.—

“(1) REPORTING REQUIREMENT.—Not later than March 1 of each year, each local correctional facility that receives a grant under this section shall submit to the Attorney General, through the State, a description and evaluation of the jail-based substance abuse treatment program carried out by the local correctional facility with the grant amount, in such form and containing such information as the Attorney General may reasonably require.

“(2) PERFORMANCE REVIEW.—The Attorney General shall conduct an annual review of each jail-based substance abuse treatment program assisted under this section, in order to verify the compliance of local correctional facilities with the requirements of this section.

“(h) NO EFFECT ON STATE ALLOCATION.—Nothing in this section shall be construed to affect the allocation of amounts to States under section 1904(a).”

(b) TECHNICAL AMENDMENT.—The table of contents for title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.) is amended, in the matter relating to part S, by adding at the end the following:

“1906. Jail-based substance abuse treatment.”

By Mr. FRIST (for himself, Mr. ROCKEFELLER, Mr. DOMENICI, Mr. LIEBERMAN, Mr. GRAMM, Mr. BINGAMAN, Mr. BURNS, Mr. BREAU, Mrs. HUTCHISON, Mr. CLELAND, Mr. THOMPSON, Mr. KERRY, Mr. DEWINE, Mr. KERREY, Mr. ABRAHAM, Mr. AKAKA, Mr. ALLARD, Mrs. BOXER, Mr. ROBERTS, and Mr. ROBB):

S. 296. A bill to provide for continuation of the Federal research investment in a fiscally sustainable way, and for other purposes; to the Committee on Commerce, Science, and Transportation.

FEDERAL RESEARCH INVESTMENT ACT OF 1999

● Mr. FRIST. Mr. President, I rise today to introduce legislation that would elevate Congress' commitment to technological innovation and long-term economic growth. The Federal Research Investment Act specifically targets federally-funded, civilian research and development (R&D), while establishing greater accountability mechanisms for both Congress and the White House. The bill would bolster the aggregate amount of federal funding for R&D over an 11-year period. Although this legislation passed the Senate by unanimous consent last year, the rush to finish the 1999 federal budget kept it from reaching the floor of the House of Representatives and the President's desk.

Senator ROCKEFELLER, my partner in this endeavor, and I are not discouraged. We believe that we laid a solid foundation to build on by getting this legislation through the Senate last year. Now, we intend to persistently advocate for increased funding levels for basic R&D until they are realized. This legislation is the product of numerous hearings, caucus events, forums, and meetings with scientists and scholars from across the country. We have been working closely together on this legislation and feel that now, more than ever, Congress must advocate for greater R&D funding to preserve the future economic prosperity of our nation.

Innovation is a key element of economic growth in the United States. Economists widely agree that more than 50 percent of our economic growth is directly linked to technological innovation. It is the principle driving force behind our long-term growth and our rising standard of living. Technology contributes to economic growth through the creation of new jobs, new goods and services, new capital and even new industries.

The Federal Government plays a critical role in driving the innovation process in the United States. The majority of the Federal Government's basic R&D is directed toward critical missions to serve the public interest in areas including health, environmental pollution control, space exploration,

and national defense. Federal funds support nearly 60 percent of the nation's basic research, with a similar share performed in colleges and universities. Congressional support reflects a consensus that although basic research is the foundation for many innovations, the rate of return to society generated by investments in R&D is significantly larger than the benefits that can be captured by the performing institution.

The National Institutes of Health (NIH) received the largest dollar increase in history in the fiscal year (FY) 1999 federal budget. The agency received a record 14.1 percent increase in its R&D budget, nearly \$2 billion. Due to steady increases every year, the NIH R&D budget is now 28 percent larger in inflationary-adjusted terms than it was in FY 1994.

NIH's overwhelming support by Congress reflects a growing popular movement both in the Senate and House to double funding for NIH over the next five years. Many of my colleagues, eager to fund the biotechnology that enables our citizens to live longer, more healthy lives, are embracing this crusade. I believe, however, many of them are missing the critical link that exists between the breakthrough advances we are experiencing today and what has enabled them to occur. The funding surge of R&D in the sciences in the 1960's created a wealth of research opportunities for scientists throughout the nation. Since that time though, funding has declined steadily with no hint of a reversal of that downward trend. If we are to dedicate ourselves to advancement of biotechnology and all the benefits that it will afford, we must support it with solid funding for the basic sciences. One truly depends upon the other. And that critical link, I believe, has been lost in the revolution of health care policy.

Fiscal constraints due to recent efforts to balance the federal budget threaten the U.S. R&D infrastructure. This is due to both a long-term problem of the ever-increasing level of mandatory spending of discretionary funding that must be allocated across an increasing range of programs. Now, for the first time in nearly three decades, the Federal Government has attained a budget surplus of \$70 billion in 1998. Additionally, the Congressional Budget Office estimates a budget surplus of approximately \$1.5 trillion over the next ten years. As Congress debates how to allocate surplus funds, serious consideration must be given to federal research and development investment.

As a result of the current monetary environment in Congress and the desire to utilize the surplus prudently, I am confident that investing in basic R&D, and in turn the technological innovation of the future, is a proper use of the federal taxpayers dollars. Furthermore, the increased funding called for in this legislation is coupled with a judicious strategy for federal investment and strong accountability mechanisms to

help guide the Administration and Congress. Nothing less is acceptable.

Mr. President, despite its modest share of total U.S. R&D funding, the Federal Government continues to play a vital role in the nation's R&D enterprise. With dramatic decreases in U.S. defense R&D spending in the post Cold-War era, devoting attention to civilian basic research is more critical now than ever before. This pivotal need for a resurgence in basic R&D investments is evident when we further consider our nation's increased dependency on technology and the global competition that threatens our sustained leadership position. R&D drives the innovation process, which in turn drives the U.S. economy. Now is not the time to turn our backs on the nation's future prosperity. ●

● Mr. ROCKEFELLER. Mr. President, I would like to join Senator FRIST and other distinguished colleagues in introducing the Federal Research Investment Act. This legislation will set a long-term vision for federal funding of research and development programs so that the United States can continue to be the world leader in high-tech industries.

One only needs to look as far as the front page of the newspaper to see the effect of high-technology on our country. New drugs are becoming available for fighting cancer; new communication hardware is allowing more people to connect to the internet; and advances in fuel-cell technology are leading to low-emission, high-efficiency alternative fuel vehicles. In fact, seventy percent of all patent applications cite non-profit or federally-funded research as a core component to the innovation being patented. People are living longer, with a higher quality of life, in a better economy due to processes, procedures, and equipment which are based on federally-funded research.

What I am afraid of is that many people are not aware that these products do not simply appear out of nowhere. They are the result of a basis of knowledge which has been built up by researchers supported by federal funding. American companies pull from this knowledge base in order to develop the latest high-tech products which you and I read about in the paper and see on our store shelves every day.

I view this knowledge base as a bank. The U.S. government puts in modest amounts of funding in the form of support for scientific research. The payback comes from the economic growth which is produced as this knowledge is turned into actual products by American companies.

In fact, a large part of the current rosy economic situation is due to our dominant high-tech industries. High-tech companies are currently responsible for one-third of our economic output and half of our economic growth. However, if we are to continue at this pace, we need to support the fundamental, pre-competitive research critical to these industries, at the necessary

levels, and in a stable manner from year to year, and we need to do so now.

In the last session of the 105th Congress Senators FRIST, BINGAMAN, DOMENICI, GRAMM, BREAUX, BURNS, and I introduced S. 2217, the Federal Research Investment Act, and previous to that Senators DOMENICI and BINGAMAN, introduced S. 1305, the National Research Investment Act. Both S. 1305 and S. 2217 have been extremely successful in galvanizing members of the scientific and engineering community to pull together and work constructively towards a common ideal. In addition, it has brought together the co-sponsors of these bills and moved them forward as a group with their original idea. S. 2217 passed without dissent in the Senate at the end of last session, and gained 36 co-sponsors—18 Democrats and 18 Republicans. Our aim, in re-introducing the Federal Research Investment Act, is to now take the next step in this process, bringing to fruition the goals of our bill.

The Federal Research Investment Act is a long-term vision for federal R&D funding. It creates legislative language which stresses the importance of R&D funding to the strength of our nation's innovation infrastructure. It also sets out guidelines for Congress to use in prioritizing funding decisions.

Just three years ago, federal science funding was in a serious decline and fewer than half a dozen members of Congress gave it any attention, but now as a significant consequence of both S. 1305 and S. 2217 the trend, at least in the last two years, seems to have reversed and a universal spirit of cooperation for strong R&D funding is developing on all fronts. In the last two years the science budget has increased above inflation. In particular, for Fiscal Year 1999, an unprecedented 10% increase in civilian R&D funding was appropriated. Yet, we appear to be in a crisis situation once again due to unexpected budgetary constraints resulting from last year's appropriations. Thus, we need to continue our fight to implement the R&D budgetary guidelines in our bill. This uncertainty in the level of R&D funding from year to year can be as detrimental to the health of the scientific enterprise as a lack of adequate funding levels. It will be a sad day for our nation, and its future economic prosperity, if we manage to lose what progress we have made to date.

Based on a careful review and analysis of our past history, our bill authorizes an annual funding increase of 5.5%, starting in the year 2000 and going through 2010, for federally-funded, civilian, R&D programs. This would increase federal R&D spending to 2.6% of total, overall budget by 2010, a near doubling in R&D funding from 1998 levels. In order to make sure that these increases are fully incorporated into budgetary process we request that the President include these increases in his annual budget request to Congress.

We are currently in an economic upturn. This continues to be a perfect

time to increase funding for R&D so that we can continue this growth. I have faith that, as long as the economic situation allows it, my thoughtful and wise colleagues will support increasing R&D funding to the levels that we have laid out in this bill. However, I am also a realist. I realize that the economy may not always remain as strong as it is right now. That is why we have introduced a funding firewall. Without this firewall I am seriously concerned that history will repeat itself. In the past, R&D funding is one of the first things that has been cut during times of crisis. This is the wrong approach. I believe that cutting R&D funding levels below a bare minimum level causes serious, long-term harm to the R&D infrastructure in the United States. Our firewall would not allow this to happen. It is not meant as a goal, it is meant as a bare minimum which should only be implemented in the leanest of years.

Many, if not most, recent 'quantum leaps' in knowledge have occurred at the interface between traditional disciplines of research. Therefore, we legislatively mandate that this funding increase must be macroscopically balanced, so that there is not preferential growth of one agency, program or field of study at the expense of other, equally qualified and deserving agencies. One of the original reasons that I started to get involved with technology issues such as EPSCoR and EPSCoT, was because I believe that technology should be shared by everyone, not just those in Silicon Valley or the Route 128 corridor in Boston. Therefore, this bill should not be seen as a means of promoting elitist science but as a mechanism for allowing for diversity in our national innovation infrastructure.

Finally, so that we are able to assure other Members of Congress and the general public that this money authorized by this Act would be well spent, we have included accountability measures which will assure that there is no waste of federal money on out-dated, or ill-conceived projects. This bill puts into place a system of accountability for each affected agency. Our bill institutes a study by the National Academy of Sciences to determine how to effectively measure the progress of R&D based agencies and then have them institute performance measures based on these metrics. This will allow increases in funding without concerns over wasteful spending being generated.

In conclusion, with the help of Senators GRAMM, LIEBERMAN, DOMENICI, and BINGAMAN, Senator FRIST and I have put together a long-term vision for federal R&D funding which we hope will instigate real increases in federal funding for research and development. Federally-funded research has been, and will continue to be, a driving power behind our economic success. If we are to maintain and enhance our current economic prosperity we must make sure that research programs are funded at adequate levels in a consist-

ent long-term manner. I urge my colleagues to support this bill. ●

● Mr. DOMENICI. Mr. President, I'm pleased to see the Federal Research Investment Act introduced in the 106th Congress. This bill is one that I've supported throughout its history, because it addresses the health of our nation's science and technology base.

Our science and technology base is vital to the nation's future. Any number of studies have confirmed its importance. As one excellent example, the National Innovation Summit, organized by MIT last March with the Council on Competitiveness, confirmed that the integrity of that base is one of the cornerstones to our future economic prosperity. At that Summit, many of the nation's top CEOs emphasized that the nation's climate for innovation is a major determinant of our ability to maintain and advance our high standard of living and strong economy.

Advanced technologies are responsible for driving half of our economic growth since World War II, and that growth has developed our economy into the envy of the world. We need to continually refresh our stock of new products and processes that enable good jobs for our citizens in the face of increasing global challenges to all our principal industries.

This bill emphasizes a broad range of research targets, from fundamental and frontier exploration, through pre-competitive engineering research. This emphasis on a spectrum of research maturity is absolutely critical. The nation is not well served by a focus on so-called "basic" research that can open new fields, but then leave those fields without resources to develop new ideas to a pre-competitive stage applicable to future commercial products and processes.

The new bill addresses a spectrum of research fields with its emphasis on expanding S&T funding in many agencies. We need technical advances in many fields simultaneously. In more and more cases, the best new ideas are not flowing from explorations in a single narrow field, but instead are coming from inter-disciplinary studies that bring experts from diverse fields together for fruitful collaboration. This is especially evident in medical and health fields, where combinations of medical science with many other specialties are critical to the latest health care advances.

This new bill has additional features that were critical components of last year's S. 2217. It proposes to utilize the National Academy of Science in developing approaches to evaluation of program and project performance. This should lead to better understanding of how Government Performance Results Act goals and scientific programs can be best coordinated. The new role for the National Academy can help define criteria to guide decisions on continued and future funding. The bill also sets up procedures to use these evaluations

to terminate federal programs that are not performing at acceptable levels.

The new bill incorporates a set of well-developed principles for federal funding of science and technology. These principles were developed by our Senate Science and Technology Caucus. Those principles, when carefully applied, can lead to better choices among the many opportunities for federal S&T funding. The new bill also incorporates recommendations for independent merit-based review of federal S&T programs, which should further strengthen them.

Many aspects of the Federal Research Investment Act support and compliment key points in the study released by Representative VERN EHLERS last year. His study, "Unlocking our Future," will serve as an important focal point for continuing discussions on the critical goal of strengthening our nation's science and technology base.

This Federal Research Investment Act continues the goals expressed in S. 1305 last year. That was followed by S. 2217 that proposed a more realistic time scale for achieving this expanded support, added GPRA performance goals, and included language that recognized the importance of the budgets caps. This new bill is very similar to S. 2217.

The new Federal Research Investment Act builds and improves on the goals of the previous bills. With this act, we will build stronger federal Science and Technology programs that will underpin our nation's ability to compete effectively in the global marketplace of the 21st century. ●

By Mr. SHELBY:

S. 297. A bill to amend title 37, United States Code, to authorize members of the uniformed services to participate in the Thrift Savings Plan, and for other purposes; to the Committee on Governmental Affairs.

THRIFT SAVINGS PLAN (TSP) LEGISLATION

● Mr. SHELBY. Mr. President, I rise today to introduce legislation to increase the retirement benefits for military personnel by allowing them to participate in the Thrift Savings Plan (TSP).

Many of us are concerned about the current state of readiness in our military forces, and rightly so. In the last decade, the number of Americans wearing their nation's uniform has decreased precipitously along with the funding that pays for their weapons, aircraft, ships, wages, housing, and benefits. Tragically, as the defense budget withers, our military's operational tempo soars. Overseas deployments have steadily increased in number, scope, and duration. Our troops are working harder than ever and yet, we have failed to support them. In addition to inadequately funding much needed weapons modernization, we have kept their wages low and slowly eroded their benefits. As we make it less and less attractive to serve, we

will not be able to recruit high quality people and those that now serve will continue to leave. Recruiting and retention are the backbone of our military services. Without either there is no readiness. Our service men and women are being stretched to the breaking point, and they are voting with their feet. We must act now.

Senior Pentagon officials have determined that retirement benefits are a key consideration in the decision to pursue a military career and therefore are critical to the retention of our best people. Because of reduced retirement benefits—commonly referred to as “Redux”—an increasing number of mid-career personnel are deciding to leave the military. In recent testimony to the Senate, General Henry Shelton, the Chairman of the Joint Chiefs of Staff, stated that “that is why, among a number of pressing needs, reforming military retirement and military pay remains the Joint Chiefs’ highest priority.”

The bill I am introducing today is simple and straightforward. It shores up the military retirement system by allowing military personnel to supplement direct benefits through participation in the Thrift Saving Plan (TSP). This legislation will provide ALL military personnel a retirement benefit that is available to federal employees and all of us in the Senate and our staffs. Furthermore, the inherent flexibility of TSP will give military personnel and their families greater control over their retirement benefits. For these reasons, this legislation is a priority for the leadership in the Senate.

Specifically, my bill will allow members of the armed services to contribute up to 5 percent of basic pay in a tax-deferred individual account where the funds are held in trust and invested and can later be withdrawn at retirement. As an additional incentive for a military career, personnel will be qualified to contribute up to 10 percent of their basic pay after 10 years of service. As is the case with the Federal Employee Retirement System (FERS), the government would provide up to 5 percent to match the individual’s contribution.

So often we marvel over our high-tech weapons systems and we forget that they are useless without highly skilled and professional Americans to operate them. If the services continue to hemorrhage qualified people at current rates, there will be a reckoning the magnitude of which we are not prepared to endure. We must take action now to slow the exodus of qualified personnel from the military. I believe that this bill will be a powerful tool to assist the services in retaining personnel, and I urge my colleagues to cosponsor this legislation.

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. 297

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

SECTION 1. PARTICIPATION OF MEMBERS OF THE UNIFORMED SERVICES IN THE THRIFT SAVINGS PLAN.

(b) AUTHORITY.—(1) Chapter 3 of title 37, United States Code, is amended by adding at the end the following:

“§211. Participation in Thrift Savings Plan

“(a) PARTICIPATION AUTHORIZED.—(1) A member of the uniformed services may contribute to the Thrift Savings Fund out of basic pay.

“(2) An election to contribute to the Thrift Savings Fund under paragraph (1) may be made only during a period provided under section 8432(b) of title 5 for individuals subject to chapter 84 of such title.

“(b) APPLICABILITY OF THRIFT SAVINGS PLAN PROVISIONS.—Except as otherwise provided in this section, the provisions of subchapters III and VII of chapter 84 of title 5 shall apply with respect to members of the uniformed services making contributions to the Thrift Savings Fund as if such members were employees within the meaning of section 8401(11) of such title.

“(c) MAXIMUM CONTRIBUTION FROM BASIC PAY.—(1) The amount contributed by a member of the uniformed services for any pay period out of basic pay may not exceed the amount equal to the maximum allowable percent of such member’s basic pay for such pay period.

“(2) For the purposes of paragraph (1), the maximum allowable percent of basic pay applicable to a member with respect to a pay period is as follows:

“(A) If the member has less than 5 years of service computed under section 205 of title 37 on or before the last day of the pay period, 5 percent.

“(B) If the member has at least 5 years of service computed under section 205 of title 37 on or before the last day of the pay period, 10 percent.

“(d) AGENCY CONTRIBUTIONS.—Contributions shall be made under paragraph (2), but not any other paragraph, of section 8432(c) of title 5 for the benefit of a member of the uniformed services making contributions to the Thrift Savings Fund under subsection (a). For the purposes of this subsection, the reference in paragraph (2) of such section to contributions under paragraph (1) of such section does not apply.

“(e) RULES OF CONSTRUCTION.—The following rules of construction apply for the purposes of this section:

“(1) In applying section 8433 of title 5 to a member of the uniformed services who has an account balance in the Thrift Savings Fund, any reference in such section to separation from Government employment shall be construed to refer to the following actions:

“(A) Release of the member from active-duty service (not followed by a resumption of active-duty service within 30 days after the effective date of the release).

“(B) Transfer of the member to an inactive status.

“(C) Transfer of the member by the Secretary concerned to a retired list maintained by the Secretary.

“(2) The reference in section 8433(g)(1) of title 5 to contributions made under section 8432(a) of such title shall be treated as being a reference to contributions made to the Fund by the member, whether made under this section or section 8351 or 8432(a) of title 5.”

“(3) The table of sections at the beginning of such chapter is amended by adding at the end the following:

“211. Participation in Thrift Savings Plan.”.

(b) RELATIONSHIP TO PARTICIPATION UNDER OTHER AUTHORITY.—Section 8432b(b)(2)(B) of title 5, United States Code, is amended by inserting after “section 8432(a)” the following “of this title or section 211 of title 37”.•

By Mr. SHELBY:

S. 298. A bill to amend the Federal Election Campaign Act of 1971 (2 U.S.C. 431 et seq.) to clarify that donations of hard and soft money by foreign nationals are prohibited; to the Committee on Rules and Administration.

PROHIBITION OF DONATIONS BY FOREIGN NATIONALS

• Mr. SHELBY. Mr. President, I rise today to speak in support of legislation that I am introducing which is intended to prevent foreign nationals from making financial contributions to federal elections.

Last October, in the trial of Charlie Trie, Judge Paul L. Friedman ruled that the Federal Election Campaign Act (FECA) does not prohibit foreigners from making campaign donations to political parties or Congressional Campaign Committees. The holding of this case is based on an extremely narrow reading of the language of the FECA. Judge Friedman ruled that because the FECA specifically prohibits foreign nationals from making direct contributions to the campaigns of candidates for federal office but does not specifically prohibit donations, or “soft money” expenditures to the parties, such donations are not prohibited by the FECA. While we can argue the merits of this decision and question whether it merely tracks the letter rather than the entire spirit of the FECA, it is quite clear that this ruling opens up our system of federal elections to the possibility of foreign influence.

My bill clarifies the law by amending the FECA to prohibit donations by foreign nationals to “a national committee of a political party or a Senatorial or Congressional Campaign Committee of a national political party for any purpose.” This new provision along with the existing prohibition of direct contributions by foreign nationals, will provide the Federal Election Commission with the ability to prosecute those who illegally attempt to influence federal elections. Ultimately, my bill will get us closer to achieving the desired effect originally contemplated by the FECA—ensuring that federal campaigns are free of foreign money.

Mr. President, regardless of any member’s views concerning the direction that campaign finance reform should take, I believe that amending the FECA to prohibit foreign influence in federal campaigns requires swift action. •

By Mr. MCCAIN (for himself, Mr.

INOUYE, and Mr. CONRAD):

S. 299. A bill to elevate the position of Director of the Indian Health Service within the Department of Health and Human Services to Assistant Secretary for Indian Health, and for other purposes; to the Committee on Indian Affairs.

ASSISTANT SECRETARY FOR INDIAN HEALTH ACT
OF 1999

• Mr. MCCAIN. Mr. President, I rise to introduce legislation that will establish the Director of the Indian Health Service within the Department of Health and Human Services as an Assistant Secretary for Indian Health. My colleagues, Senators INOUE and CONRAD, are joining me in this effort as original co-sponsors. I am pleased to note that Congressman NETHERCUTT from Washington introduced companion legislation on the House side.

Last year, we came very close to successful passage of this same bill, but the legislative clock expired. It is our hope that we can move this legislation forward expeditiously this year as this bill enjoys widespread support from Indian tribes nationwide and the Administration.

The history of this legislation spans back several years. Every year, the Congress deliberates on how best to raise the standard of health care for all Americans. Yet, in nearly every debate, the health care needs of Indian people are either marginalized or ignored. The need for this legislation arose out of the continuing frustration expressed by the tribes that their health concerns were not adequately addressed under the existing administrative policy and budgetary processes.

As the primary health care delivery system, the Indian Health Service is the principal advocate for Indian health care needs, both on the reservation level and for urban populations. More than 1.3 million Indian people are served every year by the IHS. At its current capacity, the IHS estimates that it can only meet 62 percent of tribal health care needs. The IHS will continue to be challenged by a growing Indian population as well as an increasing disparity between the health status of Indian people as compared to other Americans. Thousands of Indian people continue to suffer from the worst imaginable health care conditions in Indian country—from diabetes to cancer to infant mortality. In nearly every category, the health status of Native Americans falls far below the national standard.

The purpose of this bill can be simplified to three primary needs. Indian people desire a stronger leadership and policy role within the primary health care agency, the Department of Health and Human Services. The Assistant Secretary for Indian Health will ensure that critical policy and budgetary decisions will be made with the full involvement and consultation of not only the Indian Health Service, but also the direct involvement of the Tribal governments.

Second, the enactment of this legislation is consistent with the unique government-to-government relationship between federally recognized Indian tribes and the federal government. This legislation is long overdue in bringing focus and national attention to the health care status of Indian peo-

ple and fulfilling the federal trust responsibility toward Indian tribes.

Finally, passage of this legislation is critical as the Congress is set to deliberate several pieces of Indian health policy. Reauthorization of the Indian Health Care Improvement Act and development of legislation to permanently extend tribal self-governance authority to tribes will be vital components of Indian health care in the future. Implementation of this bill is intended to support the long-standing policies of Indian self-determination and tribal self-governance and assist Indian tribes who are making positive strides in providing direct health care to their own communities.

At this critical time, the IHS is in dire need of a senior policy official who is knowledgeable about the programs administered by the IHS and who can provide the leadership for the health care needs of American Indians and Alaska Natives. We continue to pursue passage of this legislation as many believe that the priority of Indian health issues within the Department should be raised to the highest levels within our federal government.

I look forward to working with my colleagues on both sides of the aisle to ensure prompt passage of this legislation. I ask unanimous consent that the full text and section-by-section analysis of this bill be included in the RECORD.

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

S. 299

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

SECTION 1. OFFICE OF ASSISTANT SECRETARY FOR INDIAN HEALTH.

(a) ESTABLISHMENT.—There is established within the Department of Health and Human Services the Office of the Assistant Secretary for Indian Health in order to, in a manner consistent with the government-to-government relationship between the United States and Indian tribes—

(1) facilitate advocacy for the development of appropriate Indian health policy; and

(2) promote consultation on matters related to Indian health.

(b) ASSISTANT SECRETARY FOR INDIAN HEALTH.—In addition to the functions performed on the date of enactment of this Act by the Director of the Indian Health Service, the Assistant Secretary for Indian Health shall perform such functions as the Secretary of Health and Human Services (referred to in this section as the “Secretary”) may designate. The Assistant Secretary for Indian Health shall—

(1) report directly to the Secretary concerning all policy- and budget-related matters affecting Indian health;

(2) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

(3) advise each Assistant Secretary of the Department of Health and Human Services concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

(4) advise the heads of other agencies and programs of the Department of Health and Human Services concerning matters of In-

dian health with respect to which those heads have authority and responsibility; and

(5) coordinate the activities of the Department of Health and Human Services concerning matters of Indian health.

(c) REFERENCES.—Reference in any other Federal law, Executive order, rule, regulation, or delegation of authority, or any document of or relating to the Director of the Indian Health Service shall be deemed to refer to the Assistant Secretary for Indian Health.

(d) RATE OF PAY.—

(1) POSITIONS AT LEVEL IV.—Section 5315 of title 5, United States Code, is amended—

(A) by striking the following:

“Assistant Secretaries of Health and Human Services (6).”; and

(B) by inserting the following:

“Assistant Secretaries of Health and Human Services (7).”.

(2) POSITIONS AT LEVEL V.—Section 5316 of title 5, United States Code, is amended by striking the following:

“Director, Indian Health Service, Department of Health and Human Services.”.

(e) DUTIES OF ASSISTANT SECRETARY FOR INDIAN HEALTH.—Section 601(a) of the Indian Health Care Improvement Act (25 U.S.C. 1661(a)) is amended—

(1) by inserting “(1)” after “(a)”; and

(2) in the second sentence of paragraph (1), as so designated, by striking “a Director,” and inserting “the Assistant Secretary for Indian Health.”; and

(3) by striking the third sentence of paragraph (1) and all that follows through the end of the subsection and inserting the following: “The Assistant Secretary for Indian Health shall carry out the duties specified in paragraph (2).”

“(2) The Assistant Secretary for Indian Health shall—

“(A) report directly to the Secretary concerning all policy- and budget-related matters affecting Indian health;

“(B) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

“(C) advise each Assistant Secretary of the Department of Health and Human Services concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

“(D) advise the heads of other agencies and programs of the Department of Health and Human Services concerning matters of Indian health with respect to which those heads have authority and responsibility; and

“(E) coordinate the activities of the Department of Health and Human Services concerning matters of Indian health.”.

(f) CONTINUED SERVICE BY INCUMBENT.—The individual serving in the position of Director of the Indian Health Service on the date preceding the date of enactment of this Act may serve as Assistant Secretary for Indian Health, at the pleasure of the President after the date of enactment of this Act.

(g) CONFORMING AMENDMENTS.—

(1) AMENDMENTS TO INDIAN HEALTH CARE IMPROVEMENT ACT.—The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended—

(A) in section 601—

(i) in subsection (c), by striking “Director of the Indian Health Service” both places it appears and inserting “Assistant Secretary for Indian Health”; and

(ii) in subsection (d), by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”; and

(B) in section 816(c)(1), by striking “Director of the Indian Health Service” and inserting “Assistant Secretary for Indian Health”.

(2) AMENDMENTS TO OTHER PROVISIONS OF LAW.—The following provisions are each amended by striking “Director of the Indian

Health Service" each place it appears and inserting "Assistant Secretary for Indian Health":

(A) Section 203(a)(1) of the Rehabilitation Act of 1973.

(B) Subsections (b) and (e) of section 518 of the Federal Water Pollution Control Act (33 U.S.C. 1377 (b) and (e)).

(C) Section 803B(d)(1) of the Native American Programs Act of 1974 (42 U.S.C. 2991b-2(d)(1)).

SECTION-BY-SECTION ANALYSIS

Subsection (a) provides that the Office of Assistant Secretary for Indian Health is established within the Department of Health and Human Services.

Subsection (b) requires that the Assistant Secretary for Indian Health shall perform functions designated by the Secretary of Health and Human Services in addition to the functions of the Director of Indian Health. The Assistant Secretary for Indian Health shall report directly to the Secretary of HHS and shall also consult with the Assistant Secretary of Health and other Assistant Secretaries on all matters pertaining to Indian health policy.

Subsection (c) provides that any references to the Director of Indian Health Service in any other Federal law, Executive order, rule, regulation, or delegation of authority, or any document shall be deemed to refer to the Assistant Secretary for Indian Health.

Subsection (d)(1) amends Title 5 section 5315 of the U.S.C. by striking "Assistant Secretaries of Health and Human Services (6)" and inserting "Assistant Secretaries of Health and Human Services (7)." Subsection (d)(1) further amends 5316 of title 5 by striking "Director, Indian Health Service, Department of Health and Human Services."

Subsection (d)(2) abolishes the position of the Director of Indian Health Service.

Subsection (e) amends section 601 of the Indian Health Care Improvement Act, 25 U.S.C. 1661, and other Acts by deleting all provisions referring to the "Director" or "Director of Indian Health Service" and inserting in lieu thereof "the Assistant Secretary for Indian Health."

Subsection 601 of 25 U.S.C. 1661(a), as amended by subsection (b), is further amended by striking the term limits for the Assistant Secretary for Indian Health. •

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

S. 300. A bill to improve access and choice of patients to quality, affordable health care; to the Committee on

Health, Education, Labor, and Pensions.

PATIENTS' BILL OF RIGHTS PLUS ACT

• Mr. NICKLES. Mr. President, today I am introducing the Senate Republican Patients' Bill of Rights Plus. Joining me in this effort are 49 of my colleagues who recognize the importance of ensuring that all Americans are able to not only receive the care they have been promised, but also the highest quality of care available. The foundation of this proposal is to address some of the very real concerns that patients have about their health care needs and to provide significant opportunities for all consumers in choosing their doctors and health plans.

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

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

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

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

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

We are proud of what we have been able to accomplish. For the first time, patients can choose to be unencumbered in their relationship with their doctor. They will be able to choose their own doctor and get the middle man out of the way. There will be no corporate bureaucrat, no government bureaucrat and no lawyer standing between a patient and their doctor. In addition our legislation does what no other bill has done. It provides the patient with more choice in their health plans.

Mr. President the bill we introduce today:

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

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

See their ob-gyns and pediatricians without referral. Guarantees parents and families peace of mind by giving patients direct access to pediatricians and ob-gyns without prior referral from a "gatekeeper."

Have a "prudent layperson" standard applied to their claims for emergency care. Our bill will require health plans to cover—without prior authorization—emergency care that a "prudent layperson" would consider medically necessary.

Communicate openly with their doctors without "gag" clauses.

Holds health plans accountable for their decisions.

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

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

Requires health plans to disclose to enrollees consumer information, including what's covered, what's not, how much they'll have to pay in deductibles and coinsurance, and how to appeal adverse coverage decisions to independent medical experts.

Guarantees consumers access to their medical records.

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

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

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

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

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

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

Makes health insurance more accessible and affordable by:

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

Making medical savings accounts available to everyone.

Reforming flexibility spending accounts to let consumers save for future health care costs.

Mr. President, this bill is a comprehensive bill of rights that will benefit all Americans, and I am proud to join with so many of my colleagues in introducing it. This legislation is built around several basic principles which distinguishes it from other proposals.

First and foremost, it recognizes that regulation adds costs and not value. The legislation places a priority on ensuring that we will not increase the number of uninsured or make health care unaffordable through excessive regulation.

Second, our legislation rightly places patients ahead of trial lawyers. The inclusion of a strong, internal and external appeals provision holds HMOs accountable, while guaranteeing that patients get the care they need when they need it.

Third, our legislation protects the historic and traditional role of states to regulate private health insurance. States are best equipped to determine the needs of their citizens. Our legislation ensures that the Federal Government and HCFA will not be empowered to expand their reach into the private market. The creation of new federal bureaucracies will only serve to stagnate and destroy what is best about our health care system.

Finally, our legislation places a high priority on choice. Unlike every other

proposal our bill will give every American the right to fire their HMO. Every patient will have their choice of doctor and health plan.

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

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

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

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

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

Our bill assures that health care dollars are used to serve patients. It does not divert dollars away from patients and into the pockets of trial lawyers.

Mr. President, another big difference between our bill and others proposed is that their bill takes a "big government" approach to health reform.

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

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

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

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

On July 16, 1998, a GAO witness testified before the Ways and Means Committee on how well HCFA was doing in implementing the Balanced Budget Act and enforcing the Medicare patients' bill of rights. According to GAO, HCFA has "missed 25 percent of the implementation deadlines, including the quality-of-care medical review process for skilled nursing facilities. It is clear that HCFA will continue to miss implementation deadlines as it attempts to balance the resource demands generated by the Balanced Budget Act with other competing objectives."

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

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

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

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

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

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

One just has to look at HCFA's record on the Health Insurance and Portability and Accountability Act

(HIPAA). This Act gave HCFA enforcement authority in states that do not meet federal health standards. But how has HCFA done in the enforcement of HIPAA? A GAO report analyzing HCFA's success states that HCFA has done very little in this area. HCFA's activities, to date, have been "limited primarily to responding to consumer queries and complaints and providing guidance" to carriers in 4 of the 5 states that are not in compliance.

The GAO report goes on to say that even HCFA admits "the agency has thus far pursued a "Band Aid" or minimalist approach to regulating HIPAA. The failure to fully address this regulatory responsibility is due to the fact that HCFA lacks the "appropriate experience" in the regulating of the private health insurance market.

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

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

The doctor-patient relationship is one of the most important in people's lives. Our legislation preserves and protects that relationship, while taking many common-sense steps forward to affirm and expand quality and access.

I look forward to a deliberative, thoughtful process this year on examining the complex issues addressed in our Patients Bill of Rights PLUS. Last year, the debate surrounding this legislation was extremely politicized and resulted in a partisan standoff. That was unfortunate.

I am hopeful that the Committees will work this year to examine these issues completely and substantively. Health care costs are rising everyday, Mr. President. We must balance the need to protect patients with the need to make health care accessible. The Committees will need to examine the current trends in the market place and evaluate any legislation on all fronts, not just political rhetoric. Health care is just too important to politicize.

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

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

S. 300

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

Sec. 1. Short title; table of contents.

TITLE I—PATIENTS' BILL OF RIGHTS**Subtitle A—Right to Advice and Care**

Sec. 101. Patient right to medical advice and care.

"SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

"Sec. 721. Patient access to emergency medical care.

"Sec. 722. Offering of choice of coverage options.

"Sec. 723. Patient access to obstetric and gynecological care.

"Sec. 724. Patient access to pediatric care.

"Sec. 725. Continuity of care.

"Sec. 726. Protection of patient-provider communications.

"Sec. 727. Generally applicable provision.

Sec. 102. Effective date and related rules.

Subtitle B—Right to Information About Plans and Providers

Sec. 111. Information about plans.

Sec. 112. Information about providers.

Subtitle C—Right to Hold Health Plans Accountable

Sec. 121. Amendment to Employee Retirement Income Security Act of 1974.

Subtitle D—Miscellaneous Provisions

Sec. 131. Amendments to the Internal Revenue Code of 1986.

TITLE II—INDIVIDUAL RIGHTS WITH RESPECT TO PERSONAL MEDICAL INFORMATION

Sec. 201. Short title.

Subtitle A—Access to Medical Records

Sec. 211. Inspection and copying of protected health information.

Sec. 212. Amendment of protected health information.

Sec. 213. Notice of confidentiality practices.

Subtitle B—Establishment of Safeguards

Sec. 221. Establishment of safeguards.

Subtitle C—Enforcement; Definitions

Sec. 231. Civil penalty.

Sec. 232. Definitions.

Sec. 233. Effective date.

TITLE III—GENETIC INFORMATION AND SERVICES

Sec. 301. Short title.

Sec. 302. Amendments to Employee Retirement Income Security Act of 1974.

Sec. 303. Amendments to the Public Health Service Act.

Sec. 304. Amendments to the Internal Revenue Code of 1986.

TITLE IV—HEALTHCARE RESEARCH AND QUALITY

Sec. 401. Short title.

Sec. 402. Amendment to the Public Health Service Act.

"TITLE IX—AGENCY FOR HEALTHCARE RESEARCH AND QUALITY**"PART A—ESTABLISHMENT AND GENERAL DUTIES**

"Sec. 901. Mission and duties.

"Sec. 902. General authorities.

"PART B—HEALTHCARE IMPROVEMENT RESEARCH

"Sec. 911. Healthcare outcome improvement research.

"Sec. 912. Private-public partnerships to improve organization and delivery.

"Sec. 913. Information on quality and cost of care.

"Sec. 914. Information systems for healthcare improvement.

"Sec. 915. Research supporting primary care and access in underserved areas.

"Sec. 916. Clinical practice and technology innovation.

"Sec. 917. Coordination of Federal Government quality improvement efforts.

"PART C—GENERAL PROVISIONS

"Sec. 921. Advisory Council for Healthcare Research and Quality.

"Sec. 922. Peer review with respect to grants and contracts.

"Sec. 923. Certain provisions with respect to development, collection, and dissemination of data.

"Sec. 924. Dissemination of information.

"Sec. 925. Additional provisions with respect to grants and contracts.

"Sec. 926. Certain administrative authorities.

"Sec. 927. Funding.

"Sec. 928. Definitions.

Sec. 403. References.

Sec. 404. Study.

TITLE V—ENHANCED ACCESS TO HEALTH INSURANCE COVERAGE

Sec. 501. Full deduction of health insurance costs for self-employed individuals.

Sec. 502. Full availability of medical savings accounts.

Sec. 503. Carryover of unused benefits from cafeteria plans, flexible spending arrangements, and health flexible spending accounts.

Sec. 504. Permitting contribution towards medical savings account through Federal employees health benefits program (FEHBP).

TITLE I—PATIENTS' BILL OF RIGHTS**Subtitle A—Right to Advice and Care****SEC. 101. PATIENT RIGHT TO MEDICAL ADVICE AND CARE.**

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

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

(2) by inserting after subpart B the following:

"Subpart C—Patient Right to Medical Advice and Care**"SEC. 721. PATIENT ACCESS TO EMERGENCY MEDICAL CARE.**

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

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

"(2) the plan shall provide coverage for benefits for additional emergency medical

care to stabilize an emergency medical condition following an emergency medical screening examination (if determined necessary under paragraph (1)), pursuant to the definition of stabilize under section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

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

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

“(1) IN GENERAL.—The term ‘emergency medical care’ means, with respect to a participant or beneficiary under a group health plan (other than a fully insured group health plan), covered inpatient and outpatient services that—

“(A) are furnished by any provider, including a nonparticipating provider, that is qualified to furnish such services; and

“(B) are needed to evaluate or stabilize (as such term is defined in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd)) an emergency medical condition (as defined in paragraph (2)).

“(2) EMERGENCY MEDICAL CONDITION.—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) placing the health of the participant or beneficiary (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

“(B) serious impairment to bodily functions, or

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

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

“(a) REQUIREMENT.—

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

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

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

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

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

“(c) SMALL EMPLOYER EXEMPTION.—

“(1) IN GENERAL.—This section shall not apply to any group health plan (other than a fully insured group health plan) of a small employer.

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

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

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

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

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

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

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

“(a) IN GENERAL.—In any case in which a group health plan (other than a fully insured group health plan)—

“(1) provides coverage for benefits consisting of—

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

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

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

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

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

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

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

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

ordered. Nothing in subsection (b) shall be construed to preclude the health plan from requiring that the obstetrician or gynecologist notify the primary care provider or the plan of treatment decisions.

“SEC. 724. PATIENT ACCESS TO PEDIATRIC CARE.

“(a) IN GENERAL.—In any case in which a group health plan (other than a fully insured group health plan)—

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

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

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

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

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

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

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

“SEC. 725. CONTINUITY OF CARE.

“(a) IN GENERAL.—

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

“(A) notify the individual on a timely basis of such termination;

“(B) provide the individual with an opportunity to notify the plan of a need for transitional care; and

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

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

“(3) CONTRACTS.—For purposes of this section, the term ‘contract between a group health plan (other than a fully insured group health plan) and a health care provider’ shall include a contract between such a plan and an organized network of providers.

“(b) TRANSITIONAL PERIOD.—

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

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

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

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

“(B) the provider was treating the pregnancy before the date of the termination; the transitional period under this subsection with respect to provider's treatment of the pregnancy shall extend through the provision of post-partum care directly related to the delivery.

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

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

“(B) the provider was treating the terminal illness before the date of termination; the transitional period under this subsection shall be for care directly related to the treatment of the terminal illness.

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

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

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

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

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

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

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

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

to engage in the delivery of such services in the State, is so licensed.

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

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

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

“SEC. 727. GENERALLY APPLICABLE PROVISION.

“In the case of a group health plan that provides benefits under 2 or more coverage options, the requirements of sections 721, 723, 724, 725 and 726 shall apply separately with respect to each coverage option.”

(b) RULE WITH RESPECT TO CERTAIN PLANS.—

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

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

(c) DEFINITION.—Section 733(a) of the Employee Retirement Income Security Act of 1974 (42 U.S.C. 1186(a)) is amended by adding at the end the following:

“(3) FULLY INSURED GROUP HEALTH PLAN.—The term ‘fully insured group health plan’ means a group health plan where benefits are provided pursuant to the terms of an arrangement between a group health plan and a health insurance issuer and are guaranteed by the health insurance issuer under a contract or policy of insurance.”

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

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

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

“SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

“Sec. 721. Patient access to emergency medical care.

“Sec. 722. Offering of choice of coverage options.

“Sec. 723. Patient access to obstetric and gynecological care.

“Sec. 724. Patient access to pediatric care.

“Sec. 725. Continuity of care.

“Sec. 726. Protection of patient-provider communications.

“Sec. 727. Generally applicable provisions.”.

SEC. 102. EFFECTIVE DATE AND RELATED RULES.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to plan

years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The Secretary shall issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

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

Subtitle B—Right to Information About Plans and Providers

SEC. 111. INFORMATION ABOUT PLANS.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105-277), is amended by adding at the end the following:

“SEC. 714. HEALTH PLAN COMPARATIVE INFORMATION.

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

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

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

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

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

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

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

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

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

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

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

“(10) A summary of the rules for access to emergency room care. Also, any available

educational material regarding proper use of emergency services.

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

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

“(13) A statement regarding—

“(A) the manner in which an enrollee may access an obstetrician, gynecologist, or pediatrician in accordance with section 723 or 724;

“(B) the manner in which an enrollee obtains continuity of care as provided for in section 725; and

“(C) the manner in which an enrollee has access to the medical records of the enrollee in accordance with subtitle A of title II of the Patients’ Bill of Rights Plus Act.

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

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

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

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

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

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

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

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

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

“(c) MANNER OF DISTRIBUTION.—

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

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

“(A) in the case of the plan, to participants and beneficiaries at the address contained in

such records with respect to such participants and beneficiaries; or

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

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

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

(b) CONFORMING AMENDMENTS.—

(1) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185(a)) is amended by striking “section 711, and inserting “sections 711 and 714”.

(2) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001) is amended by inserting after the item relating to section 713, the following:

“Sec. 714. Health plan comparative information.”.

SEC. 112. INFORMATION ABOUT PROVIDERS.

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

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

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

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

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

Subtitle C—Right to Hold Health Plans Accountable

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

(a) IN GENERAL.—Section 503 of the Employee Retirement Income Security Act of

1974 (29 U.S.C. 1133) is amended to read as follows:

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

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

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

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

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

“(1) PROCEDURES.—

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

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

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

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

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

“(2) TIMELINE FOR MAKING DETERMINATIONS.—

“(A) ROUTINE DETERMINATION.—A group health plan or a health insurance issuer shall maintain procedures to ensure that prior authorization determinations concerning the provision of non-emergency items or services are made within 30 days from the date on which the request for a determination is submitted, except that such period may be extended where certain circumstances exist that are determined by the Secretary to be beyond control of the plan or issuer.

“(B) EXPEDITED DETERMINATION.—

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

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

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

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

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

“(3) NOTICE OF DETERMINATIONS.—

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

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

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

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

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

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

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

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

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

“(d) INTERNAL APPEAL OF COVERAGE DETERMINATIONS.—

“(1) IN GENERAL.—An enrollee (or the legal representative of the enrollee) and the treating health care professional with the consent

of the enrollee (or the legal representative of the enrollee), may appeal any adverse coverage determination under subsection (b) under the procedures described in this subsection.

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

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

“(4) EXPEDITED DETERMINATION.—

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

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

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

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

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

“(7) NOTICE.—

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

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

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

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

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

“(e) EXTERNAL REVIEW.—

“(1) IN GENERAL.—A group health plan or a health insurance issuer shall have written

procedures to permit an enrollee (or the legal representative of the enrollee) access to an external review with respect to a coverage determination concerning a particular item or service where—

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

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

“(i) does not meet the plan's or issuer's requirements for medical appropriateness or necessity and the amount involved exceeds a significant financial threshold; or

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

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

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

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

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

“(C) PROVISION OF INFORMATION.—The plan or issuer involved shall forward all necessary information (including medical records, any relevant review criteria, the clinical rationale consistent with the terms and conditions of the contract between the plan or issuer and the enrollee for the coverage denial, and evidence of the enrollee's coverage) to the external reviewer selected under paragraph (3)(B).

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

“(3) CONDUCT OF EXTERNAL REVIEW.—

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

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

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

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

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

“(v) Any fully accredited teaching hospital.

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

“(B) DESIGNATION OF EXTERNAL REVIEWER BY EXTERNAL APPEALS ENTITY.—The external appeals entity designated under subparagraph (A) shall, not later than 30 days after the date on which such entity is designated under subparagraph (A), or earlier in accordance with the medical exigencies of the case, designate one or more individuals to serve as external reviewers with respect to a request received under paragraph (2)(A). Such reviewers shall be independent medical experts who shall—

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

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

“(iii) be experts in the diagnosis or treatment under review and, when reasonably available, be of the same speciality of the physician prescribing the treatment in question;

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

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

“(4) STANDARD OF REVIEW.—

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

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

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

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

“(I) the plan or issuer involved;

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

“(III) the health care professional involved.

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

“(5) TIMEFRAME FOR REVIEW.—

“(A) IN GENERAL.—An external reviewer shall complete a review of an adverse coverage determination in accordance with the medical exigencies of the case.

“(B) LIMITATION.—Notwithstanding subparagraph (A), a review described in such subparagraph shall be completed not later than 30 working days after the later of—

“(i) the date on which such reviewer is designated; or

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

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

“(7) STUDY.—Not later than 2 years after the date of enactment of this section, the General Accounting Office shall conduct a

study of a statistically appropriate sample of completed external reviews. Such study shall include an assessment of the process involved during an external review and the basis of decisionmaking by the external reviewer. The results of such study shall be submitted to the appropriate committees of Congress.

“(8) EFFECT ON CERTAIN PROVISIONS.—Nothing in this section shall be construed as affecting or modifying section 514 of this Act with respect to a group health plan.

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

“(g) DEFINITIONS.—In this section:

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

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

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

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

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

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

“(7) HEALTH INSURER.—The term ‘health insurer’ means an insurance company, insurance service, or an insurance organization that meets the requirements of section 733(b)(2) and that offers health insurance coverage in connection with a group health plan.

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

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

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

(b) ENFORCEMENT.—Section 502(c)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132(c)(1)) is amended by in-

serting after “or section 101(e)(1)” the following: “, or fails to comply with a coverage determination as required under section 503(e)(6);”.

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

“Sec. 503. Claims procedures, coverage determination, grievances and appeals.”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning on or after 1 year after the date of enactment of this Act. The Secretary shall issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

Subtitle D—Miscellaneous Provisions

SEC. 131. 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 Patients’ bill of rights.”; and

(2) by inserting after section 9812 the following:

“SEC. 9813. STANDARD RELATING TO PATIENTS’ BILL OF RIGHTS.

“A group health plan shall comply with the requirements of section 714 and subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as in effect as of the date of the enactment of the Patients’ Bill of Rights Plus Act), and such requirements shall be deemed to be incorporated into this section.”.

TITLE II—INDIVIDUAL RIGHTS WITH RESPECT TO PERSONAL MEDICAL INFORMATION

SEC. 201. SHORT TITLE.

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

Subtitle A—Access to Medical Records

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 212. AMENDMENT OF PROTECTED HEALTH INFORMATION.

(a) REQUIREMENT.—

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

(A) amend such information as requested;

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

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

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

(A) created the protected health information involved; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 213. NOTICE OF CONFIDENTIALITY PRACTICES.

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

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

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

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

(b) MODEL NOTICE.—The Secretary, in consultation with the National Committee on

Vital and Health Statistics and the National Association of Insurance Commissioners, and after notice and opportunity for public comment, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

Subtitle B—Establishment of Safeguards

SEC. 221. ESTABLISHMENT OF SAFEGUARDS.

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

Subtitle C—Enforcement; Definitions

SEC. 231. CIVIL PENALTY.

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

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

SEC. 232. DEFINITIONS.

In this title:

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

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

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

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

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

(B) a Federal, State, or employer-sponsored program that directly provides items

or services that constitute health care to beneficiaries; or

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

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

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

(7) PERSON.—The term “person” means a government, governmental subdivision, agency or authority; corporation; company; association; firm; partnership; society; estate; trust; joint venture; individual; individual representative; tribal government; and any other legal entity.

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

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

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

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

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

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

(C) that is not nonidentifiable health information.

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

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

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

SEC. 233. EFFECTIVE DATE.

The provisions of this title shall become effective beginning on the date that is 1 year after the date of enactment of this Act. The Secretary shall issue regulations necessary to carry out this title before the effective date thereof.

TITLE III—GENETIC INFORMATION AND SERVICES

SEC. 301. SHORT TITLE.

This title may be cited as the “Genetic Information Nondiscrimination in Health Insurance Act of 1999”.

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

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

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

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

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

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

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

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

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

“(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

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

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

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

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

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

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

“(A) the spouse of the individual;

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

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

“(6) GENETIC INFORMATION.—The term ‘genetic information’ means information about

genes, gene products, or inherited characteristics that may derive from an individual or a family member (including information about a request for or receipt of genetic services).

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

“(8) PREDICTIVE GENETIC INFORMATION.—

“(A) IN GENERAL.—The term ‘predictive genetic information’ means—

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

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

“(iii) information about the occurrence of a disease or disorder in family members that predicts a statistically significant increased risk of a disease or disorder in the individual.

“(B) EXCEPTIONS.—The term ‘predictive genetic information’ shall not include—

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

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

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

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

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

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

(a) AMENDMENTS RELATING TO THE GROUP MARKET.—

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

(A) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105-277), is amended by adding at the end the following new section:

“SEC. 2707. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION IN THE GROUP MARKET.

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

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

“(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis

of predictive genetic information (including information about a request for or receipt of genetic services), see section 2707.”

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

“(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

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

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

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

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

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

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

“(A) the spouse of the individual;

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

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

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

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

“(18) PREDICTIVE GENETIC INFORMATION.—

“(A) IN GENERAL.—The term ‘predictive genetic information’ means—

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

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

“(iii) information about the occurrence of a disease or disorder in family members that predicts a statistically significant increased risk of a disease or disorder in the individual.

“(B) EXCEPTIONS.—The term ‘predictive genetic information’ shall not include—

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

“(ii) information derived from routine physical tests, such as the chemical, blood,

or urine analyses of the individual, unless such analyses are genetic tests; and

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

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

(b) AMENDMENT RELATING TO THE INDIVIDUAL MARKET.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-11 et seq.) (relating to other requirements), as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (Public Law 105-277) is amended—

(1) by redesignating such subpart as subpart 2; and

(2) by adding at the end the following:

“SEC. 2753. PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

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

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

“(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

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

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

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

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

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

(1) group health plans, and health insurance coverage offered in connection with

group health plans, for plan years beginning after 1 year after the date of enactment of this Act; and

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

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

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

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (as amended by section 131) is further amended by adding at the end the following:

“SEC. 9814. PROHIBITING HEALTH DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

“A group health plan shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information concerning an individual in the group or a family member of the individual (including information about a request for or receipt of genetic services).”

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

“(3) REFERENCE TO RELATED PROVISION.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or receipt of genetic services), see section 9814.”

(3) AMENDMENT TO TABLE OF SECTIONS.—The table of sections for subchapter B of chapter 100 of the Internal Revenue Code of 1986 (as amended by section 131) is further amended by adding at the end the following:

“Sec. 9814. Prohibiting premium discrimination against groups on the basis of predictive genetic information.”

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

“(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

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

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

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

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

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

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

“(A) the spouse of the individual;

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

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

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

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

“(9) PREDICTIVE GENETIC INFORMATION.—

“(A) IN GENERAL.—The term ‘predictive genetic information’ means—

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

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

“(iii) information about the occurrence of a disease or disorder in family members that predicts a statistically significant increased risk of a disease or disorder in the individual.

“(B) EXCEPTIONS.—The term ‘predictive genetic information’ shall not include—

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

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

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

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

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

TITLE IV—HEALTHCARE RESEARCH AND QUALITY

SEC. 401. SHORT TITLE.

This title may be cited as the “Healthcare Research and Quality Act of 1999”.

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

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

“TITLE IX—AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

“PART A—ESTABLISHMENT AND GENERAL DUTIES

“SEC. 901. MISSION AND DUTIES.

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

“(b) MISSION.—The purpose of the Agency is to enhance the quality, appropriateness, and effectiveness of healthcare services, and access to such services, through the establishment of a broad base of scientific re-

search and through the promotion of improvements in clinical and health system practice, including the prevention of diseases and other health conditions. The Agency shall promote healthcare quality improvement by—

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

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

“(B) the outcomes, effectiveness, and cost-effectiveness of healthcare practices, including preventive measures and primary, acute and long-term care;

“(C) existing and innovative technologies;

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

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

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

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

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

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

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

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

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

“(3) the health of children;

“(4) the elderly; and

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

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

“SEC. 902. GENERAL AUTHORITIES.

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

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

“(2) quality measurement and improvement;

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

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

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

“(6) healthcare costs, productivity, organization, and market forces;

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

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

“(9) medical liability.

“(b) HEALTH SERVICES TRAINING GRANTS.—

“(1) IN GENERAL.—The Director may provide training grants in the field of health services research related to activities authorized under subsection (a), to include pre- and post-doctoral fellowships and training programs, young investigator awards, and other programs and activities as appropriate. In carrying out this subsection, the Director shall make use of funds made available under section 487.

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

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

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

“(e) DISCLAIMER.—The Agency shall not mandate national standards of clinical practice or quality healthcare standards. Recommendations resulting from projects funded and published by the Agency shall include a corresponding disclaimer.

“(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to imply that the Agency’s role is to mandate a national standard or specific approach to quality measurement and reporting. In research and quality improvement activities, the Agency shall consider a wide range of choices, providers, healthcare delivery systems, and individual preferences.

“PART B—HEALTHCARE IMPROVEMENT RESEARCH

“SEC. 911. HEALTHCARE OUTCOME IMPROVEMENT RESEARCH.

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

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

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

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

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

“(C) other innovative mechanisms or strategies to link research with clinical practice.

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

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

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

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

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

“(A) the identification and assessment of—

“(i) methods for the evaluation of the health of enrollees in health plans by type of plan, provider, and provider arrangements; and

“(ii) other populations, including those receiving long-term care services;

“(B) the ongoing development, testing, and dissemination of quality measures, including measures of health and functional outcomes;

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

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

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

“(F) identifying and disseminating information on mechanisms for the integration of information on quality into purchaser and consumer decision-making processes.

“(b) CENTERS FOR EDUCATION AND RESEARCH ON THERAPEUTICS.—

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

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

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

“(i) To increase awareness of—

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

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

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

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

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

“(II) Pharmacists, pharmacy benefit managers and purchasers.

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

“(IV) Healthcare insurers and governmental agencies.

“(V) Patients and consumers.

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

“(I) an increase in the appropriate use of drugs, biological products, or devices; and

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

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

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

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

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

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

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

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

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

“(1) collect data on a nationally representative sample of the population on the cost, use and, for fiscal year 2000 and subsequent fiscal years, quality of healthcare, including the types of healthcare services Americans use, their access to healthcare services, frequency of use, how much is paid for the services used, the source of those payments, the types and costs of private health insurance, access, satisfaction, and quality of care for the general population and also for children, uninsured persons, poor and near-poor individuals, and persons with special healthcare needs;

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

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

“(b) QUALITY AND OUTCOMES INFORMATION.—

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

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

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

In expanding the Medical Expenditure Panel Survey, as in existence on the date of enactment of this title) in fiscal year 2000 to collect information on the quality of care, the Director shall take into account any outcomes measurements generally collected by private sector accreditation organizations.

“(2) ANNUAL REPORT.—Beginning in fiscal year 2002, the Secretary, acting through the Director, shall submit to Congress an annual

report on national trends in the quality of healthcare provided to the American people.

“SEC. 914. INFORMATION SYSTEMS FOR HEALTHCARE IMPROVEMENT.

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

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

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

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

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

“(5) the structure, content, definition, and coding of health information data and medical vocabularies in consultation with appropriate Federal and private entities;

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

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

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

“(a) PREVENTIVE SERVICES TASK FORCE.—

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

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

“(b) PRIMARY CARE RESEARCH.—

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

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

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

“(B) the management of commonly occurring clinical problems;

“(C) the management of undifferentiated clinical problems; and

“(D) the continuity and coordination of health services.

“(3) DEMONSTRATION.—The Agency shall support demonstrations into the use of new

information tools aimed at improving shared decision-making between patients and their care-givers.

“SEC. 916. CLINICAL PRACTICE AND TECHNOLOGY INNOVATION.

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

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

“(2) developing, evaluating, and disseminating methodologies for assessments of healthcare practices and healthcare technologies;

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

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

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

“(b) SPECIFICATION OF PROCESS.—

“(1) IN GENERAL.—Not later than December 31, 2000, the Director shall develop and publish a description of the methods used by the Agency and its contractors for practice and technology assessment.

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

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

“(A) safety, efficacy, and effectiveness;

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

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

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

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

“(c) SPECIFIC ASSESSMENTS.—

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

“(2) REQUESTS FOR ASSESSMENTS.—The Director is authorized to conduct or support assessments, on a reimbursable basis, for the Health Care Financing Administration, the Department of Defense, the Department of Veterans Affairs, the Office of Personnel Management, and other public or private entities.

“(3) GRANTS AND CONTRACTS.—In addition to conducting assessments, the Director may make grants to, or enter into cooperative agreements or contracts with, entities described in paragraph (4) for the purpose of conducting assessments of experimental, emerging, existing, or potentially unmodeled healthcare technologies, and for related activities.

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

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

“(a) REQUIREMENT.—

“(1) IN GENERAL.—To avoid duplication and ensure that Federal resources are used efficiently and effectively, the Secretary, acting through the Director, shall coordinate all research, evaluations, and demonstrations related to health services research and quality measurement and improvement activities undertaken and supported by the Federal Government.

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

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

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

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

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

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

“(1) IN GENERAL.—To provide the Department of Health and Human Services with an independent, external review of its quality oversight, and quality research programs, the Secretary shall enter into a contract with the Institute of Medicine—

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

“(i) an overview of pertinent health services research activities and quality improvement efforts including those currently performed by the peer review organizations and the exploration of additional activities that could be undertaken by the peer review organizations to improve quality;

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

“(iii) the exploration of programmatic areas where partnership activities between the Federal Government and the private sector or within the Federal Government could be pursued to improve quality oversight of the medicare, medicaid and child health insurance programs under titles XVIII, XIX and XXI of the Social Security Act; and

“(iv) an identification of opportunities for enhancing health system efficiency through simplification and reduction in redundancy of Federal agency quality improvement efforts, including areas in which Federal efforts unnecessarily duplicate existing private sector efforts; and

“(B) to identify options and make recommendations to improve the efficiency and effectiveness of such quality improvement programs through—

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

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

“(iii) the enhancement of the most effective programs, consolidation as appropriate,

and elimination of duplicative activities within various federal agencies.

“(2) REQUIREMENTS.—

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

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

“(ii) not later than 24 months after the date of enactment of this title, of a final report containing recommendations.

“(B) REPORTS.—The Secretary shall submit the reports described in subparagraph (A) to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Commerce of the House of Representatives.

“PART C—GENERAL PROVISIONS

“SEC. 921. ADVISORY COUNCIL FOR HEALTHCARE RESEARCH AND QUALITY.

“(a) ESTABLISHMENT.—There is established an advisory council to be known as the Advisory Council for Healthcare Research and Quality.

“(b) DUTIES.—

“(1) IN GENERAL.—The Advisory Council shall advise the Secretary and the Director with respect to activities proposed or undertaken to carry out the purpose of the Agency under section 901(b).

“(2) CERTAIN RECOMMENDATIONS.—Activities of the Advisory Council under paragraph (1) shall include making recommendations to the Director regarding—

“(A) priorities regarding healthcare research, especially studies related to quality, outcomes, cost and the utilization of, and access to, healthcare services;

“(B) the field of healthcare research and related disciplines, especially issues related to training needs, and dissemination of information pertaining to healthcare quality; and

“(C) the appropriate role of the Agency in each of these areas in light of private sector activity and identification of opportunities for public-private sector partnerships.

“(c) MEMBERSHIP.—

“(1) IN GENERAL.—The Advisory Council shall, in accordance with this subsection, be composed of appointed members and ex officio members. All members of the Advisory Council shall be voting members other than the individuals designated under paragraph (3)(B) as ex officio members.

“(2) APPOINTED MEMBERS.—The Secretary shall appoint to the Advisory Council 21 appropriately qualified individuals. At least 17 members of the Advisory Council shall be representatives of the public who are not officers or employees of the United States. The Secretary shall ensure that the appointed members of the Council, as a group, are representative of professions and entities concerned with, or affected by, activities under this title and under section 1142 of the Social Security Act. Of such members—

“(A) 4 shall be individuals distinguished in the conduct of research, demonstration projects, and evaluations with respect to healthcare;

“(B) 4 shall be individuals distinguished in the practice of medicine of which at least 1 shall be a primary care practitioner;

“(C) 3 shall be individuals distinguished in the other health professions;

“(D) 4 shall be individuals either representing the private healthcare sector, including health plans, providers, and purchasers or individuals distinguished as administrators of healthcare delivery systems;

“(E) 4 shall be individuals distinguished in the fields of healthcare quality improvement, economics, information systems, law, ethics, business, or public policy; and

“(F) 2 shall be individuals representing the interests of patients and consumers of healthcare.

“(3) EX OFFICIO MEMBERS.—The Secretary shall designate as ex officio members of the Advisory Council—

“(A) the Assistant Secretary for Health, the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Care Financing Administration, the Assistant Secretary of Defense (Health Affairs), and the Chief Medical Officer of the Department of Veterans Affairs; and

“(B) such other Federal officials as the Secretary may consider appropriate.

“(d) TERMS.—Members of the Advisory Council appointed under subsection (c)(2) shall serve for a term of 3 years. A member of the Council appointed under such subsection may continue to serve after the expiration of the term of the members until a successor is appointed.

“(e) VACANCIES.—If a member of the Advisory Council appointed under subsection (c)(2) does not serve the full term applicable under subsection (d), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

“(f) CHAIR.—The Director shall, from among the members of the Advisory Council appointed under subsection (c)(2), designate an individual to serve as the chair of the Advisory Council.

“(g) MEETINGS.—The Advisory Council shall meet not less than once during each discrete 4-month period and shall otherwise meet at the call of the Director or the chair.

“(h) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—

“(i) APPOINTED MEMBERS.—Members of the Advisory Council appointed under subsection (c)(2) shall receive compensation for each day (including travel time) engaged in carrying out the duties of the Advisory Council unless declined by the member. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for GS-18 of the General Schedule.

“(2) EX OFFICIO MEMBERS.—Officials designated under subsection (c)(3) as ex officio members of the Advisory Council may not receive compensation for service on the Advisory Council in addition to the compensation otherwise received for duties carried out as officers of the United States.

“(i) STAFF.—The Director shall provide to the Advisory Council such staff, information, and other assistance as may be necessary to carry out the duties of the Council.

“SEC. 922. PEER REVIEW WITH RESPECT TO GRANTS AND CONTRACTS.

“(a) REQUIREMENT OF REVIEW.—

“(1) IN GENERAL.—Appropriate technical and scientific peer review shall be conducted with respect to each application for a grant, cooperative agreement, or contract under this title.

“(2) REPORTS TO DIRECTOR.—Each peer review group to which an application is submitted pursuant to paragraph (1) shall report its finding and recommendations respecting the application to the Director in such form and in such manner as the Director shall require.

“(b) APPROVAL AS PRECONDITION OF AWARDS.—The Director may not approve an application described in subsection (a)(1) unless the application is recommended for approval by a peer review group established under subsection (c).

“(c) ESTABLISHMENT OF PEER REVIEW GROUPS.—

“(1) IN GENERAL.—The Director shall establish such technical and scientific peer review groups as may be necessary to carry out this section. Such groups shall be established without regard to the provisions of title 5, United States Code, that govern appointments in the competitive service, and without regard to the provisions of chapter 51, and subchapter III of chapter 53, of such title that relate to classification and pay rates under the General Schedule.

“(2) MEMBERSHIP.—The members of any peer review group established under this section shall be appointed from among individuals who by virtue of their training or experience are eminently qualified to carry out the duties of such peer review group. Officers and employees of the United States may not constitute more than 25 percent of the membership of any such group. Such officers and employees may not receive compensation for service on such groups in addition to the compensation otherwise received for these duties carried out as such officers and employees.

“(3) DURATION.—Notwithstanding section 14(a) of the Federal Advisory Committee Act, peer review groups established under this section may continue in existence until otherwise provided by law.

“(4) QUALIFICATIONS.—Members of any peer-review group shall, at a minimum, meet the following requirements:

“(A) Such members shall agree in writing to treat information received, pursuant to their work for the group, as confidential information, except that this subparagraph shall not apply to public records and public information.

“(B) Such members shall agree in writing to recuse themselves from participation in the peer-review of specific applications which present a potential personal conflict of interest or appearance of such conflict, including employment in a directly affected organization, stock ownership, or any financial or other arrangement that might introduce bias in the process of peer-review.

“(d) AUTHORITY FOR PROCEDURAL ADJUSTMENTS IN CERTAIN CASES.—In the case of applications for financial assistance whose direct costs will not exceed \$100,000, the Director may make appropriate adjustments in the procedures otherwise established by the Director for the conduct of peer review under this section. Such adjustments may be made for the purpose of encouraging the entry of individuals into the field of research, for the purpose of encouraging clinical practice-oriented or provider-based research, and for such other purposes as the Director may determine to be appropriate.

“(e) REGULATIONS.—The Director may shall issue regulations for the conduct of peer review under this section.

“SEC. 923. CERTAIN PROVISIONS WITH RESPECT TO DEVELOPMENT, COLLECTION, AND DISSEMINATION OF DATA.

“(a) STANDARDS WITH RESPECT TO UTILITY OF DATA.—

“(1) IN GENERAL.—To ensure the utility, accuracy, and sufficiency of data collected by or for the Agency for the purpose described in section 901(b), the Director shall establish standards and methods for developing and collecting such data, taking into consideration—

“(A) other Federal health data collection standards; and

“(B) the differences between types of healthcare plans, delivery systems, healthcare providers, and provider arrangements.

“(2) RELATIONSHIP WITH OTHER DEPARTMENT PROGRAMS.—In any case where standards under paragraph (1) may affect the administration of other programs carried out by the Department of Health and Human Services,

including the programs under titles XVIII, XIX and XXI of the Social Security Act, they shall be in the form of recommendations to the Secretary for such program.

“(b) STATISTICS AND ANALYSES.—The Director shall—

“(1) take appropriate action to ensure that statistics and analyses developed under this title are of high quality, timely, and duly comprehensive, and that the statistics are specific, standardized, and adequately analyzed and indexed; and

“(2) publish, make available, and disseminate such statistics and analyses on as wide a basis as is practicable.

“(c) AUTHORITY REGARDING CERTAIN REQUESTS.—Upon request of a public or private entity, the Director may conduct or support research or analyses otherwise authorized by this title pursuant to arrangements under which such entity will pay the cost of the services provided. Amounts received by the Director under such arrangements shall be available to the Director for obligation until expended.

“SEC. 924. DISSEMINATION OF INFORMATION.

“(a) IN GENERAL.—The Director shall—

“(1) without regard to section 501 of title 44, United States Code, promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this title;

“(2) ensure that information disseminated by the Agency is science-based and objective and undertakes consultation as necessary to assess the appropriateness and usefulness of the presentation of information that is targeted to specific audiences;

“(3) promptly make available to the public data developed in such research, demonstration projects, and evaluations;

“(4) provide, in collaboration with the National Library of Medicine where appropriate, indexing, abstracting, translating, publishing, and other services leading to a more effective and timely dissemination of information on research, demonstration projects, and evaluations with respect to healthcare to public and private entities and individuals engaged in the improvement of healthcare delivery and the general public, and undertake programs to develop new or improved methods for making such information available; and

“(5) as appropriate, provide technical assistance to State and local government and health agencies and conduct liaison activities to such agencies to foster dissemination.

“(b) PROHIBITION AGAINST RESTRICTIONS.—Except as provided in subsection (c), the Director may not restrict the publication or dissemination of data from, or the results of, projects conducted or supported under this title.

“(c) LIMITATION ON USE OF CERTAIN INFORMATION.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under this title may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Secretary) to its publication or release in other form.

“(d) PENALTY.—Any person who violates subsection (c) shall be subject to a civil monetary penalty of not more than \$10,000 for

each such violation involved. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A of the Social Security Act are imposed and collected.

“SEC. 925. ADDITIONAL PROVISIONS WITH RESPECT TO GRANTS AND CONTRACTS.

“(a) FINANCIAL CONFLICTS OF INTEREST.—With respect to projects for which awards of grants, cooperative agreements, or contracts are authorized to be made under this title, the Director shall by regulation define—

“(1) the specific circumstances that constitute financial interests in such projects that will, or may be reasonably expected to, create a bias in favor of obtaining results in the projects that are consistent with such interests; and

“(2) the actions that will be taken by the Director in response to any such interests identified by the Director.

“(b) REQUIREMENT OF APPLICATION.—The Director may not, with respect to any program under this title authorizing the provision of grants, cooperative agreements, or contracts, provide any such financial assistance unless an application for the assistance is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Director determines to be necessary to carry out the program in involved.

“(c) PROVISION OF SUPPLIES AND SERVICES IN LIEU OF FUNDS.—

“(1) IN GENERAL.—Upon the request of an entity receiving a grant, cooperative agreement, or contract under this title, the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the entity in carrying out the project involved and, for such purpose, may detail to the entity any officer or employee of the Department of Health and Human Services.

“(2) CORRESPONDING REDUCTION IN FUNDS.—With respect to a request described in paragraph (1), the Secretary shall reduce the amount of the financial assistance involved by an amount equal to the costs of detailing personnel and the fair market value of any supplies, equipment, or services provided by the Director. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

“(d) APPLICABILITY OF CERTAIN PROVISIONS WITH RESPECT TO CONTRACTS.—Contracts may be entered into under this part without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

“SEC. 926. CERTAIN ADMINISTRATIVE AUTHORITIES.

“(a) DEPUTY DIRECTOR AND OTHER OFFICERS AND EMPLOYEES.—

“(1) DEPUTY DIRECTOR.—The Director may appoint a deputy director for the Agency.

“(2) OTHER OFFICERS AND EMPLOYEES.—The Director may appoint and fix the compensation of such officers and employees as may be necessary to carry out this title. Except as otherwise provided by law, such officers and employees shall be appointed in accordance with the civil service laws and their compensation fixed in accordance with title 5, United States Code.

“(b) FACILITIES.—The Secretary, in carrying out this title—

“(1) may acquire, without regard to the Act of March 3, 1877 (40 U.S.C. 34), by lease or otherwise through the Director of General Services, buildings or portions of buildings in the District of Columbia or communities located adjacent to the District of Columbia for use for a period not to exceed 10 years; and

“(2) may acquire, construct, improve, repair, operate, and maintain laboratory, re-

search, and other necessary facilities and equipment, and such other real or personal property (including patents) as the Secretary deems necessary.

“(c) PROVISION OF FINANCIAL ASSISTANCE.—The Director, in carrying out this title, may make grants to public and nonprofit entities and individuals, and may enter into cooperative agreements or contracts with public and private entities and individuals.

“(d) UTILIZATION OF CERTAIN PERSONNEL AND RESOURCES.—

“(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Director, in carrying out this title, may utilize personnel and equipment, facilities, and other physical resources of the Department of Health and Human Services, permit appropriate (as determined by the Secretary) entities and individuals to utilize the physical resources of such Department, and provide technical assistance and advice.

“(2) OTHER AGENCIES.—The Director, in carrying out this title, may use, with their consent, the services, equipment, personnel, information, and facilities of other Federal, State, or local public agencies, or of any foreign government, with or without reimbursement of such agencies.

“(e) CONSULTANTS.—The Secretary, in carrying out this title, may secure, from time to time and for such periods as the Director deems advisable but in accordance with section 3109 of title 5, United States Code, the assistance and advice of consultants from the United States or abroad.

“(f) EXPERTS.—

“(1) IN GENERAL.—The Secretary may, in carrying out this title, obtain the services of not more than 50 experts or consultants who have appropriate scientific or professional qualifications. Such experts or consultants shall be obtained in accordance with section 3109 of title 5, United States Code, except that the limitation in such section on the duration of service shall not apply.

“(2) TRAVEL EXPENSES.—

“(A) IN GENERAL.—Experts and consultants whose services are obtained under paragraph (1) shall be paid or reimbursed for their expenses associated with traveling to and from their assignment location in accordance with sections 5724, 5724a(a), 5724a(c), and 5726(C) of title 5, United States Code.

“(B) LIMITATION.—Expenses specified in subparagraph (A) may not be allowed in connection with the assignment of an expert or consultant whose services are obtained under paragraph (1) unless and until the expert agrees in writing to complete the entire period of assignment, or 1 year, whichever is shorter, unless separated or reassigned for reasons that are beyond the control of the expert or consultant and that are acceptable to the Secretary. If the expert or consultant violates the agreement, the money spent by the United States for the expenses specified in subparagraph (A) is recoverable from the expert or consultant as a statutory obligation owed to the United States. The Secretary may waive in whole or in part a right of recovery under this subparagraph.

“(g) VOLUNTARY AND UNCOMPENSATED SERVICES.—The Director, in carrying out this title, may accept voluntary and uncompensated services.

“SEC. 927. FUNDING.

“(a) INTENT.—To ensure that the United States's investment in biomedical research is rapidly translated into improvements in the quality of patient care, there must be a corresponding investment in research on the most effective clinical and organizational strategies for use of these findings in daily practice. The authorization levels in subsections (b) and (c) provide for a proportionate increase in healthcare research as the United States's investment in biomedical research increases.

“(b) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this title, there are authorized to be appropriated \$185,000,000 for fiscal year 2000, and such sums as may be necessary for each of the fiscal years 2001 through 2006.

“(c) EVALUATIONS.—In addition to amounts available pursuant to subsection (b) for carrying out this title, there shall be made available for such purpose, from the amounts made available pursuant to section 241 (relating to evaluations), an amount equal to 40 percent of the maximum amount authorized in such section 241 to be made available for a fiscal year.

“SEC. 929. DEFINITIONS.

“In this title:

“(1) ADVISORY COUNCIL.—The term ‘Advisory Council’ means the Advisory Council on Healthcare Research and Quality established under section 921.

“(2) AGENCY.—The term ‘Agency’ means the Agency for Healthcare Research and Quality.

“(3) DIRECTOR.—The term ‘Director’ means the Director for the Agency for Healthcare Research and Quality.”

SEC. 403. REFERENCES.

Effective upon the date of enactment of this Act, any reference in law to the “Agency for Health Care Policy and Research” shall be deemed to be a reference to the “Agency for Healthcare Research and Quality”.

SEC. 404. STUDY.

(a) STUDY.—Not later than 30 days after the date of enactment of any Act providing for a qualifying health care benefit (as defined in subsection (b)), the Secretary of Health and Human Services, in consultation with the Agency for Healthcare Research and Quality, the National Institutes of Health, and the Institute of Medicine, shall conduct a study concerning such benefit that scientifically evaluates—

(1) the safety and efficacy of the benefit, particularly the effect of the benefit on outcomes of care;

(2) the cost, benefits and value of such benefit;

(3) the benefit in comparison to alternative approaches in improving care; and

(4) the overall impact that such benefit will have on health care as measured through research.

(b) QUALIFYING HEALTH CARE BENEFIT.—In this section, the term “qualifying health care benefit” means a health care benefit that—

(1) is disease- or health condition-specific;

(2) requires the provision of or coverage for health care items or services;

(3) applies to group health plan, individual health plans, or health insurance issuers under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.) or under title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.); and

(4) was provided under an Act (or amendment) enacted on or after January 1, 1999.

(c) REPORTS.—Not later than 3 years after the date of enactment of any Act described in subsection (a), the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report based on the study conducted under such subsection with respect to the qualifying health care benefit involved.

TITLE V—ENHANCED ACCESS TO HEALTH INSURANCE COVERAGE

SEC. 501. FULL DEDUCTION OF HEALTH INSURANCE COSTS FOR SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Section 162(l)(1) of the Internal Revenue Code of 1986 (relating to allowance of deductions) is amended to read as follows:

“(1) ALLOWANCE OF DEDUCTION.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and his dependents.”

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 502. FULL AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.

(a) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Section 220(c)(1)(A) of the Internal Revenue Code of 1986 (relating to eligible individual) is amended to read as follows:

“(A) IN GENERAL.—The term ‘eligible individual’ means, with respect to any month, any individual if—

“(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

“(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

“(I) which is not a high deductible health plan, and

“(II) which provides coverage for any benefit which is covered under the high deductible health plan.”

(2) CONFORMING AMENDMENTS.—

(A) Section 220(c)(1) of such Code is amended by striking subparagraphs (C) and (D).

(B) Section 220(c) of such Code is amended by striking paragraph (4) (defining small employer) and by redesignating paragraph (5) as paragraph (4).

(C) Section 220(b) of such Code is amended by striking paragraph (4) (relating to deduction limited by compensation) and by redesignating paragraphs (5), (6), and (7) as paragraphs (4), (5), and (6), respectively.

(b) REMOVAL OF LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Section 220 of the Internal Revenue Code of 1986 (relating to medical savings accounts) is amended by striking subsections (i) and (j).

(2) MEDICARE+CHOICE.—Section 138 of such Code (relating to Medicare+Choice MSA) is amended by striking subsection (f).

(c) REDUCTION IN HIGH DEDUCTIBLE PLAN MINIMUM ANNUAL DEDUCTIBLE.—Section 220(c)(2)(A) of the Internal Revenue Code of 1986 (relating to high deductible health plan) is amended—

(1) by striking “\$1,500” in clause (i) and inserting “\$1,000”, and

(2) by striking “\$3,000” in clause (ii) and inserting “\$2,000”.

(d) INCREASE IN CONTRIBUTION LIMIT TO 100 PERCENT OF ANNUAL DEDUCTIBLE.—

(1) IN GENERAL.—Section 220(b)(2) of the Internal Revenue Code of 1986 (relating to monthly limitation) is amended to read as follows:

“(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/2 of the annual deductible of the high deductible health plan of the individual.”

(2) CONFORMING AMENDMENT.—Section 220(d)(1)(A) of such Code is amended by striking “75 percent of”.

(e) LIMITATION ON ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Section 220(f)(4) of the Internal Revenue Code of 1986 (relating to additional tax on distributions not used for qualified medical expenses) is amended by adding at the end the following:

“(D) EXCEPTION IN CASE OF SUFFICIENT ACCOUNT BALANCE.—Subparagraph (A) shall not

apply to any payment or distribution in any taxable year, but only to the extent such payment or distribution does not reduce the fair market value of the assets of the medical savings account to an amount less than the annual deductible for the high deductible health plan of the account holder (determined as of January 1 of the calendar year in which the taxable year begins).”

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 503. CARRYOVER OF UNUSED BENEFITS FROM CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND HEALTH FLEXIBLE SPENDING ACCOUNTS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended by redesignating subsections (h) and (i) as subsections (i) and (j) and by inserting after subsection (g) the following new subsection:

“(h) ALLOWANCE OF CARRYOVERS OF UNUSED BENEFITS TO LATER TAXABLE YEARS.—

“(1) IN GENERAL.—For purposes of this title—

“(A) notwithstanding subsection (d)(2), a plan or other arrangement shall not fail to be treated as a cafeteria plan or flexible spending or similar arrangement, and

“(B) no amount shall be required to be included in gross income by reason of this section or any other provision of this chapter,

solely because under such plan or other arrangement any nontaxable benefit which is unused as of the close of a taxable year may be carried forward to 1 or more succeeding taxable years.

“(2) LIMITATION.—Paragraph (1) shall not apply to amounts carried from a plan to the extent such amounts exceed \$500 (applied on an annual basis). For purposes of this paragraph, all plans and arrangements maintained by an employer or any related person shall be treated as 1 plan.

“(3) ALLOWANCE OF ROLLOVER.—

“(A) IN GENERAL.—In the case of any unused benefit described in paragraph (1) which consists of amounts in a health flexible spending account or dependent care flexible spending account, the plan or arrangement shall provide that a participant may elect, in lieu of such carryover, to have such amounts distributed to the participant.

“(B) AMOUNTS NOT INCLUDED IN INCOME.—Any distribution under subparagraph (A) shall not be included in gross income to the extent that such amount is transferred in a trustee-to-trustee transfer, or is contributed within 60 days of the date of the distribution, to—

“(i) a qualified cash or deferred arrangement described in section 401(k),

“(ii) a plan under which amounts are contributed by an individual’s employer for an annuity contract described in section 403(b),

“(iii) an eligible deferred compensation plan described in section 457, or

“(iv) a medical savings account (within the meaning of section 220).

Any amount rolled over under this subparagraph shall be treated as a rollover contribution for the taxable year from which the unused amount would otherwise be carried.

“(C) TREATMENT OF ROLLOVER.—Any amount rolled over under subparagraph (B) shall be treated as an eligible rollover under section 220, 401(k), 403(b), or 457, whichever is applicable, and shall be taken into account in applying any limitation (or participation requirement) on employer or employee contributions under such section or any other provision of this chapter for the taxable year of the rollover.

“(4) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning in a cal-

endar year after 1999, the \$500 amount under paragraph (2) shall be adjusted at the same time and in the same manner as under section 415(d)(2), except that the base period taken into account shall be the calendar quarter beginning October 1, 1998, and any increase which is not a multiple of \$50 shall be rounded to the next lowest multiple of \$50.”

“(5) APPLICABILITY.—This subsection shall apply to taxable years beginning after December 31, 1999.”

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1999.

SEC. 504. PERMITTING CONTRIBUTION TOWARDS MEDICAL SAVINGS ACCOUNT THROUGH FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP).

(a) GOVERNMENT CONTRIBUTION TO MEDICAL SAVINGS ACCOUNT.—

(1) IN GENERAL.—Section 8906 of title 5, United States Code, is amended by adding at the end the following:

“(j)(1) In the case of an employee or annuitant who is enrolled in a catastrophic plan described by section 8903(5), there shall be a Government contribution under this subsection to a medical savings account established or maintained for the benefit of the individual. The contribution under this subsection shall be in addition to the Government contribution under subsection (b).

“(2) The amount of the Government contribution under this subsection with respect to an individual is equal to the amount by which—

“(A) the maximum contribution allowed under subsection (b)(1) with respect to any employee or annuitant, exceeds

“(B) the amount of the Government contribution actually made with respect to the individual under subsection (b) for coverage under the catastrophic plan.

“(3) The Government contributions under this subsection shall be paid into a medical savings account (designated by the individual involved) in a manner that is specified by the Office and consistent with the timing of contributions under subsection (b).

“(4) Subsections (f) and (g) shall apply to contributions under this section in the same manner as they apply to contributions under subsection (b).

“(5) For the purpose of this subsection, the term ‘medical savings account’ has the meaning given such term by section 220(d) of the Internal Revenue Code of 1986.”

(2) ALLOWING PAYMENT OF FULL AMOUNT OF CHARGE FOR CATASTROPHIC PLAN.—Section 8906(b)(2) of such title is amended by inserting “(or 100 percent of the subscription charge in the case of a catastrophic plan)” after “75 percent of the subscription charge”.

(b) OFFERING OF CATASTROPHIC PLANS.—

(1) IN GENERAL.—Section 8903 of title 5, United States Code, is amended by adding at the end the following:

“(5) CATASTROPHIC PLANS.—One or more plans described in paragraph (1), (2), or (3), but which provide benefits of the types referred to by paragraph (5) of section 8904(a), instead of the types referred to in paragraphs (1), (2), and (3) of such section.”

(2) TYPES OF BENEFITS.—Section 8904(a) of such title is amended by inserting after paragraph (4) the following new paragraph:

“(5) CATASTROPHIC PLANS.—Benefits of the types named under paragraph (1) or (2) of this subsection or both, to the extent expenses covered by the plan exceed \$500.”

(3) DETERMINING LEVEL OF GOVERNMENT CONTRIBUTIONS.—Section 8906(b) of such title is amended by adding at the end the following: “Subscription charges for medical savings accounts shall be deemed to be the amount of Government contributions made under subsection (j)(2).”

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contract terms beginning on or after January 1, 2000.

SUMMARY OF SENATE REPUBLICAN PATIENTS' BILL OF RIGHTS

The Senate Republican bill has six major components that will provide consumer protections, enhance health care quality and increase access. These are:

1. Consumer protection standards for self-funded plans.
2. Appeals standards for all group health plans.
3. Access to and confidentiality of medical information.
4. Ban on the use of genetic information for all plans.
5. New quality focus and expedited research activities for the Agency for Health Care Policy and Research.
6. Improved access to health insurance coverage by allowing full deduction of health insurance for the self-employed and expansion of MSAs.

The following summarizes the key aspects of the bill:

1. Consumer protection standards for self-funded plans: Since States are responsible for regulating insured health plans, the bill provides that the following standards would apply only to self-funded plans governed by ERISA.

Emergency Care: Plans would be required to use the "prudent layperson" standard for providing initial emergency screening exams and "additional emergency services" determined necessary by a "prudent emergency medical professional."

Mandatory Point of Service: Plans that offer network-only plans would be required to offer enrollees the option to purchase point-of-service coverage. Small employers with 50 or fewer workers would be exempt. Also exempt would be group plans that offer a choice of two or more health insurance options or two or more options with significantly different providers. Plans could charge higher premiums and cost sharing for the POS option.

OB-GYN/Pediatricians: Health plans would be required to allow direct access to obstetricians/gynecologist and pediatricians without referrals.

Continuity of Care: Plans who terminate or non renew providers from their networks would be required to notify enrollees and allow continued use of the provider (at the same payment and cost-sharing rates) for up to 90 days if: the enrollee is receiving institutional care, is in the second (or late) trimester of pregnancy, or is terminally ill.

Gag Rules: Plans would be prohibited from including "gag rules" in providers' contracts.

Comparative Information: Plans would be required to provide a wide range of information about health insurance options, such as descriptions of the networks, premium and cost-sharing information. Quality outcomes data and information is not mandated.

Effective Dates: The new rules would become effective for group plan years beginning on or after January 1 of the second calendar year following the date of enactment. In other words, the effective date would be January, 2001, assuming enactment in 1999.

2. Grievance and Appeals: Plans would be required to have written grievance procedures and have both an internal and external appeals procedure. Grievances would not be appealable.

Prior Authorization: Routine requests would need to be completed within 30 days, and expedited requests for care that could jeopardize enrollee's health would have to be handled within 72 hours.

Qualification of Doctors for Internal Appeals: Appeals for coverage determinations based on lack of medical necessity or experimental treatment must be by a doctor "with appropriate expertise in field of medicine involved" who was not involved in the initial decision.

External Appeals: Enrollees and providers could appeal to independent medical reviewers for amounts above a significant financial threshold for issues based on medical necessity or for services that involve an experimental treatment where the enrollees' life is in jeopardy. External reviews could include those licensed by the State or under Federal contract for this purpose, a teaching hospital, or entities meeting specific criteria. External review is binding on plans and issuers.

3. Patient medical records: Plans, providers, schools, and others would be required to permit enrollees to inspect and copy their own medical records, except when such information could endanger a person's physical safety.

Disclose their confidentiality practices and to establish appropriate safeguards for patient information.

Civil money penalties would be imposed for violations.

4. Genetic Information: All plans—self-funded and insured group plans, as well as individual plans—would be prohibited from denying coverage, or adjusting premiums or contribution amounts based on "predictive genetic information." The term "predictive genetic information" includes individual's genetic tests, genetic tests of family members, or information about family medical history.

5. Refocusing AHCPR on Quality Improvement: The bill would refocus AHCPR (and rename it the Agency for Healthcare Quality Research) to encourage overall improvement of quality in the nation's health care systems. The new agency would facilitate support of state-of-the-art information systems, support of primary care research, technology assessment and coordination of the Federal Government's own quality improvement efforts.

6. Improved Access to Health Insurance: The bill includes three provisions to improve access:

Allows full deduction of health insurance for self-employed individuals.

Gives individuals the ability to carry forward up to \$500 in their flexible spending accounts from one year to the next or to be deposited into an IRA, and MSA, or a 401(k) plan.

Lifts the caps for MSAs and would allow all individuals, including Federal employees, the option to purchase these plans.●

● Ms. COLLINS. Mr. President, I am pleased to be joining my colleagues in introducing this Patients' Bill of Rights, which is the product of more than a year's worth of intensive work and negotiations by the Senate Republican Health Care Task Force on which I serve.

This comprehensive legislation has three major purposes. First, it will protect patients' rights and hold HMOs accountable for providing the care they have promised. Second, it will expand consumer choice and access to affordable care. And third, it will improve health care quality and outcomes.

Mr. President, there is a growing unease across our country about changes in how we receive our health care. People worry that if they or their loved ones become seriously ill, their

HMO will deny them coverage and force them to accept either inadequate care or financial ruin—or perhaps both.

They feel that vital decisions affecting their lives will be made, not by a supportive family doctor, but by an unfeeling bureaucracy. The American people, known for taking charge of their destiny, feel increasingly powerless about their health care. Our bill will ensure that medical decisions remain in the hands of patients and physicians, not HMO accountants and trial lawyers.

All of us agree that medically-necessary patient care should not be sacrificed to the bottom line. However, according to a 1997 study by Lewin, every one percent increase in health care premiums results in as many as 400,000 uninsured Americans. I have therefore been alarmed by reports that American businesses everywhere—from large multinational corporations to the corner store—are facing huge hikes in health insurance premiums in 1999, ranging from about 8 percent on average, to 20 percent or more. This is a remarkable contrast to the last few years, when premiums rose less than 2 or 3 percent, if at all.

We are engaged in an extremely delicate balancing act as we attempt to respond to concerns about quality, without resorting to unduly burdensome federal controls and mandates that will further drive up costs, causing thousands of Americans to lose their coverage and pushing health insurance further out of reach for many uninsured Americans.

Our Patients' Bill of Rights does not pre-empt, but rather builds upon the good work that states have done in the area of patients' rights and protections. Congress agreed that states should have primary responsibility for the regulation of health insurance when it passed the McCarran-Ferguson Act in 1945. And, as someone who has overseen a Bureau of Insurance in state government, I think state regulators have done a good job of responding to the needs and concerns of their citizens. For instance, at my last count, 44 states had passed laws prohibiting "gag clauses" that restrict communications between patients and their doctors, and the remaining six had bills pending in their legislatures. States acted without any mandate or prod from Washington to protect consumers.

Moreover, one size does not fit all, and what may be appropriate for one state may not be necessary in another. Florida, for instance, provides for direct access to a dermatologist, which is understandable, given the high rate of skin cancer in that state. But in a state like Maine this may not be so important.

So why does Congress need to act? The answer is that federal law prohibits states from regulating the self-funded, employer-sponsored health plans that cover 48 million Americans.

Our bill extends many of the same rights and protections to these individuals and their families that Americans

in state-regulated plans already enjoy. For the first time, they will be guaranteed the right to talk freely and openly with their doctors about their treatment options without being subject to "gag clauses" that limit communications. They will be guaranteed coverage for emergency room care that a "prudent layperson" would consider medically necessary without prior authorization from their health plan. They will be able to see their OB-GYN or pediatrician without a referral from their plan's "gatekeeper," and they will have the option of seeing a doctor who is not a part of their HMO's network. They will also have some assurance of continuity of care if their health plan terminates its contract with their doctor or hospital.

Moreover, all patients will be given the right to review their medical records and will have added protections to ensure that this information will be kept confidential. Finally, insurers will be prohibited from collecting or using predictive genetic information about a patient to deny coverage or set premium rates.

Mr. President, the states are way ahead of the federal government in the area of insurance reform, and the State of Maine has already enacted many of these same consumer rights and protections—a ban on gag clauses, a prudent layperson definition for emergency care, and direct access to OB/GYNs. Our bill would extend these and other rights to the nearly 220,000 Maine citizens in health plans that are not subject to state regulation and who currently do not enjoy these protections.

A key provision of our bill would give all 125 million Americans in employer-sponsored plans assurance that they will get the care that they need, when they need it. This includes 535,735 people in Maine who are in fully-insured ERISA plans. For the first time, these individuals will be entitled to clear and complete information about their health plan—about what it does and does not cover, about any cost-sharing requirements, and about the plan's providers. Helping patients understand their coverage before they need to use it will help to avoid coverage disputes later.

The goal of any patient protection legislation should be to solve disputes about coverage up front, when the care is needed. Not months, or even years later, in a court room.

Our bill would accomplish this goal by creating both an internal and external review process. First, patients or doctors who are unhappy with an HMO's decision could appeal it internally through a review conducted by individuals with "appropriate expertise" who were not involved in the initial decision. Moreover, this review would have to be conducted by a physician if the coverage denial is based on a determination that the service is not medically necessary or is an experimental treatment. Patients could ex-

pect results from this review within 30 days, or 72 hours in cases when delay poses a serious risk to the patient's life or health.

Patients turned down by this internal review would then have the right to a free, external review by medical experts who are completely independent of their health plan. This review must be completed within thirty days—and even faster in a medical emergency or when delay would be detrimental to the patient's health. Moreover, the decision of these outside reviewers is binding on the health plan, but not on the patient. If the patient is not satisfied, they retain the right to sue in federal or state court for attorneys' fees, court costs, the value of the benefit and injunctive relief.

Our bill differs from the Democrats' bill in a fundamental respect: it places treatment decisions in the hands of doctors, not lawyers. If your HMO denies you treatment that your doctor believes is medically necessary, you should not have to resort to a costly and lengthy court battle to get the care you need. After all, doesn't it make more sense to put medical care in the hands of doctors, not lawyers? You should not have a resort to hiring a lawyer and filing an expensive lawsuit to get the treatment. You just can't sue your way to quality health care.

The purpose of our bill is to solve problems up-front when the care is needed, not months or even years later after the harm has occurred. According to the GAO, it takes an average of 33 months to resolve malpractice cases. One case in the study took 11 years. This does absolutely nothing to ensure a patient's right to timely and appropriate care. Moreover, patients only receive 43 cents out of every dollar awarded in malpractice cases. The rest winds up in the pockets of the trial lawyers and administrators of the court and insurance systems.

Finally, more lawsuits are certain to mean higher health care costs. According to the Barents Group of KPMG Peat Marwick, increased lawsuits could drive up premiums as much as 8.6 percent, forcing businesses to pay \$94.1 billion (\$1,284 per worker) in extra premiums over five years. Close to two million Americans could lose their health insurance next year as increased costs force many employers to eliminate coverage altogether, or to pass on higher premiums and out-of-pocket costs to employees who can't afford them.

Last fall I met with a group of Maine employers who expressed their serious concerns about the Democrats' proposal to expand liability for health plans and employers. The Assistant Director for Human Resources at Bowdoin College talked about how moving to a self-funded, ERISA plan enabled them to continue to offer affordable coverage to Bowdoin employees when premiums for their fully-insured plan skyrocketed in the late

1980s. Since they self-funded, they have actually been able to lower premiums for their employees, while at the same time, enhance their benefit designs with such features as well-baby care, free annual physicals, and prescription drug cards with low copayments. They told me that the Democrats' proposal to expand liability seriously jeopardizes their ability to offer affordable coverage for their employees. Similar concerns were expressed by the Maine Municipal Association, L.L. Bean, Bath Iron Works, and others.

Mr. President, our bill also contains important provisions to improve health care quality and outcomes for all Americans.

For example, I am particularly pleased that our bill contains the proposal introduced by my colleague from Maine, Senator SNOWE, that prohibits insurers from discriminating on the basis of predictive genetic information.

Genetic testing holds tremendous promise for individuals who have a genetic predisposition to beat cancer and other diseases and conditions with a genetic link. However, this promise is significantly threatened when insurance companies use the results of such testing to deny or limit coverage to consumers on the basis of genetic information. In addition to the potentially devastating consequences of being denied health insurance on the basis of genetic information, the fear of discrimination may discourage individuals who might benefit from having this information from ever getting tested.

And finally, our bill will make health insurance more affordable by allowing self-employed individuals to deduct the full amount of their health care premiums beginning not in 2003, as in current law, but next year.

Establishing parity in the tax treatment of health insurance costs between the self-employed and those working for large businesses is a matter of basic equity, and it will also help to reduce the number of uninsured, but working, Americans. It will make health insurance more affordable for the 82,000 people in Maine who are self-employed. They include our lobstermen, our hairdressers, our electricians, our plumbers, and the many owners of mom-and-pop stores that dot communities throughout the state.

Mr. President, I believe that our plan strikes the right balance as we effectively address concerns about quality and choice without resorting to unduly burdensome federal controls and mandates that would further drive up costs and cause some Americans to lose their health insurance altogether. I urge all of my colleagues to join us in cosponsoring this proposal.●

● Mr. FRIST. Mr. President, I rise to voice my support for the bill we are introducing today and to urge my colleagues to pass a strong Patients' Bill of Rights this year. Our Patients' Bill of Rights is a good bill that will improve the quality of health care for patients in this country.

We have the benefit of starting off in a new Congress. The partisan rhetoric of elections is behind us. Today, we are here to convey our genuine interest to pass managed care reform this year as well as to provide the necessary building blocks to improve health care quality.

Not much attention was given in last year's debate to the many areas of agreement between the Republican and Democratic proposals. It is my hope that we can work together this year in a deliberative, thoughtful manner to pass bipartisan legislation. For example, there is bipartisan support to enact strong patient protection standards including coverage for emergency screening exams and services; allowing continuity of care so that patients may keep their physician, even if he or she is dropped from the plan, during a terminal illness, institutional care or pregnancy; and to prohibit plans from including gag clauses in their contracts. There is also strong consensus that we must require health plans to provide comparative information about their plans and to hold plans accountable for their decisions by allowing patients to appeal coverage denials to an independent medical expert, including expedited reviews, and receive a timely response.

In addition, I am pleased that many provisions that are in the Senate Republican bill also have received bipartisan support. Our bill last year included the "Women's Health Research and Prevention Amendments," which I also introduced as S. 1722, that passed the Senate unanimously at the end of last year. These programs provide a broad spectrum of activities to improve the quality of women's health; including research, prevention, treatment, education and data collection.

We must remember that the central focus of this debate—the genesis for the entire debate—is to embark on a national discussion of how we can truly improve real quality of care for patients. Our bill this year will again contain two measures which have broad bipartisan support and will greatly improve the quality of health care in this country.

Title III of our bill prohibits genetic discrimination against individuals in health insurance. Prohibiting genetic discrimination translates into a patient's right to quality care. Genuine quality care means that patients and practitioners have the very best information available to them when they make health care decisions. Patients should not be afraid to benefit from new genetic technologies, or share personal information that has immense potential to improve care and save lives. This is not a political or partisan issue. Our 49 Republican cosponsors last year, several of our Democratic colleagues, and President Clinton all support enacting legislation to prohibit genetic discrimination.

Title IV of our bill refocuses the Agency for Health Care Policy and Re-

search to support our federal efforts to improve health care quality through a vigorous research agenda. I also introduced this proposal as a stand alone bill (S. 2208) last year which had broad bipartisan support. Our goal is to enhance the agency to become the driving force of our federal efforts to support the science necessary to provide patients with information about the quality of care they receive and to provide physicians with research data to improve health care outcomes for their patients.

There is no question Congress will need to revisit some issues in the managed care debate. However, we will work deliberatively and in a bipartisan manner through our committee work this year to pass comprehensive legislation because we all share the ultimate goal of improving health care quality for patients.●

● Mr. JEFFORDS. Mr. President, I want to begin by commending Senator NICKLES and all of the members who participated in putting the legislation together. I think it is solid legislation that will result in a greatly improved health care system for Americans, and I am proud to be a co-sponsor of the "Patients' Bill of Rights Plus."

As Chairman of the Committee on Health, Education, Labor, and Pensions, with its jurisdiction of private health insurance and public health programs, I anticipate that the Committee will have an active health care agenda during the 106th Congress. In fact, on January 20th, the Committee held a hearing on health plan information requirements and internal and external appeals rights. And, this hearing builds on the foundation of fourteen related hearings that my Committee held during the 105th Congress.

People need to know what their plan will cover and how they will get their health care. The "Patients' Bill of Rights Plus" requires full information disclosure by an employer about the health plans he or she offers to employees. Patients also need to know how adverse decisions by the plan can be appealed, both internally and externally, to an independent medical reviewer.

The limited set of standards under the Employee Retirement and Income Security Act (ERISA) may have worked well for the simple payment of health insurance claims under the fee-for-service system in 1974. Today, however, our system is much more complex, and there are many types of decisions being made—from routine reimbursements to pre-authorizations for hospital stays. And it is in the context of these changes, particularly the evolution of managed care, that ERISA needs to be amended in order to give participants and beneficiaries the right to appeal adverse coverage or medical necessity decisions to an independent medical expert.

The provision of our bill giving consumers a new right of an external grievance and appeals process is one of

which I am particularly proud, since it is the cornerstone of S. 1712, the Health Care QUEST Act, which I introduced with Senator LIEBERMAN during the last Congress. Under the "Patients' Bill of Rights Plus," enrollees will get timely decisions about what will be covered. Furthermore, if an individual disagrees with the plan's decision, that individual may appeal the decision to an independent, external reviewer. The reviewer's decision will be binding on the health plan. However, the patient maintains his or her current rights to go to court.

As the Health and Education Committee works on health care quality legislation, I will keep in mind three goals. First, to give families the protections they want and need. Second, to ensure that medical decisions are made by physicians in consultation with their patients. And, finally, to keep the cost of this legislation low so that it displaces no one from getting health care coverage.

Our goal is to give Americans the protections they want and need in a package that they can afford and that we can enact. This is why I hope the "Patients' Bill of Rights Plus" we have introduced today will be enacted and signed into law by the President.●

● Mr. CRAIG. Mr. President, today, Senate Republicans are responding to America's number one health care concern: the high cost of health insurance and medical care. By granting all Americans access to tax-free medical savings accounts; by allowing self-employed Americans to deduct 100 percent of the cost of their health insurance premiums; and by allowing workers with flexible savings accounts to keep some of the money in those accounts, our "Patients' Bill of Rights—Plus" will tear down the barriers that government has put in the way of affordable health coverage and care.

Our proposal stands in stark contrast to those offered by others in Congress. With millions of Americans unable to afford insurance because of the unfairness of the federal tax code, some members of Congress want to force consumers to buy government-prescribed benefits—including many that are giveaways to special interests—even if it causes millions more to lose their health coverage.

While other so-called "patients' rights" bills contain nothing but expensive mandates, hidden taxes and costly lawsuits, our bill will deliver quality health insurance to millions of Americans. Our bill will make a down payment on serious health care reform that puts patients first—not doctors, not lawyers, not insurance companies, and certainly not government bureaucrats.

Rather than support a patients' bill of rights minus access, I urge my colleagues to take a step forward by making health insurance accessible instead of taking a step backward by making it more expensive.●

• Mr. BURNS. Mr. President, I am pleased to support and co-sponsor patient protection legislation. There is nothing more important than protecting the patient-doctor relationship and guaranteeing our citizens the right to choose their own doctor. It is important to make sure patients have the information they need to make decisions about their health care and make sure doctors, not accountants or lawyers, decide which medical services are needed.

Under Senator NICKLES' Patients' Bill of Rights Act, no health plan will be beyond the scope of federal or state patient safeguards. The bill will expand access to doctors, including guaranteed access to obstetrical and gynecological care and pediatric care, and require managed care plans to offer patients the option to receive care outside a plan's network of doctors.

In addition, health plans would have to provide patients with information on covered services, cost-sharing requirements, payment restrictions for services from out-of-network providers, rules for out-of-area coverage, preauthorization requirements and procedures, and rules for grievance and appeals filings. Health plans would be required to have both an internal appeal and external third-party review if coverage for any service is denied. Plans would also be required to safeguard patients' medical information or face civil penalties.

The Patients' Bill of Rights Act will also make it easier for many Americans to afford health care. Over 3 million self-employed individuals and their families will benefit from increasing the tax deductibility of health insurance to 100 percent, the same deduction most companies take for their employees. This bill also gives every American the right to have medical savings accounts (MSAs) and puts MSAs on an equal tax treatment footing with standard health care insurance. These flexible savings plans allow you to save money for health expenses tax-free as long as you have a high-deductible health insurance plan. MSAs are currently only available for employees in companies with 50 or fewer employees.

In this era of managed care, patients need a Bill of Rights to make sure they get quality health care and not a plan that will lead to higher costs and greater numbers of uninsured. I am happy to co-sponsor this important legislation. •

• Mr. DOMENICI. Mr. President, I rise today in support of the recently introduced Republican Patients' Bill of Rights.

I would like to begin by making an observation about the impact of any potential changes to the managed care system.

I would submit that whether a decision relating to healthcare is made by business or the government, the results will always have consequences on the those actually utilizing the system.

Let me put that another way, we must always proceed with what the impact of any changes will mean to families and beneficiaries.

Thus, when decisions are made, they must be thought out and done so in a responsible manner. And I believe the Republican Patients' Bill of Rights does just that by: holding HMO's accountable, increasing access, improving quality and, expanding choice.

At the same time we must work to ensure that: costs are not unnecessarily increased, more Americans are not forced into the ranks of the uninsured and, additional layers of bureaucracy are not placed between patients and their doctors.

Let me take just a moment to talk about the state of health care in New Mexico.

Health care is close to a \$5 billion a year industry in New Mexico. Almost 3,000 physicians practice in the state and overall the industry employs close to 52,000 New Mexicans. Over 600,000 New Mexicans are enrolled in managed care plans.

With this in mind, I would like to make several points about New Mexico as a whole, that are relevant to any debate relating to managed care: 78% of New Mexico businesses have 10 or fewer employees and 96% of all businesses have 50 or fewer employees. New Mexico ranks 40th in the nation in terms of the number of people uninsured, a full 25% of the population.

The preceding merely emphasizes a point that we must take into consideration and that is the potential impact upon a state and its people.

I think everyone would agree that the managed care system is not perfect and we have all heard one or another of those so called HMO horror stories. As a result, there is now a debate going on here and around the country about the need for HMO/Managed Care reform.

I also want to take a moment to point out that New Mexico is already at the forefront of HMO/Managed Care Reform.

New Mexico has already implemented many of the so called "patient protections" like: no gag clauses; a prudent layperson standard for emergency care; direct access to an OB/GYN; choice of providers; access to prescription drugs; confidentiality of medical records and; a grievance and appeals procedure.

I think it is important to stop and make a point that I believe is extremely important in light of the large number of small employers and high rate of uninsured not only in New Mexico, but the rest of the country. For every 1% increase in premium costs, 400,000 individuals will lose their health insurance coverage.

That is an extremely sobering thought when one realizes that small employers often have the most difficult time providing insurance for their employees because of the already high cost.

The Republican bill simply addresses Americans' concerns that their rights

be assured in health care coverage, in addition to increasing access to care, improving quality of care, and expanding choice.

However, there is one thing the Bill will not do, create a new right to go into the courts and sue managed care companies for unlimited damages. I believe that we on this side of the aisle have adopted a sense about health care and it says: lawyers and lawsuits do not deliver health care. Rather, lawyers and lawsuits generally make health care cost more.

I also think that it is very important to note that under the Employee Retirement Income Security Act (ERISA) a participant or beneficiary can already sue a managed care company. Let me repeat that, the right to sue a HMO is already available.

Now why would we want to create even more lawsuits, when for years we have been attempting to enact tort reform.

I know many New Mexicans share in the fears expressed by many Americans about the availability and quality of their health care. That is why I support the Republican Patients' Bill of Rights because it will ensure that patients receive: more affordable care and more choices; greater access to more and better information about health plans, benefits and the doctors that provide their care; and the advantages of a system that holds health plans accountable for medical decisions through a strong internal and external appeals process.

The Bill reforms the Agency for Health Care Policy and Research, renaming it the Agency for Healthcare Quality Research (AHQR). It will make annual reports on the state of quality and cost of America's health care, support primary care research in underserved rural and urban areas, provide technology assessment, and coordinate federal quality improvement efforts.

Furthermore, the Bill includes a provision that will prohibit insurance plans from using predictive genetic information to deny coverage or to set premium rates.

Finally, the Bill would provide relief to those New Mexicans and Americans who are self-employed by allowing them to deduct 100% of their health insurance costs. More than 25 million people live in families headed by a self-employed individual (5.1 million of whom are currently uninsured).

In closing, I believe that the key to improving our healthcare system and to improving our HMO/Managed Care System is to work together.

As I have said, we must find a solution that would most benefit not only New Mexicans, but everyone across our country. However, at the same time we must remember that our decisions cannot affect these same people in an adverse manner. •

By Mr. CAMPBELL:

S. 301. A bill to amend title 39, United States Code, relating to mailability, false representations, civil penalties, and for other purposes; to the Committee on Governmental Affairs.

HONESTY IN SWEEPSTAKES ACT OF 1999

• Mr. CAMPBELL. Mr. President, today I introduce the Honesty in Sweepstakes Act of 1999. This bill addresses one of the most troubling and persistent consumer abuse issues we face today: highly deceptive, and all too often financially damaging, sweepstakes and other mass mail promotions.

Our nation's seniors and other vulnerable consumers are clearly being taken advantage of, and in some cases seriously financially harmed, by intentionally misleading sweepstakes promotions. Thousands of nationwide victims are being deliberately misled into believing that they have just won or are likely to win a sweepstakes when in fact they have neither won nor are in fact likely to win such a prize.

Each year American consumers also receive hundreds of millions of cashier's check look-alikes that deceptively masquerade as real cashier's checks while actually being worthless. These ploys unfairly prey upon some people's hopes and dreams.

Over the years sweepstakes have become increasingly sophisticated and deceptive. While these promotional tactics may be technically legal they are designed to skirt the intentions and outer limits of the law. These deceptive tactics run counter to core American values of honesty and forthrightness. There is abundant evidence, including the deceptive sweepstakes and other promotions each of us receives in our mailboxes on a regular basis, that current laws aimed at stopping these deceptive promotions simply are not working. Something needs to be done.

This bill addresses these deceptive sweepstakes and cashier's checks look-alikes by requiring up-front, clear and easy to read Honesty in Sweepstakes disclosures that will help protect consumers by counterbalancing false promises and deception. While honest and straight-forward sweepstakes promoters have nothing to fear from this bill, those promotions that revert to false and deceptive tactics will feel the heat.

The Honesty in Sweepstakes Act of 1999 is a refined version of my original legislation, S. 2141, that I introduced during the 105th Congress. The bill I am introducing today incorporates valuable input I received during a Senate hearing on S.2141 and from productive discussions and negotiations involving key interested parties. Included among those who have made valuable contributions are: my Senate colleagues; the U.S. Postal Service; the General Accounting Office; Attorneys General from several states including Colorado, Florida, Michigan and New York; the American Association of Retired Persons; the Consumer Federation of

America; the National Consumers League; the Direct Marketing Association; the Magazine Publishers of America and other industry representatives and experts. I want to thank them for their contributions to the Honesty in Sweepstakes Act of 1999.

The AARP has informed me that "Research has shown that older Americans may be particularly vulnerable to techniques used by sweepstakes companies. At times they end up purchasing products that they do not want in the hopes of improving their chances of winning. Additionally, it has been shown that participation in these sweepstakes can lead to a rise in the number of telemarketing calls a person receives as well as an increase in mailed solicitations."

The Honesty in Sweepstakes Act of 1999 will go a long way toward protecting our nation's seniors and other vulnerable consumers from misleading and deceptive sweepstakes promotions. The most vulnerable consumers among us deserve this protection. I urge my colleagues to support this legislation.

I ask unanimous consent that this bill and a letter from the AARP be printed in the RECORD.

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

S. 301

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

SECTION 1. HONESTY IN SWEEPSTAKES ACT OF 1999.

(a) **SHORT TITLE.**—This Act may be cited as the "Honesty in Sweepstakes Act of 1999".

(b) **UNMAILABLE MATTER.**—Section 3001 of title 39, United States Code, is amended by—

(1) redesignating subsections (j) and (k) as subsections (l) and (m), respectively; and
(2) inserting after subsection (i) the following:

“(j)(1) Matter otherwise legally acceptable in the mails that—

“(A) constitutes a solicitation or offer in connection with the sales promotion for a product or service (including any sweepstakes) that includes the chance or opportunity to win anything of value; and
“(B) contains words or symbols that suggest that—

“(i) the recipient has or will receive anything of value if that recipient has in fact not won that thing of value; or
“(ii) the recipient is likely to receive anything of value if statistically the recipient is not likely to receive anything of value,

shall not be carried or delivered by mail, and may be disposed of as the Postal Service directs, unless such matter bears the notice described in paragraph (2).

“(2)(A) The notice referred to in paragraph (1) is the following notice:

“(i) ‘This is a game of chance (or sweepstakes, if applicable). You have not automatically won. Your chances of winning are (inserting corresponding mathematical probability for each prize shown). No purchase is required either to win a prize or enhance your chances of winning a prize.’, or a notice to the same effect in words which the Postal Service may prescribe; or
“(ii) a standardized Postal Service designed warning label to the same effect as the Postal Service may prescribe.

“(B) The notice described in subparagraph (A) shall be in conspicuous and legible type

in contrast by typography, layout, or color with other printing on its face, in accordance with regulations that the Postal Service shall prescribe and be prominently displayed on the first page of the enclosed printed material and on any other pages enclosed.

“(C) If the matter described in paragraph (1) is an envelope, the face of the envelope shall bear the notice described in subparagraph (A).

“(D) If the matter described in paragraph (1) is an order entry device, the face of the order entry device shall bear the following notice:

“‘This is a game of chance (or sweepstakes, if applicable). No purchase is required either to win a prize or enhance your chances of winning a prize.’, or a notice to the same effect in words which the Postal Service may prescribe.

“(k) Matter otherwise legally acceptable in the mails that constitutes a solicitation or offer in connection with the sales promotion for a product or service that uses any matter resembling a negotiable instrument shall not be carried or delivered by mail, and may be disposed of as the Postal Service directs, unless such matter bears on the face of the negotiable instrument in conspicuous and legible type in contrast by typography, layout, or color with other printing on its face, in accordance with regulations which the Postal Service shall prescribe the following notice: ‘This is not a check (or negotiable instrument). This has no cash value.’, or a notice to the same effect in words which the Postal Service may prescribe.”

(c) **TECHNICAL AMENDMENT.**—Section 3005(a) of title 39, United States Code, is amended by—

(1) striking “or” after “(h),” both places it appears; and

(2) inserting “, (j), or (k)” after “(i)”.

(d) **PENALTIES.**—

(1) **IN GENERAL.**—Section 3012 of title 39, United States Code, is amended—

(A) by redesignating subsections (b), (c), and (d), as subsections (c), (d), and (e), respectively;

(B) by inserting after subsection (a) the following:

“(b) Any person who, through use of the mail, sends any matter which is nonmailable under sections 3001 (a) through (k), 3014, or 3015 of this title, shall be liable to the United States for a civil penalty in accordance with regulations the Postal Service shall prescribe. The civil penalty shall not exceed \$50,000 for each mailing of less than 50,000 pieces; \$100,000 for each mailing of 50,000 to 100,000 pieces; with an additional \$10,000 for each additional 10,000 pieces above 100,000, not to exceed \$2,000,000.”

(C) in subsection (c)(1) and (2), as redesignated, by inserting after “of subsection (a)” the following: “or subsection (b),”; and

(D) in subsection (d), as redesignated, by striking “Treasury of the United States” and inserting “Postal Service Fund established by section 2003 of this title”.

(2) **ALLOCATION OF FUNDS.**—It is the sense of Congress that civil penalties collected through the enforcement of the amendment made by paragraph (1) should be allocated by the Postal Service to increase consumer awareness of misleading solicitations received through the mail, including releasing an annual listing of the top 10 offenders of the Honesty in Sweepstakes Act of 1999.

(e) **NO PREEMPTION.**—Nothing in this Act shall preempt any State law that regulates advertising or sales promotions or goods and services that includes the chance or opportunity to win anything of value.

AARP,

Washington, DC, January 22, 1999.

Hon. BEN NIGHTHORSE CAMPBELL,
Russell Senate Office Building, Washington,
DC.

DEAR SENATOR CAMPBELL: AARP thanks you for drawing attention to the problem of deceptive and misleading sweepstakes solicitations by introducing the "Honesty in Sweepstakes Act of 1999." Research has shown that older Americans may be particularly vulnerable to techniques used by sweepstakes companies. At times they end up purchasing products that they do not want in the hopes of improving their chances of winning. Additionally, it has been shown that participation in these sweepstakes can lead to a rise in the number of telemarketing calls a person receives as well as an increase in mailed solicitations.

AARP appreciates your efforts on behalf of consumers to eradicate the practice of fraudulent sweepstakes mailings through the introduction of the "Honesty in Sweepstakes Act of 1999." We look forward to working with you and other Members on a bi-partisan basis to address this issue in the 106th Congress.

Sincerely,

HORACE B. DEETS.●

ADDITIONAL COSPONSORS

S. 6

At the request of Mr. DASCHLE, the names of the Senator from South Carolina (Mr. HOLLINGS) and the Senator from Michigan (Mr. LEVIN) were added as cosponsors of S. 6, 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.

S. 10

At the request of Mr. DASCHLE, the name of the Senator from Hawaii (Mr. INOUE) was added as a cosponsor of S. 10, a bill to provide health protection and needed assistance for older Americans, including access to health insurance for 55 to 65 year olds, assistance for individuals with long-term care needs, and social services for older Americans.

S. 16

At the request of Mr. DASCHLE, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. 16, a bill to reform the Federal election campaign laws applicable to Congress.

S. 17

At the request of Mr. DODD, the name of the Senator from South Carolina (Mr. HOLLINGS) was added as a cosponsor of S. 17, a bill to increase the availability, affordability, and quality of child care.

S. 18

At the request of Mr. HARKIN, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 18, a bill to amend the Federal Meat Inspection Act and the Poultry Products Inspection Act to provide for improved public health and food safety through enhanced enforcement.

S. 49

At the request of Mr. MURKOWSKI, his name was added as a cosponsor of S. 49, a bill to amend the wetlands program under the Federal Water Pollution Control Act to provide credit for the low wetlands loss rate in Alaska and recognize the significant extent of wetlands conservation in Alaska property owners, and to ease the burden on overly regulated Alaskan cities, boroughs, municipalities, and villages.

S. 56

At the request of Mr. KYL, the name of the Senator from Kentucky (Mr. BUNNING) was added as a cosponsor of S. 56, a bill to repeal the Federal estate and gift taxes and the tax on generation-skipping transfers.

S. 75

At the request of Mr. LUGAR, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 75, a bill to repeal the Federal estate and gift taxes and the tax on generation-skipping transfers.

S. 76

At the request of Mr. LUGAR, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 76, a bill to phase-out and repeal the Federal estate and gift taxes and the tax on generational-skipping transfers.

S. 77

At the request of Mr. LUGAR, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 77, a bill to increase the unified estate and gift tax credit to exempt small businesses and farmers from estate taxes.

S. 78

At the request of Mr. LUGAR, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 78, a bill to amend the Internal Revenue Code of 1986 to increase the gift tax exclusion to \$25,000.

S. 241

At the request of Mr. JOHNSON, the names of the Senator from Montana (Mr. BAUCUS) and the Senator from Wyoming (Mr. THOMAS) were added as cosponsors of S. 241, a bill to amend the Federal Meat Inspection Act to provide that a quality grade label issued by the Secretary of Agriculture for beef and lamb may not be used for imported beef or imported lamb.

S. 242

At the request of Mr. JOHNSON, the names of the Senator from Montana (Mr. BAUCUS) and the Senator from Wyoming (Mr. THOMAS) were added as cosponsors of S. 242, a bill to amend the Federal Meat Inspection Act to require the labeling of imported meat and meat food products.

S. 254

At the request of Mr. HATCH, the name of the Senator from Nebraska (Mr. HAGEL) was added as a cosponsor of S. 254, a bill to reduce violent juvenile crime, promote accountability by rehabilitation of juvenile criminals,

punish and deter violent gang crime, and for other purposes.

S. 258

At the request of Mr. MCCAIN, the name of the Senator from Nebraska (Mr. HAGEL) was added as a cosponsor of S. 258, a bill to authorize additional rounds of base closures and realignments under the Defense Base Closure and Realignment Act of 1990 in 2001 and 2003, and for other purposes.

S. 271

At the request of Mr. FRIST, the names of the Senator from Oklahoma (Mr. NICKLES), the Senator from Alabama (Mr. SESSIONS), the Senator from Arkansas (Mr. HUTCHINSON), the Senator from Wyoming (Mr. THOMAS), the Senator from Arkansas (Mrs. LINCOLN), and the Senator from Louisiana (Mr. BREAU) were added as cosponsors of S. 271, a bill to provide for education flexibility partnerships.

S. 277

At the request of Mr. COVERDELL, the name of the Senator from Arkansas (Mr. HUTCHINSON) was added as a cosponsor of S. 277, a bill to improve elementary and secondary education.

S. 280

At the request of Mr. FRIST, the names of the Senator from Oklahoma (Mr. NICKLES) and the Senator from Alabama (Mr. SESSIONS) were added as a cosponsor of S. 280, a bill to provide for education flexibility partnerships.

SENATE JOINT RESOLUTION 2

At the request of Mr. KYL, the name of the Senator from Kentucky (Mr. BUNNING) was added as a cosponsor of Senate Joint Resolution 2, a joint resolution proposing an amendment to the Constitution of the United States to require two-thirds majorities for increasing taxes.

SENATE JOINT RESOLUTION 3

At the request of Mr. KYL, the name of the Senator from Wyoming (Mr. THOMAS) was added as a cosponsor of Senate Joint Resolution 3, a joint resolution proposing an amendment to the Constitution of the United States to protect the rights of crime victims.

SENATE RESOLUTION 22

At the request of Mr. CAMPBELL, the name of the Senator from Wyoming (Mr. THOMAS) was added as a cosponsor of Senate Resolution 22, a resolution commemorating and acknowledging the dedication and sacrifice made by the men and women who have lost their lives serving as law enforcement officers.

SENATE CONCURRENT RESOLUTION 3—CONDEMNING THE IRREGULAR INTERRUPTION OF THE DEMOCRATIC POLITICAL INSTITUTIONAL PROCESS IN HAITI

Mr. DEWINE (for himself, Mr. GRAHAM, Mr. HELMS, and Mr. COVERDELL) submitted the following concurrent resolution; which was referred to the Committee on Foreign Relations: