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House of Representatives

The House met at 9 a.m.

The Chaplain, Reverend James David Ford, D.D., offered the following prayer:

When all is said and done, O God, we are aware and appreciative of all Your gifts to us and to all people. We have been blessed in ways that have been greater than our deserving. Your grace has touched our lives with love and compassion and mercy. O gracious God, from whom all blessings flow, we ask Your benediction on us and those about us that in all things Your hand will sustain us and Your mercy will be without end. This is our earnest prayer. Amen.

THE JOURNAL

The SPEAKER. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE

The SPEAKER. Will the gentleman from New York (Mr. SOLOMON) come forward and lead the House in the Pledge of Allegiance.

Mr. SOLOMON led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Lundregan, one of its clerks, announced that the Senate had passed without amendment a bill and a concurrent resolution of the House of the following titles:

H.R. 39. An act to reauthorize the African Elephant Conservation Act.

H. Con. Res. 298. concurrent resolution expressing deepest condolences to the State and people of Florida for the losses suffered as a result of the wild land fires occurring in June and July 1998, expressing support to the State and people of Florida as they overcome the effects of the fires, and commending the heroic efforts of firefighters from across the Nation in battling the fires.

ANNOUNCEMENT BY THE SPEAKER

The SPEAKER. The Chair will entertain one-minutes after legislative business.

PATIENT PROTECTION ACT OF 1998

Mr. GOSS. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 509 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 509

Resolved, That upon the adoption of this resolution it shall be in order to consider in the House the bill (H.R. 4250) to provide new patient protections under group health plans. The bill shall be considered as read for amendment. The amendments printed in the report of the Committee on Rules accompanying this resolution shall be considered as adopted. The previous question shall be considered as ordered on the bill, as amended, and on any further amendment thereto to final passage without intervening motion except: (1) one hour of debate on the bill, as amended, equally divided and controlled by Representative Hastert of Illinois and a Member opposed to the bill; (2) the further amendment printed in the Congressional Record and numbered 2 pursuant to clause 6 of rule XXIII, which shall be in order without intervention of any point of order or demand for division of the question, shall be considered as read, and shall be separately debatable for one hour equally divided and controlled by the proponent and an opponent; and (3) one motion to recommit with or without instructions.

The SPEAKER pro tempore (Mr. LAHOOD). The gentleman from Florida (Mr. GOSS) is recognized for 1 hour.

Mr. GOSS. Mr. Speaker, I am going to depart from normal custom and yield the first minute of this to the distinguished gentleman from New York (Mr. LAZIO) for a matter of colleague comity.

(Mr. LAZIO of New York asked and was given permission to speak out of order.)

HONORING THE HONORABLE ROB PORTMAN

Mr. LAZIO of New York. I want to thank the gentleman from Florida (Mr. GOSS) and the gentleman from New York (Mr. SOLOMON) for their courtesy.

Mr. Speaker, I rise to honor my pal and colleague, the gentleman from Ohio, Mr. ROB PORTMAN. He is one of the most accomplished people in this Congress. He stood up for America's taxpayers and was the driving force behind the landmark IRS reform bill signed into law this week. He authored the National Underground Railroad Act signed into law this week. By preserving underground railroad sites, America celebrates the journey of slaves from bondage to freedom.

The gentleman from Ohio is the congressional leader in the war against drugs. His Drug-Free Communities Act, signed into law, will give us peace of mind when our children are away from home. His pro-business mandates legislation is the law of this House and his pro-environment tropical rain forest legislation should be signed into law next week.

In an era when bipartisanship is essential for legislative success, Rob Portman is the even-headed leader we need. He is balanced and principled, substantive, competent, intelligent. He is a man of integrity, of modesty and of great character.

The gentleman form Ohio, Mr. ROB PORTMAN, gets the job done for families in Cincinnati, in Ohio, and throughout America.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would like to announce that the rules do not allow Members to wear badges when they are addressing the

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House. The Chair will enforce this rule throughout the debate today.

Mr. GOSS. Mr. Speaker, for purposes of debate only, I yield the customary 30 minutes to the gentleman from Texas (Mr. FROST), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, this is a structured rule that allows timely consideration of this very, very important legislation on health care. In yesterday's Rules meeting, which actually went on for quite a while, the minority requested that the Dingell substitute be made in order and we indeed have obliged them in this rule. It provides for 1 hour of debate on the Patient Protection Act to be equally divided between the gentleman from Illinois (Mr. HASTERT) and an opponent, and 1 hour of debate on the Dingell substitute. These are two very different approaches to providing better health care for more Americans and I am sure that we will have quite a vigorous debate on the merits of each today. Finally, the rule provides for one motion to recommit with or without instructions. In effect, giving the minority two bites at the apple. I certainly feel this is a fair rule.

Mr. Speaker, today we will move to restore true patient power. The Patient Protection Act is the only bill that restores commonsense patient protections to Americans while also extending affordable coverage to the 41 million Americans who currently lack it and cannot get health care coverage. One clear difference between the two approaches is the fact that the Kennedy-Dingell Patients' Bill of Rights makes no effort to secure affordable health insurance for the 40-plus million Americans who have none currently. In fact, when asked what the Kennedy-Dingell bill does for uninsured Americans, the minority leader in the other body reportedly summed it up in two words, and I quote, ''Not much.'' Instead of turning our backs on the uninsured, our bill attacks their problem head-on. We know that over 75 percent of uninsured Americans are in a family where the primary caregiver works for a small business. This is especially true in southwest Florida, which I represent, where mom and pop shops cannot afford to provide their employees with health insurance. The Patient Protection Act allows small businesses to pool their resources and the achieve economies of scale needed to offer quality, affordable health insurance to their employees. If it is good enough for the Microsofts and the IBMs and the GMs of the world, should it not be good enough for the little guys, too? We take care of that.

As with any major proposal, there comes a certain level of misinformation and this effort is no exception. Many of my friends on the other side of the aisle have confused a patient's bill of rights with a trial lawyer's right to bill. Under our bill, patients would still have the right to sue their HMO for malpractice and that includes punitive damages. I wonder how many times I am going to be saying that in the next few months. Under our bill, patients would still have the right to sue their HMO for malpractice, and that includes punitive damages. I think we are going to be hearing some debate on that subject today. If the HMO runs the wrong tests on you or they happen to cut off the wrong foot, you will have recourse through the courts, of course. That is essential and that is protected. But as we studied the problem and talked to people, the folks who were being denied care in what we call coverage disputes, we thought we could do better than settling for, or encouraging even more litigation. I do not know many people who have gotten much good medical attention in a courtroom. We came to the conclusion that we have an innovative solution that assures patients get the care they need, up front, when they need it, at a place they need it, from a doctor, from a real medical person. Our expedited internal and external appeals process means that if your HMO denies your experimental treatment, or your treatment, you will be able to have a doctor, independent of the HMO, review that decision. Of course if you are unsatisfied at the end of that process, you can take the offending HMO to court. However, unlike the current law, the judge will have the flexibility to serve a fine up to $250,000 against the HMO plan. This is not available under current law and it is a healthy and reasonable constraint on HMO abuse. I know it has already got their attention.

We have provided commonsense patient protections in this package. Women will have direct access to their OB-GYN. Kids will get to see a pediatrician without any red tape or having to get permission from a government official. And, most importantly, doctors will have no restrictions on the recommendations they give their patients. No gag rule. These are positive steps to improve the doctor-patient relationship, not a retreat into more nonsensical and, I would say, very expensive bureaucracy that other approaches take.

Mr. Speaker, as a member of Chairman HASTERT's working group, I can assure you that we have worked hard and I think we have come up with a pretty good package that provides real protections without returning us to the days of double-digit inflation. I encourage my friends on both sides of the aisle to ignore the demagogues and focus on the pro-patient, pro-small business, pro-family provisions in our health care bill. I believe they will find it is worth reading.

Mr. Speaker, I reserve the balance of my time.

Mr. FROST. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, there is no doubt that the American public wants managed care reform. Today we have the opportunity to respond. At long last after months and months of denying that a problem exists, the Republican majority has agreed to let the House vote on a bill that seeks to provide a response to the concerns of millions of Americans. While what we have before us today is two bills, one written behind closed doors by the Republican leadership and supported by the insurance industry, there really is only one bill which meets the critical test of addressing the concerns of our constituents. That bill is a bipartisan proposal supported by doctors, nurses and consumers.

Mr. Speaker, there are two bills before us today, but if we listen carefully to what our constituents have been saying, there is little doubt how we should vote. Only the bipartisan bill sponsored by the gentleman from Iowa (Mr. GANSKE) and the gentleman from Michigan (Mr. DINGELL) really offers working families what they have been asking for. The bipartisan Ganske-Dingell Patients' Bill of Rights assures working families access to necessary medical care and will return health care decision-making to patients and their doctors. The bipartisan bill will give patients real remedies for real problems. The Ganske-Dingell Patients' Bill of Rights will reform a system that is badly in need of repair.

My Republican colleagues will say today that the bipartisan bill is nothing more than big government. They will say the bipartisan bill is nothing more than a lawyers full employment act. Well, if that is the case, Mr. Speaker, why then is the Ganske-Dingell substitute supported by the American Medical Association, an organization not normally known to support big government or trial lawyers? Why then is it supported by the American Nurses Association, an organization representing those health care givers closest to the patient? Why then, Mr. Speaker, is it supported by consumer groups and opposed by insurance companies? The arguments my Republican colleagues will make against the Ganske-Dingell bill are just plain bogus and no one should be fooled. Ganske-Dingell offers real reform, not just election year posturing.

That we are even able to consider and debate Ganske-Dingell today is testimony to the power of the call of the American people. For far too long, my Republican colleagues have denied that there is a problem, but the voices of working families who have been demanding that the Congress respond to their real concerns has been heard.

□ 0915

In their efforts to deny the House the opportunity to respond to those concerns, the Republican leadership had us guessing until 12:30 a.m. this morning whether they were even going to give the bipartisan substitute a place at the table. I suspect that only after it became clear that the rule might not pass without the Ganske-Dingell

amendment made in order that the Republican leadership relented and agreed to make the substitute in order.

Mr. Speaker, every Member in this House needs to recognize that the bipartisan substitute offers American working families something more than election year rhetoric. Ganske-Dingell is a good bill and deserves the support of every Member of this body. To do less is to do disservice to our constituents. I urge Members to do the right thing and to support Ganske-Dingell.

Mr. Speaker, I reserve the balance of my time.

Mr. GOSS. Mr. Speaker, I yield as much time as he may consume to the distinguished gentleman from Glens Falls, New York (Mr. SOLOMON), chairman of the Committee on Rules.

Mr. SOLOMON. Mr. Speaker, I was not going to speak this morning. We spoke enough yesterday and last night into the wee hours. But I just want to make sure that all the Members on both sides of the aisle know, as the gentleman from Florida (Mr. GOSS) has just outlined, that this is a negotiated fair rule that was approved by the Democrat minority.

The Dingell substitute is made in order with ample time for debate so that this House has its choice, and that is the way that it should be. I just want to point out that we are going to be somewhat repetitive here, because what is going to be said now in this next hour on the rule could have not been wasted if we had had unanimous consent.

The gentleman from Michigan (Mr. DINGELL) last night agreed to unanimous consent to bring this bill on the floor without taking this extra hour of time on the rule. That means that Members could have gone back home. It is difficult in these last 3 or 4 weeks now before we recess for the August break, and taking up the rule today is going to add another hour and a half. It is too bad that the Democratic minority objected to us offering a unanimous consent to bring this bill on the floor, and I just wanted Members to know that.

But I hope that they will come over and vote for the rule, vote for the bill, and we will at least will have made some great progress in patients' rights.

Mr. FROST. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, the gentleman from New York was bemoaning the fact that we could not bring this measure up under unanimous consent but, rather, that we would have an hour's debate on the rule. This may be the most important piece of legislation we will consider this year. Certainly it is reasonable to have an hour debate on the rule on this matter.

The other side was so anxious to bring this up quickly early this morning and out of the line of fire without public attention. It is clearly appropriate to have an hour's debate on the rule.

Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GREEN).

(Mr. GREEN asked and was given permission to revise and extend his remarks.)

Mr. GREEN. Mr. Speaker, I thank my colleague and friend, the gentleman from Texas, and a Member of the Committee on Rules for allowing me to speak this morning.

I rise, not in opposition to the rule, but in opposition to the process where we have gotten to today, Mr. Speaker. Managed care reform is not about politics; it is about people.

We have a responsibility to guarantee the American people top quality health care. We have a responsibility to protect our children from negligent medical decisions made by insurance companies.

The Republican proposal that we will be debating today is simply profit over people. The only people in our country who are guaranteed immunity from their decisions are foreign diplomats and HMO officials.

We cannot really have a Patients' Bill of Rights without access to specialists, a timely internal and external appeals process, point of service options, choice for our patients, accountability of that decision matter, and open communication between the patient and a provider; in other words, no gag rule.

Can we honestly say that the system will protect patients without an enforcement mechanism, without an accountability? There is no responsibility.

The Republican bill that will be voted on today never enjoyed a public hearing. It was drafted behind closed doors. In fact, I serve on the committee that would have been helping draft this bill, and we did have hearings over the last few months, but this bill never had a public hearing.

We did not see it until late last night. Do my colleagues know why? Because, one, it does not end gag rules. It does not define severe pain as a reason a constituent of mine can go to the emergency room. It also does not actually provide for the point of service option that we want, the choice for that patient. That is easily bypassed by the HMO decision makers.

The Republican bill also will decide what medically necessary is. My concern is we are not giving the patient and that physician or that provider the decision making that the Democratic bill provides; and that is why, later on today, we hopefully will pass the Dingell-Ganske bill.

Mr. Speaker, I include the following for the RECORD:

ISSUES OF CONCERN IN THE HASTERT TASK FORCE BILL

Does not end gag rules

While the bill claims to end gag rules, the statutory language creates a loophole that guts the protection. Under the Balanced Budget Act, Medicare and Medicaid plans cannot ''prohibit or otherwise restrict'' medical communications. The GOP bill only refers to prohibitions. So a plan could ''allow'' medical communications, but only after the doctor first complies with certain restrictions (such as calling the plan first and delivering the advice in pig latin). The deletion of the words ''or restrict'' render this protection hollow. This also creates the possibility for lawsuits over whether something is a restriction or a prohibition.

Does not define/include ''severe pain'' as a reason to get ''emergency medical care

The access to emergency care language in Medicare and Medicaid contains a specific definition of what a prudent layperson would think required immediate treatment: ''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—(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.''

By contrast, the GOP bill does not include ''severe pain'' as a condition that health plans must cover in the emergency room. The deletion is significant. For example, the American Heart Association advises that anyone experiencing crushing chest pain should go to the ER immediately, as that is a warning sign of a possible heart attack.

Under H.R. 4250, a health plan can refuse to pay the ER bills of a man who went to the emergency room with crushing chest pain but whose EKG came out negative. That might be only a temporary result; he might have a heart attack when the plan gives him a bill for the ER services!

Allows the plan to decide what is ''medically necessary''

At its heart, the debate over HMO reform is really about ensuring that health care decisions are made by doctors and patients, not by HMO business executives. H.R. 4250, however, does not fulfill that promise. Under the disclosure section, plans must inform participants of whether care may be excluded because ''of a failure to meet the plan's requirements for medical appropriateness. . . .'' In other words, it is not the doctor and patient who decide what is medically necessary; it is the plan which retains that capability.

During Commerce Committee testimony two years ago, Dr. Linda Penno, a former HMO medical reviewer, described this as a plan's 'smart-bomb' capability. By retaining the power to define what is and what is not medically necessary, the plan is able to take control of health care decisionmaking.

This is also relevant to the external appeals provisions of the Hastert Task Force Bill. The review is limited to whether the plan followed its own definition of medical necessity or whether or not a treatment is experimental.

Point of service provision is easily by-passed

The most powerful argument in the health care debate is the right to choose your own doctor. The GOP bill attempts to respond to this by including a point of service provision for closed panel HMOs (allowing patients to see providers outside the network). H.R. 4250, however, contains loopholes that effectively gut the provision. Employers would not have to offer employees point of service coverage if they could prove that this will cause premiums to rise just 1%—even if all of the added costs would be borne by employees who chose this option! And this ''proof'' could be prospective—meaning a company would not have to offer a single employee a POS option to determine its actual effect on premiums.

I am concerned that it will be easy for employers to ''prove'' that premiums will increase 1%. For example, one study by opponents of this legislation suggested that managed care reform legislation would increase premiums between 3 and 90%. While CBO's very low estimate of 4% should put those wild allegations to bed, they show how easy it is to prospectively make a doom and gloom forecast with a straight face. Combine that with the fact that insurance premiums are expected to take a big jump this year, and it is not hard to see how health plans will be able to use the 1% threshold to avoid offering their employees a choice of health care providers.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Speaker, I want to thank the Committee on Rules for bringing a fair rule to the floor. I intend to support it. I encourage all my colleagues to support the rule.

Mr. Speaker, think about how far we have come in the last 6 months. Six months ago, we would have never had this debate on the abuses in managed care. Today we are going to have that debate.

Let me briefly outline some of the arguments you will hear today so you can evaluate the competing proposals. Here is a sample of key protections which are not included in the Hastert task force bill, but are included in the substitute plan that I will offer:

The Ganske-Dingell substitute provides patients with access to clinical trials. The Hastert bill does not.

The Ganske-Dingell substitute allows doctors to override drug formularies when medically necessary. The Hastert bill does not.

The Ganske substitute provides for ongoing access to specialists for chronic conditions. The Hastert bill does not.

The Ganske substitute prevents plans from giving doctors financial incentives to deny care. The Hastert bill does not.

The Ganske substitute has hospital stay protection for mastectomy patients. The Hastert bill does not.

The Ganske substitute provides choice for doctors within the plan. The Hastert bill does not.

The Ganske substitute has a provision for guaranteeing continuity of care when providers leave the network. The Hastert bill does not.

The Ganske substitute requires plans to collect quality data or to maintain quality improvement programs. The Hastert plan does not.

There are other significant provisions in the Hastert bill that are of significant concern. The Hastert bill allows a plan to decide what is medically necessary. The Hastert bill requires enrollees to spend their own money to secure an independent review.

Finally, I would draw your attention to the HealthMart and MEWA, Multiply Employee Working Association, provisions which could make it more difficult for States to fund high-risk pools and other programs to help keep health insurance affordable. I am glad to support the rule. I look forward to the debate today.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. STUPAK).

Mr. STUPAK. Mr. Speaker, I thank the gentleman for yielding to me. I am going to oppose this bill today and I am going to oppose the rule here today, because we are going to have 2 hours, basically, to debate this bill.

I think it shows the insensitivity of this rule, insensitivity to basic rights that every American demands, and insensitivity to a basic understanding to health care in this Nation.

We as parents, we all know the world stops when a child falls ill. As sons and daughters, we want the best for our parents when they need health care. As husbands and wives and brothers and sisters, when a family member is stricken, we insist that nothing comes between that patient and their health care. We want the best possible treatment. Unfortunately, the Hastert bill does not provide it.

That is what health insurance is supposed to be about. We pay for it, we have it, and we want it when we need it. The doctors, the nurses, the hospitals, the emergency room, the medicine, we want whatever it takes to get our child, our parents back healthy again. That is how it used to be.

But in the last years, millions of Americans have moved into managed care plans, and something got in the way. Priorities were shifted from patients to profits. Emergency room crises were compromised by boardroom considerations. Professionals in white lab coats start taking orders, not from doctors, but insurance bureaucrats. The delivery of top-notch health care became less important; and the bottom line, profit.

When we take a look at the bill today, we will see that the Democratic bill, the Ganske-Dingell bill is the only one that will get the job done for us when we pay for health care and we demand quality care.

The Democratic bill is designed to provide medical coverage. Medical professions will be back in control of medical decisions. Emergency care in an emergency, no questions asked, underneath the Democratic plan. Expedited appeals process to approve the care we deserve before it is too late. Access to a specialist when you need it.

I hope we will defeat this rule and put some time into the Democratic plan.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I would note to the gentleman who just spoke that we have tried very hard to accommodate all the schedules. It is a busy time of year. But surely our plan is more sensitive for the debate of this important issue than the discharge petition that they have provided for.

Mr. Speaker, I am very pleased to yield such time as he may consume to the distinguished gentleman from Illinois (Mr. HASTERT), the leader of the Speaker's task force on health care.

Mr. HASTERT. Mr. Speaker, today is an important day for American families. Today we will take a step forward to strengthen the Nation's health care system. Today we will debate and vote upon the House Republican-sponsored Patient Protection Act.

Our legislation is the only proposal on the table that truly protects patients and guarantees choices without the heavy hand of big government. Specifically, our bill guarantees patients have increased access to affordable health care they need when they need it most by holding insurance companies accountable.

How? Our proposal guarantees the unprecedented expedited review process internally and externally. We want patients to receive the care they need first rather than be thrown into a long, drawn-out legal process controlled by lawyers after harm or death has occurred. Patients should be treated in hospital rooms, not courtrooms.

Besides true accountability, our plan has another major advantage over other proposals in this Congress. The Patient Protection Act is the only bill which will help cover the 42 million uninsured working Americans.

We create new initiatives to guarantee more access to affordable health care choices. Association Health Care Plans, HealthMarts, Community Health Organizations, and Expanded Medical Savings Account help employees and employers work together to provide the coverage that best meet their need.

As a matter of fact, just this week at a news conference, the Senate minority leader TOM DASCHLE was asked, ''What does the Democrat plan do for the uninsured?'' His response, ''Not much.'' At least he was truthful.

I hope my colleagues on the other side of the aisle today are just as forthright and resist the temptation to distort the facts about what is in the House Republican plan. We truly believe that high quality health care depends upon the patient-doctor relationship.

Personally, I believe that doctors owe their patients the benefit of their education, the benefit of their experience, and the benefit of their good judgment. Medical decisions should be decided by doctors, not by insurance company bureaucrats.

We prevent health plans from gagging doctors for explaining the full range of treatment options available no matter what the cost, no matter if the other options are covered by the plan or not. We also ensure patients have ready access to emergency room care and prohibit their health plan from arbitrarily refusing to pay for it. We guarantee that women and children have direct access to their doctors without having first going to the insurance company gatekeeper.

Our proposal will also empower patients and doctors through information. It creates new access to plan coverage information while also protecting individual patient records from abuse through new confidentiality requirements.

□ 0930

Access to affordable health care is a fundamental patient protection. Without affordability, you cannot have accessibility, nor, for that matter, health care coverage at all. As you can see, we are protecting patients and guaranteeing choices, without the heavy hand of big government.

Mr. Speaker, we must have a comprehensive approach to meeting America's health care needs. Our Patient Protection Act is the only proposal before Congress that increases accessibility, affordability and accountability in our health care system. I urge my colleagues to support this rule so we can deliver the health care reform that Americans need.

Mr. FROST. Mr. Speaker, I yield three minutes to the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I do want to first thank the gentleman from Michigan (Mr. DINGELL) and the gentleman from Iowa (Mr. GANSKE) and the members of the Democratic Health Care Task Force and all those who worked very hard to make sure that this substitute came up today. The discharge petition effort, which I think has over 190 Members, and other efforts to appear before the Committee on Rules finally brought fruit, I think, and made it possible for us to bring the substitute up today, and that hard work, I believe, paid off.

In my view, there is nothing more important in the managed care debate than giving patients the right to hold their HMO accountable when they are denied the care they need. Any legislation that fails to give patients that renders the protections within it absolutely meaningless. The Patient's Bill of Rights includes an enforcement mechanism which ensures patients will finally get that right. Our bill repeals the ERISA exemption, the 1974 law which shields HMOs from being sued if they deny people needed care.

The other bill we are considering today, the Republican bill, does nothing to hold HMOs accountable for their actions. If not only leaves ERISA essentially intact, it actually exacerbates the problem. Its external appeals process only applies to people whose insurance comes under ERISA. Individuals in the private insurance market are left without any external recourse when they are denied care. What is even worse is that those who are fortunate enough to be covered by ERISA are subject to the HMO's definition of ''medical necessity.''

The Republican bill allows HMOs, and not doctors and patients, to define ''medical necessity.'' This provision, of course, flies in the face of the whole idea of managed care debate, that medical necessity should be the determinant of whether or not a patient needs care and not cost considerations. It all but guarantees that insurance company bureaucrats will continue to make medical decisions and people will continue to be denied care because of it.

I also want to dispel a myth that my Republican colleagues have been working overtime to spread. The Patients' Bill of Rights does not create any new Federal legislation. Repealing the ERISA exemption would simply allow patients to go back to their states, where individuals would normally bring suit. In other words, the Patients' Bill of Rights does not create a new Federal remedy. Its approach is essentially states' rights by repealing a Federal preemption.

Another piece of propaganda the Republicans have been actively spreading is the charge that the Patients' Bill of Rights provides for employers to be sued for medical malpractice. This is patently false. In fact, the Patients' Bill of Rights specifically excludes employers from liability. Any employer can only be held liable if they intervene in a medical decision that leads to injury or death.

Mr. Speaker, President Clinton recently said that ''a right without a remedy is not a right,'' referring to HMOs. If you want good patient protections, and, just as importantly, enforcement of those protections, vote ''yes'' on the Patients' Bill of Rights and vote ''no'' on the Republican bill.

Mr. GOSS. Mr. Speaker, I yield two minutes to the distinguished gentleman from Kentucky (Mr. BUNNING).

(Mr. BUNNING asked and was given permission to revise and extend his remarks.)

Mr. BUNNING. Mr. Speaker, I rise in strong support of the rule and the Patient Protection Act. This bill is a well-crafted piece of legislation which addresses many of the problems facing our Nation's rapidly changing health care system.

What the bill does makes it worth supporting. It strengthens health care plan accountability by providing a system of reviews and appeals, to make sure that Americans who have health insurance get the care they need when they need it; it guarantees patients' choice by ensuring a point of service option, so that patients have the freedom to see the provider of their choice; it expands the availability and affordability of health insurance for millions of Americans through the creation of HealthMarts and Association Health Plans, by creating Community Health Center networks, and by expanding Medical Savings Accounts; it guarantees the right of patients to emergency room service; it guarantees the right of women to have direct access to their OB-GYN; it guarantees parents the right to direct access to pediatricians for their children.

These are much-needed improvements, and they are the one big reason to support the Patient Protection Act, the things it does.

But there is another reason to support the Patient Protection Act, and that is what it does not do. It does not load down the health care system with a new layer of bureaucracy; it does not guarantee an explosion of unnecessary costs and costly litigation, it puts people into care, and not into courtrooms; and it would not increase the cost of health care dramatically, like the Patients' Bill of Rights would do.

Mr. Speaker, it is a very good piece of legislation because of what it does, and even because of what it does not do.

I urge my colleagues to support the Patient Protection Act.

Mr. FROST. Mr. Speaker, I yield two minutes to the gentlewoman from the Virgin Islands (Ms. CHRISTIAN-GREEN).

Ms. CHRISTIAN-GREEN. Mr. Speaker, I thank my colleague for yielding me time.

Mr. Speaker, I rise in support of the Ganske-Dingell bill. As a physician who has practiced medicine for more than 20 years, I know well many of the troubling aspects of the industry, particularly as they affect minorities. That is why I rise today to support the Ganske-Dingell bill and to bring to this body's attention and to the attention of the American people an issue which might not be discussed today, the discrimination of African-American physicians and patients by managed care plans.

Because minority physicians often serve poorer, sicker and are often solo practitioners and not a part of a group that makes a tidy profit each year, we do not make attractive candidates for inclusion into managed care plans.

Similarly, because minority patients are often uninsured and receive medical assistance from programs such as Medicare and Medicaid, they are also not attractive sources of revenue to such plans as well. As we seek to reform the managed care industry, we must not forget the concerns of minorities in this effort and their struggle to have their health care needs addressed.

My friends in the majority must stop playing politics with the lives of the American public and pass the Patients' Bill of Rights. The people who put us here and depend on us have asked us for and deserve a better health care delivery system. The Ganske-Dingell bill does that. I urge its passage. Let us put the ''care'' back in health care.

Mr. FROST. Mr. Speaker, I yield three minutes to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. Mr. Speaker, before coming to this Congress, I worked each day in a much different place, in a courtroom, as a judge on the highest court in Texas. I was called a justice, as were my colleagues, and asked to do justice. And yet, time after time, I found my hands and those of my colleagues tied by a Federal law.

We saw victims of injustice, who had suffered not only some grievous loss in

terms of an illness or an injury, but the same families who suffered abuse at the hands of insurance companies, and, because of a law that was passed in this National capital, we were powerless to do anything about it.

Recently the State of Texas became the first state to pass a new law to try to hold these managed care companies accountable for what they were doing. And, wouldn't you know it, the same insurance companies that used to come into my court went into another court to try to block this new state accountability law.

Today that same group of health care companies finds willing allies over here from the Republican leadership to help them continue to do the very same thing. They are folks who would deny help to the infirm. What is happening here is much like a firefighter, who sometimes builds a small fire in order to stop a much larger fire. There is a fire of outrage burning across this country, as one family after another suffers abuse and limitation of care at the hands of managed care companies.

So the Republican leadership has come forward today in a very contrived fashion. They tried to provide the least amount of reform possible and still call it ''patients rights,'' while doing essentially nothing to untie the hands of judges all across this country to provide a remedy.

Mr. Speaker, they say that what they are about is providing help to patients and not getting lawyers in the process. But, you know, that is false under their whole procedure. They keep lawyers involved in the process. They keep them involved only for the insurance company, not for the victim of the insurance company's abuse. They say that it is okay to have the lawyers that write the loopholes, that counsel the insurance companies to interfere with some clerk, who never had any health care experience, in the best recommendations of a physician or other health care provider to help that physician's patient get well. But Republicans would deny any enforcement, any accountability, for that insurance company.

They say they are opposed to getting juries involved in this process, and that is also false. They simply leave the only jury as not a jury of one's peers, but an insurance company, that acts as judge, jury and, in too many cases, executioner when it comes to providing health care. We would remedy that through the Dingell proposal, not through some election year sop.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Speaker, I rise in support of the Ganske-Dingell bill and truly relish this debate. I truly wish we had more time for it.

Today we are going to vote on a Republican sham HMO reform bill which actually leaves patients with less rights than they have under current law.

Let me give you an example. The GOP bill will repeal state laws that keep HMOs from giving out your private medical records. Under this Republican proposal, your employer could call for your medical records and your HMO could release your personal medical records without your permission.

But the worst thing about this political charade is that the Republican bill does not address the one problem that millions of Americans have asked us to fix, that doctors and patients should make medical decisions, not insurance company bean counters.

Under the GOP bill, HMOs will continue to define what is medical necessity and accountants will continue to decide what medical care Americans ought to receive. And if some HMO bureaucrat with no medical training makes a mistake that injures or kills you or a member of your family, you have no legal recourse. The GOP bill says, too bad, and tough luck.

This is a sham bill, and that is why the American Medical Association and dozens of other medical groups oppose it, and why the HMO companies support it. It has no protections and no enforcement mechanism. That is why the President has said he will veto it.

Let us pass real reform for the American people in this country. That is what they want, that is what they need. Pass the Democratic Patients' Bill of Rights. It is the way that we need to address the serious issue of getting back the decisionmaking between doctors and patients, and out of the hands of the HMOs.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, regrettably, the last speaker has been victimized by misinformation in the paper, in the Washington Post this morning, as have other Members. When we get to the debate we will explain that much of what was presented was incorrect.

Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Missouri (Mr. TALENT), a member of the special task force.

□ 0945

Mr. TALENT. Mr. Speaker, I thank the gentleman for yielding me this time.

I am very pleased to rise in strong support of the Patient Protection Act because it is the only bill on the House floor today that will provide health care coverage to millions of people, hard-working Americans who currently do not have it. It is the only bill that will ensure that Americans who have health care coverage get the coverage their physician recommends when they need it, before they get sick, and it is the only bill that does what it does without big government and big bureaucracy.

First, access to the uninsured. Mr. Speaker, there are 42 million Americans today who do not have health care coverage. Most of them work for small employers who, because of the high administrative costs and the low buying power with small pools, cannot afford to provide them health insurance. If they worked for IBM, they would have access to a variety of different options.

So what our bill does is allows those small employers to pool together and get the buying power of a pool. It will cover millions of people with good, private sector health insurance and provide many more choices to millions of those who currently only have one choice or two.

What does the Dingell bill do? What does it do for the uninsured? Well, according to a cosponsor from the other body, not much. In fact, the ''not-much'' plan is worse than not much, because according to the CBO, it will drive costs up to the point that 1.6 million people who now have health insurance will be thrown off the health insurance rolls.

Our bill also ensures that people will get the care they need when they need it, and does it without big government. It provides swift, certain, low-cost access for somebody whose physician has recommended care whose plan has turned it down to get that decision reversed. First internal review has to be before a physician, not a health care professional, not a nurse. That is a difference from the Dingell bill.

Second, automatic appeal has a right to an external review before physicians. The Dingell bill does not have that. We get people in the treatment rooms, not waste billions of dollars that should be spent on health care in the courtrooms.

Mr. Speaker, all of us who have dealt with this issue have dealt with the stories about people who have needed coverage and have had it denied by their managed care plans. Those are not just horror stories, they are horrible stories. Tales of human misery, of pain, of loss of babies, loss of limbs; that should not happen. Under our bill and only under our bill those stories would not have happened and will not happen in the future.

That is what this debate today is about, that is what this bill is about. It should not be about politics, it should not be about an issue for November; it should be about helping the people to get the care that they need when their physician recommends it. That is why I rise in strong support of the Patient Protection Act.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentlewoman from Texas, (Ms. EDDIE BERNICE JOHNSON).

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, it is ironic that I stand here and know so well that every taxpaying American has paid for much of the research that persons now are denied the result of.

I wish this was not such a partisan area, because we are dealing with the most basic need and right of the American people, and that is health care. No insurance company has the right to only insure young, healthy people.

I have heard all kinds of rhetoric about the bureaucracy. The bureaucracy rests with the insurance companies who are doing everything they can to deny care so that health care premiums can be used as cash cows. That is most unfortunate. Can we imagine someone who goes to an emergency room, very ill, very confused and frightened, and then be told they have to wait to get permission to take care of them. That is where we are today.

I do not understand, frankly, how we can become so committed to an industry, the insurance industry, that we forget that we are here to protect people.

Mr. Speaker, I rise against this rule because I do not want it to continue to gag physicians who have been educated and trained to take care of patients. I do not want to support a system that only makes money for the insurance companies. It has been never intended that health care services be cash cows for insurance companies.

This is a terrible rule. I hope we all understand that the people are crying out for help. They do not mean help the insurance companies. They want help themselves.

We owe it to the American people to offer them this protection. We have failed to do it with this Republican plan, and I rise against this rule and ask everyone to vote against it until we can produce a decent plan.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume to say to the gentlewoman that I hope she will be relieved to find when she reads our bill that we have, in fact, removed the gag order.

Mr. Speaker, I yield 1 minute to the distinguished gentleman from Texas (Mr. PAUL).

Mr. PAUL. Mr. Speaker, I thank the gentleman for yielding me this time.

I rise in support of the rule. Under the circumstances, the rule is very fair. It offers an opportunity for our side to vote for the Patient Protection Act as well as a vote for the opposition. I think that is quite fair, so I strongly support the rule.

I would like to call to the attention of my colleagues one particular part of our bill that I think is very important and addresses a problem I see as being very serious.

In 1996, the Kennedy-Kassebaum bill allowed for a national identifier and a national data bank to control all our medical records at a national level. This is very dangerous. In a bill that is called the Patient Protection Act, obviously the best thing we can do is protect patient privacy. If we do not, we interfere with the doctor-patient relationship, and this is a disaster.

This whole concept of a national identifier—the administration is already working to establish this—is dangerous and we must do whatever is possible to stop it.

I compliment the authors of this bill to prohibit this national medical data bank.

Mr. FROST. Mr. Speaker, I would inquire about the time remaining.

The SPEAKER pro tempore (Mr. LAHOOD). The gentleman from Texas has 11 minutes remaining and the gentleman from Florida has 10 minutes remaining.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. TRAFICANT).

Mr. TRAFICANT. Mr. Speaker, I support the rule; I also support the Democrat substitute, and if it fails, I will support the Republican bill. Both bills are better than the current system, and the need for reform is greater than Democrat and Republican posturing.

Doctors should make decisions on our health care, not businessmen. Patients should be able to choose the doctor they want. Insurance companies and business managers without medical degrees should not be delivering our health care system.

Mr. Speaker, I say to my colleagues, this current system is not managed care; this system in America is managed cost. Dollars are all they see, not pain, not disease, not people, not children, not cancer, not cures; they see dollars.

The Congress of the United States is appropriately making necessary changes today, and these business people have to understand that the American people want a doctor, not an accountant, when they have a gall bladder problem, I say to my colleagues. And hospitals should not be throwing them out because of dollar concerns; it should be predicated on sound medical practice.

It is a shame when Congress has to intervene, but America has gone from the Hippocratic oath to hypocrisy in a managed cost health care system.

I will support whatever survives; it is better than the animal that still lives.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the gentlewoman from Kentucky (Mrs. NORTHUP).

Mrs. NORTHUP. Mr. Speaker, I am glad to be a part of this debate. In my previous life I was part of the Kentucky General Assembly, and while they were altruistic legislators that created the disaster that we had in Kentucky, the fact is that that is exactly what they created, a terrible disaster.

We had what would be proposed today by the Democrats in the term of health care reform, and what it created were enormously escalating prices, prices that escalated so fast that we tried to intervene by capping the prices of our insurance premiums. What did that do? It chased 45 out of 47 of the insurance companies that were selling insurance in Kentucky right out of the State.

So what did our consumers in Kentucky get left with? They got left with higher prices for insurance, they got left with higher copayments, and they got left with fewer choices.

I am so proud to be here today, to be part of an effort to give the American people what they really want. What do they want? They want essential medical services. They want them to be affordable, both the insurance and the copayments, and they want more choices. We are taking a giant step in that direction today.

What we are doing is helping make sure that medical money stays in medicine. The American people resent the fact that they pay for their insurance, that their employer contributes to their insurance, and they make copayments, and a tremendous amount of that money gets diverted to lawyers, to court costs, to liability costs and to administrative costs.

We need to make sure that all the money we spend in medicine, understanding that there is a finite amount of money that gets spent on good health delivery, for patients when they need it.

We need to make sure that we do not create a bill that has so many mandates in it that we begin to say to the American people, you are going to pay more and more because we know what you need and want, not you. I thank the task force for creating this opportunity.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Maryland (Mr. CARDIN).

Mr. CARDIN. Mr. Speaker, I thank my friend from Texas for yielding me this time.

Mr. Speaker, this is one of the most important issues that we are going to deal with in this Congress, how we provide patients protection in the health care system of this country. I am outraged, and I hope my colleagues are outraged, by the process that we are using in considering this legislation.

There have been no hearings on the Republican bill. It did not go through any of the committees of jurisdiction for the purpose of markup or to try to get the drafting done correctly, and no wonder that this bill is drafted so poorly. My Republican colleagues did not get it right. It is not going to do what they are advertising.

Let me just give one example. H.R. 815, which I introduced many, many months ago, deals with access to emergency care. We have 240 cosponsors of that legislation that adopts the prudent layperson standard so that an HMO has to reimburse a patient who should go to an emergency room. We passed it last year for Medicare and Medicaid, and yet the Republican bill does not get it right. It does not include pain. So if one has severe pain and reasonably should go to an emergency room, one's HMO can deny coverage. That is wrong. Even the HMOs acknowledge that pain is a reason to go to an emergency room. But my Republican colleagues did not put it in their bill and they did not allow a correction to be made. That is wrong.

Let me give another example. My Republican colleagues brag about an external appeal process, that they are giving the patients the right to take an

appeal, but what they are not saying is they did not get that right. The decision is not binding on the HMO. It is not independent. The HMO gets to select the people that serve on the panel. My Republican colleagues did not get it right.

There is legislation that has been filed that deals with external appeal, but my Republican colleagues did not bother taking it through the committees so that we could have that debate.

I urge my colleagues to adopt the bipartisan bill, which is our only chance today to provide meaningful patient protection.

Mr. GOSS. Mr. Speaker, I thank the distinguished gentleman from Maryland (Mr. CARDIN), my friend, who is indeed my close friend. I did not get it exactly right in describing our bill as the debate will show, but that is why we have the debate.

Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. BOEHNER).

(Mr. BOEHNER asked and was given permission to revise and extend his remarks.)

□ 1000

Mr. BOEHNER. Mr. Speaker, in just 3 years this Congress has delivered the first balanced budget in a generation, the first tax cuts from Washington in 16 years, and real reforms that are improving the lives of many who are on welfare today as they are able to move from welfare to work.

Today we are going to move in a bipartisan fashion to continue to add to our record of success and an opportunity to help the American people.

As I travel around my district, I have had many conversations with my constituents who are concerned about access to good-quality health care. As much as they want access, they are also concerned about making sure that it is affordable.

As I look at the two pieces of legislation that we are going to debate today, it is clear to me that the bill brought to us by the task force, headed by the gentleman from Illinois (Mr. DENNIS HASTERT), is a bill that does that. It empowers consumers, not lawyers. It makes sure that health care continues to be affordable and accessible for all Americans.

I think, in the end, that is what people want. They do not want to go to court. They want to be able to go to the doctor. They want to be able to get the treatments they need. And I think the empowerment that we see in our piece of legislation is exactly that.

The other bill that we will be debating, the proposal by the gentleman from Michigan, in fact creates an awful lot of big government, an awful lot of access to lawsuits and to lawyers and to courts, driving up the cost of health care. My greatest concern about the proposal from the gentleman from Michigan is that, by opening up employers to the lawsuit abuse that could occur, many employers in America are going to say we are not going to be providing health care coverage to our employees anymore.

I know myself, as a small employer, I would not continue to offer health care to my employees if I am subject to being sued by doctors, who may be on solid ground, maybe not. I am going to give them a voucher and let them go fight for their own.

I do not think that is what the American people want. They want reasonable access, reasonable cost to good-quality care.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentlewoman from North Carolina (Mrs. CLAYTON).

(Mrs. CLAYTON asked and was given permission to revise and extend her remarks.)

Mrs. CLAYTON. Mr. Speaker, I thank the gentleman for yielding me this time.

When a child has a disease that can be cured, should the decision of whether to provide needed treatment be made by a doctor and the child's parents or by bureaucrats who are counting dollars and cents?

When a wife or mother has had a mastectomy and the procedure has not yet worn off, should she be forced to leave the hospital because of a rigid routine for saving dollars rather than saving lives?

When a husband and a father is unable to get prior approval from the insurance who he is paying for an emergency, should he be required to pay that medical bill himself?

When a grandfather is stricken with a life-threatening stroke, should the person transporting him be required to pass a hospital that is closest to him to go to one that is further away because a narrow-thinking person is more interested in saving dollars than, again, in saving lives?

H.R. 3605, which is the Patients' Bill of Rights, the Democrat substitute, indeed speaks to a number of basic rights that all of these patients that I just described should have and not have to suffer. The Republican bill, H.R. 4250, does not.

Many of the patient rights that we are talking about indeed does mean that a patient should have a right to sue. A patient should have a right to indeed hold us accountable for our liabilities and our rights. The patient should have a right to choose their doctor. A patient should have a right to choose other professionals that they desire.

H.R. 3605 does provide open communication. Although those on the other side say the gag clause is in there, I cannot find it. So I urge my colleagues to support the Patients' Bill of Rights, the Democratic substitute.

Mr. GOSS. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. WELDON), my colleague.

Mr. WELDON of Florida. Mr. Speaker, I thank the gentleman for yielding me this time.

As a physician who still practices medicine, I rise in strong support of this rule. I have worked in managed-care settings and I have worked in fee-for-service settings. The important issue here is can we, in Washington, pass legislation that will help restore the doctor-patient relationship and, importantly, help restore quality health care within managed-care networks?

Now, my good friends on the Democrat side of the aisle have their bill; we have our bill. We are going to have a very interesting debate here this morning. I think the important issue, which speaks of how much better our Republican bill is, is the fact our bill is the bill that is not going to drive up costs, where the Democrat bill will; and, importantly, our bill is going to enable people who are uninsured to have access to health care and help them to more easily afford health care.

I would encourage all my colleagues to support this rule. Listen to the debate during general debate and the debate on the amendments and, in the end, I believe our bill is going to pass. Our bill is the better bill for restoring quality, for restoring the doctor-patient relationship, for reducing cost and giving the uninsured better access to health care.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. TURNER).

(Mr. TURNER asked and was given permission to revise and extend his remarks.)

Mr. TURNER. Mr. Speaker, it has been suggested that the Republican bill is better, a better protection for patients. I submit to my colleagues that the Republican bill is worse protection for patients than exists in current law in most of our States.

I come from Texas. The Texas legislature passed patient protection legislation in 1977, fully intending that all HMOs be covered by the protections of State law.

The Republicans submit a bill today that would control patient protections at the Federal level. It would set out a set of rules that are far inferior to those in the Democratic alternative.

On the Republican bill, if the HMO denied coverage, the only remedy would be to go, if an individual is in a self-insured plan, to Federal Court. And when that individual gets there, they will not have a remedy.

In 1971, Phyllis Cannon was diagnosed with leukemia. She appealed to her HMO for a bone marrow transplant. The HMO refused. For over 40 days the HMO refused coverage. About a month after that, she died.

The court ruled that, under ERISA, she had no recovery. Under the Republican bill today, she would be entitled, her estate, to $20,000, a small price for a life, the denial of treatment. Under the Republican bill, the penalty is $500 a day. A much cheaper alternative for an HMO than providing the treatment that should have been provided to Phyllis Cannon.

I submit to my colleagues that every Member of this House needs to look at

what their State has done to protect patients, because a vote for the Republican bill is rolling back the protections that most of our States have already provided for patients under the law. In every place in this country, protecting patients enrolled in HMOs has been a bipartisan effort. Only in Washington is patient protection partisan.

Mr. GOSS. Mr. Speaker, may I ask for an accounting of the times again?

The SPEAKER pro tempore (Mr. LAHOOD). The gentleman from Florida (Mr. GOSS) has 6 minutes remaining and the gentleman from Texas (Mr. FROST) has 3 minutes remaining.

Mr. GOSS. Mr. Speaker, I yield 3 minutes to the gentlewoman from Ohio (Ms. PRYCE), who is also a member of the task force as well as a member of leadership.

Ms. PRYCE of Ohio. Mr. Speaker, I thank my friend for yielding me this time, and I rise in strong support of this rule. And as a member of the working group on health care quality, I first want to thank our chairman, the gentleman from Illinois (Mr. DENNY HASTERT), for his patience and expertise and many hours of hard work that got us here today.

Mr. Speaker, the Patient Protection Act is the only managed care reform bill that goes beyond patient protection to address the issues of access and affordability of health care. Not only does this bill ban gag rules, provide emergency room access, and guaranty a choice of provider, it increases the number of people with insurance. It does that by helping small employers purchase affordable health benefits for their employees.

Now, it is nice to talk about quality. We all want the best health care we can get. But A-plus care does not help if we cannot afford to buy it. The Democrat proposal would price many, many people out of the market. We all know that more requirements, regulations, and government is not going to make insurance any cheaper. Rest assured, more government largess is just what we will get with the Democrat health bill.

Now, liability has become the rallying cry for the opponents of the Patient Protection Act. And the health care working group discussed this issue at length and came to some very rational conclusions. As a former judge, I think the solution we provide meets every legitimate goal of liability reform. The bottom line is that Americans pay a pretty sum for their health insurance and they expect it to cover the health care that they need when they need it. That is the crux of this debate.

Patients do not want bureaucrats denying their access to care; and when a claim is denied, patients want a quick remedy that relies on the opinion of a medical professional. But my Democratic colleagues would tell these dissatisfied patients that they must hire a lawyer and they send them off to court.

Mr. Speaker, what the Democrats fail to understand is that patients do not want a lawyer, a court date and expensive litigation. They want a doctor, a diagnosis, and treatment their doctor tells them that they need.

The Republican bill will get them that care by guaranteeing patient access to expedited review by independent medical experts. The Republican plan keeps patients out of court and in the health care system, and it requires the health plans to provide the coverage that they are promised.

The expedited appeals process in the Patient Protection Act gives patients the leverage they need to quickly get the care they deserve without going to court and waiting through years and years of litigation. I urge my colleagues to support patients, not lawyers' paychecks, and vote for this rule and the Republican Patient Protection Act.

Mr. FROST. Mr. Speaker, I yield 1 minute to the gentlewoman from Texas (Ms. JACKSON-LEE).

(Ms. JACKSON-LEE asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, this is the real face of health care in America: A young boy who had a difficult birth and developed cerebral palsy. And at age 14 months the bureaucrats from the HMOs, the ones who are there just to ensure that those who need care do not get care, denied this young boy speech therapy and other kinds of therapies that he needed to have a better life.

Americans know the real deal. They understand what it means as they travel around this summer on vacation and something tragic happens and they go to an emergency room away from their State and that emergency room, because the HMO says they cannot come in, sends them away. They understand when a little one falls from a tree playing in the back yard and has pain; and the emergency room, because of the HMO, says no because all they have is pain as evidence of their injury and the HMO says pain is not enough.

I would say to my colleagues, Mr. Speaker, the real Bill of Rights is that of the Democrats, and that is what we need to support today. It is bipartisan, it is for real, it will the right health care coverage and the American people know the real thing.

Mr. FROST. Mr. Speaker, I yield the balance of my time to the gentleman from Maryland (Mr. HOYER).

(Mr. HOYER asked and was given permission to revise and extend his remarks.)

Mr. HOYER. Mr. Speaker, the gentlewoman from Ohio (Ms. PRYCE) said what the Democrats know. Let me tell my colleagues what the Democrats know. When people commit wrongs, they do not want to be held accountable, and the Republicans are making sure that is true.

I rise today in opposition to H.R. 4250, the bill that my friends on the other side of the aisle claim reforms managed care. The previous speaker, the chairman of their conference, said what the Republican Congress had brought as it pertains to a balanced budget. We will argue that some other time. The fact is, this Congress has not brought hardly anything to the American public.

□ 1015

It is the do-nothing Congress.

This bill is on the floor today because a discharge petition was signed by the gentleman from Iowa (Mr. GANSKE) and the gentleman from Michigan (Mr. DINGELL) and about 190 others of us, and says, we want a health care reform bill on this floor. That is the reason it is here and the only reason we are here today.

I rise in strong support of the substitute offered by the gentleman from Iowa (Mr. GANSKE), a Republican and a doctor, and the gentleman from Michigan (Mr. DINGELL), the former Chairman of the Committee on Commerce, now Ranking Member, and the next Chairman of the Committee on Commerce.

The Republicans have chosen to support H.R. 4250, the so-called ''Patient Protection Act.'' They bring this bill to the floor today with no hearings, no mark-ups, and no CBO estimate. In other words, they were so panicked by the discharge petition, that they brought it to the floor without the regular process.

Mr. Speaker, the American public wants access to health care. The American public wants decisions made by their doctors and by themselves, not by, as all of us have said, insurance companies. They are right. But the American public will not be fooled as to which alternative gives them protection, as to which bill gives them access, and as to which bill allows them to hold accountable those who undercut their health care protection.

My colleagues, I ask you to support the Democratic substitute, the Republican substitute, supported by Members on the other side of the aisle, the Ganske-Dingell substitute, supported by Members on the other side of the aisle, which does in fact do what everybody says they want to do.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, this debate has been on the rule. Very clearly, we have not heard much concern about the rule, with some question about sensitivity by one speaker. But I do believe we have got a better process here than a discharge petition. And I think we will have a fair, longer, more extensive, complete, and deliberative debate at a result of this rule. And I do urge that everybody support it. I honestly do not think it is controversial in any way.

What we are doing today is responding to the call of all American people for improvements in our health care system but particularly for those who have no health care insurance. We are

not responding to the interests of any special groups or any special parties. And there are plenty of those who are asking for special attention. I think we have responded to America, to the people of America, who need health care.

We are doing this in the same spirit that we resolved the job lock and portability problems, the preexisting condition problems. We are doing this in same way that made the trust fund whole in Medicare. We are addressing the problems in our country in health care and we are doing it responsibly.

There has been a lot said and there will be a lot more said, and there clearly is much misinformation. I even read some misinformation in the Washington Post this morning, which has obviously misled some of the speakers who have addressed this during this rule.

It is very clear that we have made a good bill, and it is very clear that not everybody understands it yet. It is also very clear that the Patient Protection Act does not have any big brother in it. There is no big brother in our bill. In fact, we put a halt to the big brother ID system that has been recently discussed and that so many Americans find extremely distasteful and an invasion of their privacy.

I think that many portions of the legislation that we have, as virtually everybody knows that is tuned into this, have already been through appropriate committees and they have been I think well put together and much debated.

I think the critical point probably is that what we have done in this bill is cut into the 42 million Americans, that big pool of people who do not have health care insurance, and given them the opportunity to get it.

The bill on the other side, the Dingell-Kennedy bill, adds, according to CBO, to the pool of Americans who will not have health care insurance. That is simply unacceptable. Accessibility to health care insurance is critical.

I want to close on a note that many will recognize. My wife and I experienced something this year that every parent dreads, a seriously sick youngster coming in and asking for health care and the plan that that child was under could not perform. I personally got involved with why and what went wrong.

So when I speak to my colleagues to say that I think we have a fix in the patient protection care, I speak to them as a parent, not as a legislator. I assure my colleagues, I would not be supporting this legislation if I did not think my sick youngster would be better off under this plan.

I urge support of this rule.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The SPEAKER pro tempore (Mr. LAHOOD). The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. FROST. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 279, nays 143, not voting 12, as follows:

[Roll No. 335]

YEAS—279

Aderholt
Archer
Armey
Bachus
Baesler
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bono
Boswell
Boyd
Brady (TX)
Bryant
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Capps
Chabot
Chambliss
Christensen
Clayton
Clement
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Cramer
Crane
Crapo
Cubin
Cummings
Cunningham
Danner
Davis (VA)
Deal
DeGette
Delahunt
DeLay
Diaz-Balart
Dickey
Dingell
Doyle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Etheridge
Everett
Ewing
Fawell
Foley
Fossella
Fowler
Fox
Franks (NJ)
Frelinghuysen
Frost
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Goode
Goodlatte
Goodling
Gordon
Goss
Graham
Granger
Greenwood
Gutknecht
Hall (TX)
Hamilton
Hansen
Hastert
Hastings (WA)
Hayworth
Hefley
Hefner
Hill
Hilleary
Hobson
Hoekstra
Holden
Hooley
Horn
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Inglis
Jackson-Lee (TX)
Jenkins
Johnson (CT)
Johnson, Sam
Jones
Kanjorski
Kasich
Kelly
Kennedy (MA)
Kennelly
Kildee
Kilpatrick
Kim
Kind (WI)
King (NY)
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Linder
Lipinski
Livingston
LoBiondo
Lofgren
Lucas
Manton
Manzullo
Mascara
McCarthy (MO)
McCarthy (NY)
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McIntyre
McKeon
Metcalf
Mica
Millender-McDonald
Miller (FL)
Mollohan
Moran (KS)
Moran (VA)
Morella
Murtha
Myrick
Nethercutt
Neumann
Ney
Northup
Norwood
Nussle
Obey
Ortiz
Oxley
Packard
Pallone
Pappas
Parker
Pascrell
Pastor
Paul
Paxon
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Rahall
Ramstad
Redmond
Regula
Riggs
Riley
Rivers
Roemer
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Rothman
Roukema
Royce
Ryun
Salmon
Sanford
Sawyer
Saxton
Scarborough
Schaefer, Dan
Schaffer, Bob
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherman
Shimkus
Shuster
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Smith, Adam
Smith, Linda
Snowbarger
Snyder
Solomon
Souder
Spence
Stearns
Stump
Sununu
Talent
Tauzin
Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Traficant
Upton
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Wexler
Weygand
White
Whitfield
Wicker
Wilson
Wise
Wolf

NAYS—143

Abercrombie
Ackerman
Allen
Andrews
Baldacci
Barcia
Barrett (WI)
Becerra
Bentsen
Berman
Berry
Bishop
Blagojevich
Bonior
Borski
Boucher
Brady (PA)
Brown (CA)
Brown (FL)
Brown (OH)
Cardin
Carson
Castle
Clay
Clyburn
Condit
Conyers
Costello
Coyne
Davis (FL)
Davis (IL)
DeFazio
DeLauro
Deutsch
Dicks
Dixon
Doggett
Dooley
Edwards
Engel
Eshoo
Evans
Farr
Fattah
Fazio
Filner
Forbes
Frank (MA)
Furse
Gejdenson
Gephardt
Green
Hall (OH)
Harman
Hastings (FL)
Hilliard
Hinchey
Hinojosa
Hoyer
Istook
Jackson (IL)
John
Johnson (WI)
Johnson, E.B.
Kaptur
Kennedy (RI)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
Lee
Levin
Lewis (GA)
Lowey
Luther
Maloney (CT)
Maloney (NY)
Martinez
Matsui
McDermott
McGovern
McHale
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Miller (CA)
Minge
Mink
Moakley
Nadler
Neal
Oberstar
Olver
Owens
Payne
Pelosi
Peterson (MN)
Pickett
Pomeroy
Poshard
Price (NC)
Rangel
Reyes
Rodriguez
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Schumer
Scott
Serrano
Sisisky
Skaggs
Slaughter
Spratt
Stabenow
Stark
Stenholm
Stokes
Strickland
Stupak
Tanner
Tauscher
Thompson
Thurman
Tierney
Towns
Turner
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Woolsey
Wynn

NOT VOTING—12

Chenoweth
Doolittle
Ford
Gonzalez
Gutierrez
Herger
Jefferson
Markey
Torres
Yates
Young (AK)
Young (FL)

☐ 1040

Mr. RANGEL and Mr. MENENDEZ changed their vote from ''yea'' to ''nay.''

Ms. LOFGREN, Mrs. MCCARTHY of New York, Mr. BILIRAKIS and Mr. CRAMER changed their vote from ''nay'' to ''yea.''

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Mr. HASTERT. Mr. Speaker, pursuant to House Resolution 509, I call up the bill (H.R. 4250) to provide new patient protections under group health plans, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. KOLBE). The bill is considered read for amendment.

The text of H.R. 4250 is as follows:

H.R. 4250

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

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—The Act may be cited as the ''Patient Protection Act of 1998''.

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

Sec. 1. Short title and table of contents.

TITLE I—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Subtitle A—Patient Protections.

Sec. 1001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.

Sec. 1002. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 1101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 1102. Effective date.

Subtitle C—New Procedures and Access to Courts for Grievances Arising under Group Health Plans

Sec. 1201. Special rules for group health plans.

Sec. 1202. Effective date.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

Sec. 1301. Short title of subtitle.

Sec. 1302. Rules governing association health plans.

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''Sec. 801. Association health plans.

''Sec. 802. Certification of association health plans.

''Sec. 803. Requirements relating to sponsors and boards of trustees.

''Sec. 804. Participation and coverage requirements.

''Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.

''Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.

''Sec. 807. Requirements for application and related requirements.

''Sec. 808. Notice requirements for voluntary termination.

''Sec. 809. Corrective actions and mandatory termination.

''Sec. 810. Trusteeship by the secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

''Sec. 811. State assessment authority.

''Sec. 812. Special rules for church plans.

''Sec. 813. Definitions and rules of construction.

Sec. 1303. Clarification of treatment of single employer arrangements.

Sec. 1304. Clarification of treatment of certain collectively bargained arrangements.

Sec. 1305. Enforcement provisions relating to association health plans.

Sec. 1306. Cooperation between Federal and State authorities.

Sec. 1307. Effective date and transitional and other rules.

TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

Sec. 2001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.

Sec. 2002. Requiring health maintenance organizations to offer option of point-of-service coverage.

Subtitle B—Patient Access to Information

Sec. 2101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 2102. Reporting on fraud and abuse enforcement activities.

Sec. 2103. Effective date.

Subtitle C—HealthMarts

Sec. 2201. Short title of subtitle.

Sec. 2202. Expansion of consumer choice through HealthMarts.

''TITLE XXVIII—HEALTHMARTS

''Sec. 2801. Definition of HealthMart.

''Sec. 2802. Application of certain laws and requirements.

''Sec. 2803. Administration.

''Sec. 2804. Definitions.

SUBTITLE D—COMMUNITY HEALTH ORGANIZATIONS

Sec. 2301. Promotion of provision of insurance by community health organizations.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subtitle A—Patient Protections

Sec. 3001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.

Sec. 3002. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 3101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 3102. Reporting on fraud and abuse enforcement activities.

Sec. 3103. Effective date.

Subtitle C—Medical Savings Accounts

Sec. 3201. Expansion of availability of medical savings accounts.

Sec. 3202. Exception from insurance limitation in case of medical savings accounts.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

Sec. 4001. Federal reform of health care liability actions.

Sec. 4002. Definitions.

Sec. 4003. Effective date.

Subtitle B—Uniform Standards for Health Care Liability Actions

Sec. 4011. Statute of limitations.

Sec. 4012. Calculation and payment of damages.

Sec. 4013. Alternative dispute resolution.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

Sec. 5001. Confidentiality of protected health information.

''PART D—CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

''Sec. 1181. Inspection and copying of protected health information.

''Sec. 1182. Supplementation of protected health information.

''Sec. 1183. Notice of confidentiality practices.

''Sec. 1184. Establishment of safeguards.

''Sec. 1185. Availability of protected health information for purposes of health care operations.

''Sec. 1186. Relationship to other laws.

''Sec. 1187. Civil penalties.

''Sec. 1188. Definitions.

Sec. 5002. Study and report on effect of State law on health-related research.

Sec. 5003. Study and report on State law on protected health information.

Sec. 5004. Protection for certain information developed to reduce mortality or morbidity or for improving patient care and safety.

TITLE VI—MEDICAL SAVINGS ACCOUNTS FOR FEDERAL EMPLOYEES

Sec. 6001. Medical savings accounts for Federal employees.

Sec. 6002. Effective date.

TITLE I—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Subtitle A—Patient Protections

SEC. 1001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, AND PEDIATRIC CARE.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended further by adding at the end the following new sections:

''SEC. 713. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

''(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

''(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan, the plan or issuer with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan or health insurance coverage offered in connection with the plan.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, 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 group health plan 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) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

''(1) IN GENERAL.—To the extent that the group health plan (or health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I)), except for items or services specifically excluded—

''(A) the plan or issuer shall provide 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 in order to determine whether emergency medical care (as so defined) is required, and

''(B) the plan or issuer shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in section 503(b)(9)(I).

''(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), 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 section 503(b)(9)(I)) provided to such similarly situated participants and beneficiaries under the plan.

''(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan)—

''(A) provides benefits under the terms of the plan consisting of—

''(i) routine gynecological care (such as preventive women's health examinations), or

''(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

''(B) the plan 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, then the plan (or issuer) shall meet the requirements of paragraph (2).

''(2) REQUIREMENTS.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan (or issuer)—

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

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

''(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

''(d) PATIENT ACCESS TO PEDIATRIC CARE.—

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

''(e) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.''.

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

''Sec. 713. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.''.

SEC. 1002. 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, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall first issue 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 or health insurance issuer 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 or issuer has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the provisions of subsections (b), (c), and (d) of section 713 of the Employee Retirement Income Security Act of 1974 (as added by this subtitle) shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

(d) ASSURING COORDINATION.—The Secretary of Labor, the Secretary of the Treasury, and the Secretary of Health and Human Services shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this subtitle, section 2101, and subtitle A of title III (and the amendments made thereby) are administered so as to have the same effect at all times, and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

(e) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

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

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

(B) require such plans or issuers to—

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

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

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

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

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

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

Subtitle B—Patient Access to Information

SEC. 1101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by redesignating section 111 as section 112; and

(2) by inserting after section 110 the following new section:

''DISCLOSURE BY GROUP HEALTH PLANS

''SEC. 111. (a) DISCLOSURE REQUIREMENT.—

''(1) GROUP HEALTH PLANS.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 for different options of coverage) contains, among any information otherwise required under this part, the information required under subsections (b), (c), (d), and (e)(2)(A).

''(2) HEALTH INSURANCE ISSUERS.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator on a timely basis with the information necessary to enable the administrator to comply with the requirements of paragraph (1). To the extent that any such issuer provides on a timely basis to plan participants and beneficiaries information otherwise required under this part to be included in the summary plan description, the requirements of sections 101(a)(1) and 104(b) shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the plan pursuant to part 6.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503(b), including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—In addition to the information required to be provided under section 104(b)(4), a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications; and

''(ii) the actual plan provisions setting forth the benefits available under the plan

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

''(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any

health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.

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

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided such term under section 503(b)(6).

''(2) MEDICAL CARE.—The term 'medical care' has the meaning provided such term under section 733(a)(2).

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term under section 733(b)(1).

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term under section 733(b)(2).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 102(b) of such Act (29 U.S.C. 1022(b)) is amended—

(A) by striking ''section 733(a)(1)'' each place it appears and inserting ''section 503(b)(6)''; and

(B) by inserting before the period at the end the following: ''; and, in the case of a group health plan (as defined in section 111(h)(1)), the information required to be included under section 111(a)''.

(2) The table of contents in section 1 of such Act is amended by striking the item relating to section 111 and inserting the following new items:

''Sec. 111. Disclosure by group health plans.
''Sec. 112. Repeal and effective date.''.

SEC. 1102. 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 first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

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

(c) ASSURING COORDINATION.—The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this subtitle, subtitle B of title II, and subtitle B of title III (and the amendments made thereby) are administered so as to have the same effect at all times, and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

Subtitle C—New Procedures and Access to Courts for Grievances Arising Under Group Health Plans

SEC. 1201. SPECIAL RULES FOR GROUP HEALTH PLANS.

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

(1) by inserting ''(a) IN GENERAL.—'' after ''SEC. 503.'';

(2) by inserting ''(other than a group health plan)'' after ''employee benefit plan''; and

(3) by adding at the end the following new subsection:

''(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

''(1) COVERAGE DETERMINATIONS.—Every group health plan shall—

''(A) provide adequate notice in writing in accordance with this subsection to any participant or beneficiary of any adverse coverage decision with respect to benefits of such participant or beneficiary under the plan, setting forth the specific reasons for such coverage decision and any rights of review provided under the plan, written in a manner calculated to be understood by the participant,

''(B) provide such notice in writing also to any treating medical care provider of such participant or beneficiary, if such provider has claimed reimbursement for any item or service involved in such coverage decision, or if a claim submitted by the provider initiated the proceedings leading to such decision,

''(C) afford a reasonable opportunity to any participant or beneficiary who is in receipt of the notice of such adverse coverage decision, and who files a written request for review of the initial coverage decision within 180 days after receipt of the notice of the initial decision, for a full and fair de novo review of the decision by an appropriate named fiduciary who did not make the initial decision, and

''(D) meet the additional requirements of this subsection.

''(2) TIME LIMITS FOR MAKING INITIAL COVERAGE DECISIONS FOR BENEFITS AND COMPLETING INTERNAL APPEALS.—

''(A) TIME LIMITS FOR DECIDING REQUESTS FOR BENEFIT PAYMENTS, REQUESTS FOR ADVANCE DETERMINATION OF COVERAGE, AND REQUESTS FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—Except as provided in subparagraph (B)—

''(i) INITIAL DECISIONS.—If a request for benefit payments, a request for advance determination of coverage, or a request for required determination of medical necessity is submitted to a group health plan in such reasonable form as may be required under the plan, the plan shall issue in writing an initial coverage decision on the request before the end of the initial decision period under paragraph (9)(J) following the filing completion date. Failure to issue a coverage decision on such a request before the end of the period required under this clause shall be treated as an adverse coverage decision for purposes of internal review under clause (ii).

''(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for such decision, before the end of the internal review period following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of such period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration under paragraph (4).

''(B) TIME LIMITS FOR MAKING COVERAGE DECISIONS RELATING TO URGENT AND EMERGENCY MEDICAL CARE AND FOR COMPLETING INTERNAL APPEALS.—

''(i) INITIAL DECISIONS.—A group health plan shall issue in writing an initial coverage decision on any request for expedited advance determination of coverage or for expedited required determination of medical necessity submitted, in such reasonable form as may be required under the plan—

''(I) before the end of the urgent decision period under paragraph (9)(L), in cases involving urgent medical care but not involving emergency medical care, or

''(II) before the end of the emergency decision period under paragraph (9)(M), in cases involving emergency medical care,

following the filing completion date. Failure to approve or deny such a request before the end of the applicable decision period shall be treated as a denial of the request for purposes of internal review under clause (ii).

''(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including

issuance by the plan of a written decision affirming, reversing, or modifying the initial converge decision, setting forth the grounds for the decision—

''(I) before the end of the urgent decision period under paragraph (9)(L), in cases involving urgent medical care but not involving emergency medical care, or

''(II) before the end of the emergency decision period under paragraph (9)(M), in cases involving emergency medical care,

following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of the applicable decision period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration under paragraph (4).

''(3) PHYSICIANS MUST REVIEW INITIAL COVERAGE DECISIONS INVOLVING MEDICAL APPROPRIATENESS OR NECESSITY OR EXPERIMENTAL TREATMENT.—If an initial coverage decision under paragraph (2)(A)(i) or (2)(B)(i) is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service does not meet the plan's requirements for medical appropriateness or necessity or would constitute experimental treatment or technology, the review under paragraph (2)(A)(ii) or (2)(B)(ii), to the extent that it relates to medical appropriateness or necessity or to experimental treatment or technology, shall be conducted by a physician who is selected to serve as an appropriate named fiduciary under the plan and who did not make the initial denial.

''(4) ELECTIVE EXTERNAL REVIEW BY INDEPENDENT MEDICAL EXPERT AND RECONSIDERATION OF INITIAL REVIEW DECISION.—

''(A) IN GENERAL.—The requirements of subparagraphs (B), (C) and (D) shall apply—

''(i) in the case of any failure to timely issue a coverage decision upon internal review which is deemed to be an adverse coverage decision under paragraph (2)(A)(ii) or (2)(B)(ii) (thereby failing to constitute a coverage decision for which specific reasons have been set forth as required under paragraph (1)(A)), and

''(ii) in the case of any adverse coverage decision which is not reversed upon a review conducted pursuant to paragraph (1)(C) (including any review pursuant to paragraph (2)(A)(ii) or (2)(B)(ii)), if such coverage decision is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service—

''(I) does not meet the plan's requirements for medical appropriateness or necessity, or

''(II) would constitute experimental treatment or technology.

''(B) LIMITS ON ALLOWABLE ADVANCE PAYMENTS.—The review under this paragraph in connection with an adverse coverage decision shall be available subject to any requirement of the plan (unless waived by the plan for financial or other reasons) for payment in advance to the plan by the participant or beneficiary seeking review of an amount not to exceed the greater of—

''(i) the lesser of $100 or 10 percent of the cost of the medical care involved in the decision, or

''(ii) $25,

with each such dollar amount subject to compounded annual adjustments in the same manner and to the same extent as apply under section 215(i) of the Social Security Act, except that, for any calendar year, such amount as so adjusted shall be deemed, solely for such calendar year, to be equal to such amount rounded to the nearest $10. No such payment may be required in the case of any participant or beneficiary whose enrollment under the plan is paid for, in whole or in part, under a State plan under title XIX or XXI of the Social Security Act. Any such advance payment shall be subject to reimbursement if the recommendation of the independent medical expert or experts under subparagraph (C)(iii) is to reverse or modify the coverage decision.

''(C) RECONSIDERATION OF INITIAL REVIEW DECISION.—In any case in which a participant or beneficiary who has received an adverse decision of the plan upon initial review of the coverage decision and who has not commenced review of the initial coverage decision under section 502 makes a request in writing, within 30 days after the date of such review decision, for reconsideration of such review decision, the terms of the plan shall provide for a procedure for such reconsideration under which—

''(i) one or more independent medical experts will be selected in accordance with subparagraph (E) to review the coverage decision described in subparagraph (A) to determine whether such decision was in accordance with the terms of the plan and this title,

''(ii) the record for review (including a specification of the terms of the plan and other criteria serving as the basis for the initial review decision) will be presented to such expert or experts and maintained in a manner which will ensure confidentiality of such record,

''(iii) such expert or experts will report in writing to the plan their recommendation, based on the determination made under clause (i), as to whether such coverage decision should be affirmed, modified, or reversed, setting forth the grounds (including the clinical basis) for the recommendation, and

''(iv) a physician who did not make the initial review decision will reconsider the initial review decision to determine whether such decision was in accordance with the terms of the plan and this title and will issue a written decision affirming, modifying, or reversing the initial review decision, taking into account any recommendations reported to the plan pursuant to clause (iii), and setting forth the grounds for the decision.

''(D) TIME LIMITS FOR RECONSIDERATION.—Any review under this paragraph shall be completed before the end of the reconsideration period (as defined in paragraph (9)(O)) following the review filing date in connection with such review. The decision under this paragraph affirming, reversing, or modifying the initial review decision of the plan shall be the final decision of the plan. Failure to issue a written decision before the end of the reconsideration period in any reconsideration requested under this paragraph shall be treated as a final decision affirming the initial review decision of the plan.

''(E) INDEPENDENT MEDICAL EXPERTS.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'independent medical expert' means, in connection with any coverage decision by a group health plan, a professional—

''(I) who is a physician or, if appropriate, another medical professional,

''(II) who has appropriate credentials and has attained recognized expertise in the applicable medical field,

''(III) who was not involved in the initial decision or any earlier review thereof, and

''(IV) who is selected in accordance with clause (ii) and meets the requirements of clause (iii).

''(ii) SELECTION OF MEDICAL EXPERTS.—An independent medical expert is selected in accordance with this clause if—

''(I) the expert is selected by an intermediary which itself meets the requirements of clause (iii), by means of a method which ensures that the identity of the expert is not disclosed to the plan, any health insurance issuer offering health insurance coverage to the aggrieved participant or beneficiary in connection with the plan, and the aggrieved participant or beneficiary under the plan, and the identities of the plan, the issuer, and the aggrieved participant or beneficiary are not disclosed to the expert,

''(II) the expert is selected, by an appropriately credentialed panel of physicians meeting the requirements of clause (iii) established by a fully accredited teaching hospital meeting such requirements,

''(III) the expert is selected by an organization described in section 1152(1)(A) of the Social Security Act which meets the requirements of clause (iii),

''(IV) the expert is selected by an external review organization which meets the requirements of clause (iii) and is accredited by a private standard-setting organization meeting such requirements and recognized as such by the Secretary, or

''(V) the expert is selected, by an intermediary or otherwise, in a manner that is, under regulations issued pursuant to negotiated rulemaking, sufficient to ensure the expert's independence,

and the method of selection is devised to reasonably ensure that the expert selected meets the independence requirements of clause (iii).

''(iii) INDEPENDENCE REQUIREMENTS.—An independent medical expert or another entity described in clause (ii) meets the independence requirements of this clause if—

''(I) the expert or entity is not affiliated with any related party,

''(II) any compensation received by such expert or entity in connection with the external review is reasonable and not contingent on any decision rendered by the expert or entity,

''(III) under the terms of the plan and any health insurance coverage offered in connection with the plan, the plan and the issuer (if any) have no recourse against the expert or entity in connection with the external review, and

''(IV) the expert or entity does not otherwise have a conflict of interest with a related party as determined under any regulations which the Secretary may prescribe.

''(iv) RELATED PARTY.—For purposes of clause (ii)(I), the term 'related party' means—

''(I) the plan or any health insurance issuer offering health insurance coverage in connection with the plan (or any officer, director, or management employee of such plan or issuer),

''(II) the physician or other medical care provider that provided the medical care involved in the coverage decision,

''(III) the institution at which the medical care involved in the coverage decision is provided,

''(IV) the manufacturer of any drug or other item that was included in the medical care involved in the coverage decision, or

''(V) any other party determined under any regulations which the Secretary may prescribe to have a substantial interest in the coverage decision .

''(v) AFFILIATED.—For purposes of clause (iii)(I), the term 'affiliated' means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

''(F) INAPPLICABILITY WITH RESPECT TO ITEMS AND SERVICES SPECIFICALLY EXCLUDED

FROM COVERAGE.—An adverse coverage decision based on a determination that an item or service is excluded from coverage under the terms of the plan shall not be subject to review under this paragraph, unless such determination is found in such decision to be based solely on the fact that the item or service—

''(i) does not meet the plan's requirements for medical appropriateness or necessity, or

''(ii) would constitute experimental treatment or technology (as defined under the plan).

''(5) PERMITTED ALTERNATIVES TO REQUIRED INTERNAL REVIEW.—

''(A) IN GENERAL.—A group health plan shall not be treated as failing to meet the requirements under paragraphs (2)(A)(ii) and (2)(B)(ii) relating to review of initial coverage decisions for benefits, if—

''(i) in lieu of the procedures relating to review under paragraphs (2)(A)(ii) and (2)(B)(ii) and in accordance with such regulations (if any) as may be prescribed by the Secretary—

''(I) the aggrieved participant or beneficiary elects in the request for the review an alternative dispute resolution procedure which is available under the plan with respect to similarly situated participants and beneficiaries, or

''(II) in the case of any such plan or portion thereof which is established and maintained pursuant to a bona fide collective bargaining agreement, the plan provides for a procedure by which such disputes are resolved by means of any alternative dispute resolution procedure,

''(ii) the time limits not exceeding the time limits otherwise applicable under paragraphs (2)(A)(ii) and (2)(B)(ii) are incorporated in such alternative dispute resolution procedure,

''(iii) any applicable requirement for review by a physician under paragraph (3), unless waived by the participant or beneficiary (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures), is incorporated in such alternative dispute resolution procedure, and

''(iv) the plan meets the additional requirements of subparagraph (B).

In any case in which a procedure described in subclause (I) or (II) of clause (i) is utilized and an alternative dispute resolution procedure is voluntarily elected by the aggrieved participant or beneficiary, the plan may require or allow (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) the aggrieved participant or beneficiary to waive review of the coverage decision under paragraph (3), to waive further review of the coverage decision under paragraph (4) or section 502, and to elect an alternative means of external review (other than review under paragraph (4)).

''(B) ADDITIONAL REQUIREMENTS.—The requirements of this subparagraph are met if the means of resolution of dispute allow for adequate presentation by the aggrieved participant or beneficiary of scientific and medical evidence supporting the position of such participant or beneficiary.

''(6) PERMITTED ALTERNATIVES TO REQUIRED EXTERNAL REVIEW.—A group health plan shall not be treated as failing to meet the requirements of this subsection in connection with review of coverage decisions under paragraph (4) if the aggrieved participant or beneficiary elects to utilize a procedure in connection with such review which is made generally available under the plan (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) under which—

''(A) the plan agrees in advance of the recommendations of the independent medical expert or experts under paragraph (4)(C)(iii) to render a final decision in accordance with such recommendations, and

''(B) the participant or beneficiary waives in advance any right to review of the final decision under section 502.

''(7) SPECIAL RULE FOR ACCESS TO SPECIALTY CARE.— In the case of a request for advance determination of coverage consisting of a request by a physician for a determination of coverage of the services of a specialist with respect to any condition, if coverage of the services of such specialist for such condition is otherwise provided under the plan, the initial coverage decision referred to in subparagraph (A)(i) or (B)(i) of paragraph (2) shall be issued within the specialty decision period. For purposes of this paragraph, the term 'specialist' means, with respect to a condition, a physician who has a high level of expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to treat the condition.

''(8) GROUP HEALTH PLAN DEFINED.—For purposes of this section—

''(A) IN GENERAL.—The term 'group health plan' shall have the meaning provided in section 733(a).

''(B) TREATMENT OF PARTNERSHIPS.—The provisions of paragraphs (1), (2), and (3) of section 732(d) shall apply.

''(9) OTHER DEFINITIONS.—For purposes of this subsection—

''(A) REQUEST FOR BENEFIT PAYMENTS.—The term 'request for benefit payments' means a request, for payment of benefits by a group health plan for medical care, which is made by or on behalf of a participant or beneficiary after such medical care has been provided.

''(B) REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'required determination of medical necessity' means a determination required under a group health plan solely that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's requirements for medical appropriateness or necessity (which may be subject to exceptions under the plan for fraud or misrepresentation), irrespective of whether the proposed medical care otherwise meets other terms and conditions of coverage, but only if such determination does not constitute an advance determination of coverage (as defined in subparagraph (C)).

''(C) ADVANCE DETERMINATION OF COVERAGE.—The term 'advance determination of coverage' means a determination under a group health plan that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's terms and conditions of coverage (which may be subject to exceptions under the plan for fraud or misrepresentation).

''(D) REQUEST FOR ADVANCE DETERMINATION OF COVERAGE.—The term 'request for advance determination of coverage' means a request for an advance determination of coverage of medical care which is made by or on behalf of a participant or beneficiary before such medical care is provided.

''(E) REQUEST FOR EXPEDITED ADVANCE DETERMINATION OF COVERAGE.—The term 'request for expedited advance determination of coverage' means a request for advance determination of coverage, in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

''(F) REQUEST FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for required determination of medical necessity' means a request for a required determination of medical necessity for medical care which is made by or on behalf of a participant or beneficiary before the medical care is provided.

''(G) REQUEST FOR EXPEDITED REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for expedited required determination of medical necessity' means a request for required determination of medical necessity in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

''(H) URGENT MEDICAL CARE.—The term 'urgent medical care' means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary) that failure to provide the participant or beneficiary with such medical care within 45 days can reasonably be expected to result in either—

''(i) the imminent death of the participant or beneficiary, or

''(ii) the immediate, serious, and irreversible deterioration of the health of the participant or beneficiary which will significantly increase the likelihood of death of, or irreparable harm to, the participant or beneficiary.

''(I) EMERGENCY MEDICAL CARE.—The term 'emergency medical care' means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary)—

''(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

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

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

''(III) serious dysfunction of any bodily organ or part,

or

''(ii) that immediate provision of the care is necessary because the participant or beneficiary has made or is at serious risk of making an attempt to harm himself or herself or another individual.

''(J) INITIAL DECISION PERIOD.—The term 'initial decision period' means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

''(K) INTERNAL REVIEW PERIOD.—The term 'internal review period' means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

''(L) URGENT DECISION PERIOD.—The term 'urgent decision period' means a period of 10 days, or such longer period as may be prescribed in regulations of the Secretary.

''(M) EMERGENCY DECISION PERIOD.—The term 'emergency decision period' means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

''(N) SPECIALTY DECISION PERIOD.—The term 'specialty decision period' means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

''(O) RECONSIDERATION PERIOD.—The term 'reconsideration period' means a period of 25 days, or such longer period as may be prescribed in regulations of the Secretary, except that—

''(i) in the case of a decision involving urgent medical care, such term means the urgent decision period, and

''(ii) in the case of a decision involving emergency medical care, such term means the emergency decision period.

''(P) FILING COMPLETION DATE.—The term 'filing completion date' means, in connection with a group health plan, the date as of which the plan is in receipt of all information reasonably required (in writing or in

such other reasonable form as may be specified by the plan) to make an initial coverage decision.

''(Q) REVIEW FILING DATE.—The term 'review filing date' means, in connection with a group health plan, the date as of which the appropriate named fiduciary (or the independent medical expert or experts in the case of a review under paragraph (4)) is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make a decision to affirm, modify, or reverse a coverage decision.

''(R) MEDICAL CARE.—The term 'medical care' has the meaning provided such term by section 733(a)(2).

''(S) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term by section 733(b)(1).

''(T) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term by section 733(b)(2).

''(U) WRITTEN OR IN WRITING.—

''(i) IN GENERAL.—A request or decision shall be deemed to be 'written' or 'in writing' if such request or decision is presented in a generally recognized printable or electronic format. The Secretary may by regulation provide for presentation of information otherwise required to be in written form in such other forms as may be appropriate under the circumstances.

''(ii) MEDICAL APPROPRIATENESS OR EXPERIMENTAL TREATMENT DETERMINATIONS.—For purposes of this subparagraph, in the case of a request for advance determination of coverage, a request for expedited advance determination of coverage, a request for required determination of medical necessity, or a request for expedited required determination of medical necessity, if the decision on such request is conveyed to the provider of medical care or to the participant or beneficiary by means of telephonic or other electronic communications, such decision shall be treated as a written decision.''.

(b) CIVIL PENALTIES.—

(1) IN GENERAL.—Section 502(c) of such Act (29 U.S.C. 1132(c)) is amended by redesignating paragraphs (6) and (7) as paragraphs (7) and (8), respectively, and by inserting after paragraph (5) the following new paragraph:

''(6)(A)(i) In any case in which—

''(I) a benefit under a group health plan (as defined in section 503(b)(8)) is not timely provided to a participant or beneficiary pursuant to a final decision of the plan which was not in accordance with the terms of the plan or this title, and

''(II) such final decision of the plan is contrary to a recommendation described in section 503(b)(4)(C)(iii),

any person acting in the capacity of a fiduciary of such plan so as to cause such failure may, in the court's discretion, be liable to the aggrieved participant or beneficiary for a civil penalty.

''(ii) Such civil penalty shall be in the amount of up to $250 a day from the date on which the recommendation was made to the plan until the date the failure to provide benefits is corrected, up to a total amount not to exceed $100,000.

''(B) In any action commenced under subsection (a) by a participant or beneficiary with respect to a group health plan (as defined in section 503(b)(8)) in which the plaintiff alleges that a person, in the capacity of a fiduciary and in violation of the terms of the plan or this title, has taken an action resulting in an adverse coverage decision in violation of the terms of the plan, or has failed to take an action for which such person is responsible under the plan and which is necessary under the plan for a favorable coverage decision, upon finding in favor of the plaintiff, if such action was commenced after a final decision of the plan upon review which included a review under section 503(b)(4) or such action was commenced under subsection (b)(4) of this section, the court shall cause to be served on the defendant an order requiring the defendant—

''(i) to cease and desist from the alleged action or failure to act, and

''(ii) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

The remedies provided under this subparagraph shall be in addition to remedies otherwise provided under this section.

''(C)(i) The Secretary may assess a civil penalty against a person acting in the capacity of a fidicuary of one or more group health plans (as defined in section 503(b)(8)) for—

''(I) any pattern or practice of repeated adverse coverage decisions in violation of the terms of the plan or plans or this title, or

''(II) any pattern or practice of repeated violations of the requirements of section 503 with respect to such plan or plans.

Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice.

''(ii) Such penalty shall be in an amount not to exceed the lesser of—

''(I) 5 percent of the aggregate value of benefits shown by the Secretary to have not been provided, or unlawfully delayed in violation of section 503, under such pattern or practice, or

''(II) $100,000.

''(iii) Any person acting in the capacity of a fiduciary of a group health plan or plans who has engaged in any such pattern or practice with respect to such plans, upon the petition of the Secretary, may be removed by the court from that position, and from any other involvement, with respect to such plan or plans, and may be precluded from returning to any such position or involvement for a period determined by the court.''.

(2) CONFORMING AMENDMENT.—Section 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is amended by striking ''(6)'' and inserting ''(7)''.

(c) EXPEDITED COURT REVIEW.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(1) in subsection (a)(8), by striking ''or'' at the end;

(2) in subsection (a)(9), by striking the period and inserting ''; or'';

(3) by adding at the end of subsection (a) the following new paragraph:

''(10) by a participant or beneficiary for appropriate relief under subsection (b)(4).''.

(4) by adding at the end of subsection (b) the following new paragraph:

''(4) In any case in which exhaustion of administrative remedies in accordance with paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) otherwise necessary for an action for relief under paragraph (1)(B) or (3) of subsection (a) has not been obtained and it is demonstrated to the court by means of certification by an appropriate physician that such exhaustion is not reasonably attainable under the facts and circumstances without undue risk of irreparable harm to the health of the participant or beneficiary, a civil action may be brought by a participant or beneficiary to obtain appropriate equitable relief. Any determinations made under paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) made while an action under this paragraph is pending shall be given due consideration by the court in any such action.''.

(d) STANDARD OF REVIEW UNAFFECTED.—The standard of review under section 502 of the Employee Retirement Income Security Act of 1974 (as amended by this section) shall continue on and after the date of the enactment of this Act to be the standard of review which was applicable under such section as of immediately before such date.

(e) CONCURRENT JURISDICTION.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended—

(1) in the first sentence, by striking ''under subsection (a)(1)(B) of this section'' and inserting ''under subsection (a)(1)(A) for relief under subsection (c)(6), under subsection (a)(1)(B), and under subsection (b)(4)''; and

(2) in the last sentence, by striking ''of actions under paragraphs (1)(B) and (7) of subsection (a) of this section'' and inserting ''of actions under paragraph (1)(A) of subsection (a) for relief under subsection (c)(6) and of actions under paragraphs (1)(B) and (7) of subsection (a) and paragraph (4) of subsection (b)''.

SEC. 1202. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to grievances arising in 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 first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

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

(c) COLLECTIVE BARGAINING AGREEMENTS.—Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

SEC. 1301. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Small Business Affordable Health Coverage Act of 1998''.

SEC. 1302. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''SEC. 801. ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a group health plan—

''(1) whose sponsor is (or is deemed under this part to be) described in subsection (b), and

''(2) under which at least one option of health insurance coverage offered by a health insurance issuer (which may include, among other options, managed care options, point of service options, and preferred provider options) is provided to participants and beneficiaries, unless, for any plan year, such coverage remains unavailable to the plan despite good faith efforts exercised by the plan to secure such coverage.

''(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for

periodic meetings on at least an annual basis, as a trade association, an industry association (including a rural electric cooperative association or a rural telephone cooperative association), a professional association, or a chamber of commerce (or similar business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care,

''(2) is established as a permanent entity which receives the active support of its members and collects from its members on a periodic basis dues or payments necessary to maintain eligibility for membership in the sponsor, and

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1) and (2) shall be deemed to be a sponsor described in this subsection.

''SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—The applicable authority shall prescribe by regulation a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

''(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), the applicable authority shall certify an association health plan as meeting the requirements of this part only if the applicable authority is satisfied that—

''(1) such certification—

''(A) is administratively feasible,

''(B) is not adverse to the interests of the individuals covered under the plan, and

''(C) is protective of the rights and benefits of the individuals covered under the plan, and

''(2) the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

''(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of association health plans under this part, including requirements relating to commencement of new benefit options by plans which do not consist of health insurance coverage.

''(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

''SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

''(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if—

''(1) the sponsor (together with its immediate predecessor, if any) has met (or is deemed under this part to have met) for a continuous period of not less than 3 years ending with the date of the application for certification under this part, the requirements of paragraphs (1) and (2) of section 801(b), and

''(2) the sponsor meets (or is deemed under this part to meet) the requirements of section 801(b)(3).

''(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

''(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

''(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(B) LIMITATION.—

''(i) GENERAL RULE.—Except as provided in clauses (ii) and (iii), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

''(ii) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(iii) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, clause (i) shall not apply in the case of any service provider described in subparagraph (A) who is a provider of medical care under the plan.

''(C) SOLE AUTHORITY.—The board has sole authority to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

''(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

''(1) the requirements of subsection (a) and section 801(a)(1) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b), and

''(2) the requirements of section 804(a)(1) shall be deemed met.

''(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

''(1) IN GENERAL.—In the case of a group health plan described in paragraph (2)—

''(A) the requirements of subsection (a) and section 801(a)(1) shall be deemed met,

''(B) the joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection (b) are met, and

''(C) the requirements of section 804 shall be deemed met.

''(2) REQUIREMENTS.—A group health plan is described in this paragraph if—

''(A) the plan is a multiemployer plan, or

''(B) the plan is in existence on April 1, 1997, and would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii).

''SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

''(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

''(1) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer, and

''(2) all individuals commencing coverage under the plan after certification under this part must be—

''(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers, or

''(B) the beneficiaries of individuals described in subparagraph (A).

''(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—

''(1) IN GENERAL.—Subject to paragraph (2), the requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no affiliated member of the sponsor may be offered coverage under the plan as a participating employer, unless—

''(A) the affiliated member was an affiliated member on the date of certification under this part, or

''(B) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

''(2) LIMITATION.—The requirements of this subsection shall apply only in the case of plans which were in existence on the date of the enactment of the Small Business Affordable Health Coverage Act of 1998.

''(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

''(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

''(1) under the terms of the plan, no employer meeting the preceding requirements of this section is excluded as a participating

employer, unless participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met with respect to the excluded employer,

''(2) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan, and

''(3) applicable benefit options under the plan are actively marketed to all eligible participating employers.

''SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

''(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)), and

''(C) incorporates the requirements of section 806.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) The contribution rates for any participating small employer do not vary on the basis of the claims experience of such employer and do not vary on the basis of the type of business or industry in which such employer is engaged.

''(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from

''(i) setting contribution rates based on the claims experience of the plan, or

''(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market,

subject to the requirements of section 702(b) relating to contribution rates.

''(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

''(4) MARKETING REQUIREMENTS.—

''(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

''(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

''(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority may prescribe by regulation as necessary to carry out the purposes of this part.

''(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of any law to the extent that it (1) prohibits an exclusion of a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to matters governed by section 711 or 712.

''SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—

''(1) the benefits under the plan consist solely of health insurance coverage, or

''(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

''(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

''(i) a reserve sufficient for unearned contributions,

''(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities,

''(iii) a reserve sufficient for any other obligations of the plan, and

''(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan,

and

''(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

''(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary (but not more than $200,000). The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

''(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—The requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to $2,000,000, reduced in accordance with a scale, prescribed in regulations of the applicable authority to an amount not less than $500,000, based on the level of aggregate and specific excess/stop loss insurance provided with respect to such plan.

''(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements relating to reserves and excess/stop loss insurance as the applicable authority considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any such plan or any class of such plans.

''(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

''(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

''(f) MEASURES TO ENSURE CONTINUED PAYMENT OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

''(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

''(B) PENALTIES FOR FAILURE TO MAKE PAYMENTS.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment which was not timely paid shall be payable by the plan to the Fund.

''(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

''(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS STOP/LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is,

or that there is reason to believe that there will be, (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2), or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

''(3) ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the 'Association Health Plan Fund'. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B), and earnings on investments of amounts of the Fund under subparagraph (B).

''(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

''(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

''(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term 'aggregate excess/stop loss insurance' means, in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract,

''(B) which is guaranteed renewable, and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term 'specific excess/stop loss insurance' means , in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in such contract in connection with such covered individual,

''(B) which is guaranteed renewable, and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term 'indemnification insurance' means, in connection with an association health plan, a contract—

''(1) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination),

''(2) which is guaranteed renewable and noncancellable for any reason (except as may be provided in regulations of the applicable authority), and

''(3) which allows for payment of premiums by any third party on behalf of the insured plan.

''(i) RESERVES.—For purposes of this section, the term 'reserves' means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as may be prescribed in regulations of the applicable authority.

''(j) REGULATIONS PRESCRIBED UNDER NEGOTIATED RULEMAKING.—The regulations under this section shall be prescribed under negotiated rulemaking in accordance with subchapter III of chapter 5 of title 5, United States Code, except that, in establishing the negotiated rulemaking committee for purposes of such rulemaking, the applicable authority shall include among persons invited to membership on the committee at least one of each of the following:

''(1) a representative of the National Association of Insurance Commissioners,

''(2) a representative of the American Academy of Actuaries,

''(3) a representative of the State governments, or their interests,

''(4) a representative of existing self-insured arrangements, or their interests,

''(5) a representative of associations of the type referred to in section 801(b)(1), or their interests, and

''(6) a representative of multiemployer plans that are group health plans, or their interests.

''SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form prescribed in regulations of the applicable authority, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor, and

''(B) the members of the board of trustees of the plan.

''(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

''(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

''(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

''(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

''(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

''(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

''(E) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the applicable authority as necessary to carry out the purposes of this part.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed in regulations of the applicable authority. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority).

''(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association

health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations, and

''(2) represent such actuary's best estimate of anticipated experience under the plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

''SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

''Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees—

''(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date,

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated, and

''(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed in regulations of the applicable authority.

''SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

''(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

''(b) MANDATORY TERMINATION.—In any case in which—

''(1) the applicable authority has been notified under subsection (a) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements, and

''(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

''SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulations of such Secretary, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

''(b) POWERS AS TRUSTEE.—The Secretary, upon appointment as trustee under subsection (a), shall have the power—

''(1) to do any act authorized by the plan, this title, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan,

''(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee,

''(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations of the Secretary, and applicable provisions of law,

''(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan,

''(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship,

''(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan,

''(7) to issue, publish, or file such notices, statements, and reports as may be required under regulations of the Secretary or by any order of the court,

''(8) to terminate the plan (or provide for its termination accordance with section 809(b)) and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship,

''(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options, and

''(10) to do such other acts as may be necessary to comply with this title or any order of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

''(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

''(1) the sponsor and plan administrator,

''(2) each participant,

''(3) each participating employer, and

''(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

''(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

''(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

''(f) JURISDICTION OF COURT.—

''(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

''(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

''(g) PERSONNEL.—In accordance with regulations of the Secretary, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

''SEC. 811. STATE ASSESSMENT AUTHORITY.

''(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the

date of the enactment of the Small Business Affordable Health Coverage Act of 1998.

''(b) CONTRIBUTION TAX.—For purposes of this section, the term 'contribution tax' imposed by a State on an association health plan means any tax imposed by such State if—

''(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals,

''(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan,

''(3) such tax is otherwise nondiscriminatory, and

''(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

''SEC. 812. SPECIAL RULES FOR CHURCH PLANS.

''(a) ELECTION FOR CHURCH PLANS.—Notwithstanding section 4(b)(2), if a church, a convention or association of churches, or an organization described in section 3(33)(C)(i) maintains a church plan which is a group health plan (as defined in section 733(a)(1)), and such church, convention, association, or organization makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulation prescribe), then the provisions of this section shall apply to such plan, with respect to benefits provided under such plan consisting of medical care, as if section 4(b)(2) did not contain an exclusion for church plans. Nothing in this subsection shall be construed to render any other section of this title applicable to church plans, except to the extent that such other section is incorporated by reference in this section.

''(b) EFFECT OF ELECTION.—

''(1) PREEMPTION OF STATE INSURANCE LAWS REGULATING COVERED CHURCH PLANS.—Subject to paragraphs (2) and (3), this section shall supersede any and all State laws which regulate insurance insofar as they may now or hereafter regulate church plans to which this section applies or trusts established under such church plans.

''(2) GENERAL STATE INSURANCE REGULATION UNAFFECTED.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (3), nothing in this section shall be construed to exempt or relieve any person from any provision of State law which regulates insurance.

''(B) CHURCH PLANS NOT TO BE DEEMED INSURANCE COMPANIES OR INSURERS.—Neither a church plan to which this section applies, nor any trust established under such a church plan, shall be deemed to be an insurance company or other insurer or to be engaged in the business of insurance for purposes of any State law purporting to regulate insurance companies or insurance contracts.

''(3) PREEMPTION OF CERTAIN STATE LAWS RELATING TO PREMIUM RATE REGULATION AND BENEFIT MANDATES.—The provisions of subsections (a)(2)(B) and (b) of section 805 shall apply with respect to a church plan to which this section applies in the same manner and to the same extent as such provisions apply with respect to association health plans.

''(4) DEFINITIONS.—For purposes of this subsection—

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

''(B) STATE.—The term 'State' includes a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of church plans covered by this section.

''(c) REQUIREMENTS FOR COVERED CHURCH PLANS.—

''(1) FIDUCIARY RULES AND EXCLUSIVE PURPOSE.—A fiduciary shall discharge his duties with respect to a church plan to which this section applies—

''(A) for the exclusive purpose of:

''(i) providing benefits to participants and their beneficiaries; and

''(ii) defraying reasonable expenses of administering the plan;

''(B) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

''(C) in accordance with the documents and instruments governing the plan.

The requirements of this paragraph shall not be treated as not satisfied solely because the plan assets are commingled with other church assets, to the extent that such plan assets are separately accounted for.

''(2) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every church plan to which this section applies shall—

''(A) 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;

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

''(C) provide a written statement to each participant describing the procedures established pursuant to this paragraph.

''(3) ANNUAL STATEMENTS.—In accordance with regulations of the Secretary, every church plan to which this section applies shall file with the Secretary an annual statement—

''(A) stating the names and addresses of the plan and of the church, convention, or association maintaining the plan (and its principal place of business);

''(B) certifying that it is a church plan to which this section applies and that it complies with the requirements of paragraphs (1) and (2);

''(C) identifying the States in which participants and beneficiaries under the plan are or likely will be located during the 1-year period covered by the statement; and

''(D) containing a copy of a statement of actuarial opinion signed by a qualified actuary that the plan maintains capital, reserves, insurance, other financial arrangements, or any combination thereof adequate to enable the plan to fully meet all of its financial obligations on a timely basis.

''(4) DISCLOSURE.—At the time that the annual statement is filed by a church plan with the Secretary pursuant to paragraph (3), a copy of such statement shall be made available by the Secretary to the State insurance commissioner (or similar official) of any State. The name of each church plan and sponsoring organization filing an annual statement in compliance with paragraph (3) shall be published annually in the Federal Register.

''(c) ENFORCEMENT.—The Secretary may enforce the provisions of this section in a manner consistent with section 502, to the extent applicable with respect to actions under section 502(a)(5), and with section 3(33)(D), except that, other than for the purpose of seeking a temporary restraining order, a civil action may be brought with respect to the plan's failure to meet any requirement of this section only if the plan fails to correct its failure within the correction period described in section 3(33)(D). The other provisions of part 5 (except sections 501(a), 503, 512, 514, and 515) shall apply with respect to the enforcement and administration of this section.

''(d) DEFINITIONS AND OTHER RULES.—For purposes of this section—

''(1) IN GENERAL.—Except as otherwise provided in this section, any term used in this section which is defined in any provision of this title shall have the definition provided such term by such provision.

''(2) SEMINARY STUDENTS.—Seminary students who are enrolled in an institution of higher learning described in section 3(33)(C)(iv) and who are treated as participants under the terms of a church plan to which this section applies shall be deemed to be employees as defined in section 3(6) if the number of such students constitutes an insignificant portion of the total number of individuals who are treated as participants under the terms of the plan.

''SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(2) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

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

''(5) APPLICABLE AUTHORITY.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'applicable authority' means, in connection with an association health plan—

''(i) the State recognized pursuant to subsection (c) of section 506 as the State to which authority has been delegated in connection with such plan, or

''(ii) if there if no State referred to in clause (i), the Secretary.

''(B) EXCEPTIONS.—

''(i) JOINT AUTHORITIES.—Where such term appears in section 808(3), section 807(e) (in the first instance), section 809(a) (in the second instance), section 809(a) (in the fourth instance), and section 809(b)(1), such term means, in connection with an association health plan, the Secretary and the State referred to in subparagraph (A)(i) (if any) in connection with such plan.

''(ii) REGULATORY AUTHORITIES.—Where such term appears in section 802(a) (in the first instance), section 802(d), section 802(e), section 803(d), section 805(a)(5), section 806(a)(2), section 806(b), section 806(c), section 806(d), paragraphs (1)(A) and (2)(A) of section 806(g), section 806(h), section 806(i),

section 807(a) (in the second instance), section 807(b), section 807(d), section 807(e) (in the second instance), section 808 (in the matter after paragraph (3)), and section 809(a) (in the third instance), such term means, in connection with an association health plan, the Secretary.

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning provided in section 733(d)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(9) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(10) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation.

''(11) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor, a person eligible to be a member of the sponsor or, in the case of a sponsor with member associations, a person who is a member, or is eligible to be a member, of a member association.

''(12) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

''(13) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

''(b) RULES OF CONSTRUCTION.—

''(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(A) in the case of a partnership, the term 'employer' (as defined in section (3)(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section (3)(6)) includes any partner in relation to the partnership, and

''(B) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

''(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

''(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.''.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

''(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

''(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

''(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

''(B) In any case in which health insurance coverage of any policy type is offered under an association health plan in a State and the filing, with the applicable State authority, of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

''(3) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

''(4) For purposes of this subsection, the term 'association health plan' has the meaning provided in section 801(a), and the terms 'health insurance coverage', 'participating employer', and 'health insurance issuer' have the meanings provided such terms in section 811, respectively.''.

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and which does not provide medical care (within the meaning of section 733(a)(2)),'' after ''arrangement,'', and by striking ''title.'' and inserting ''title, and''; and

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

''(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.''.

(4) Section 514(e) of such Act (as redesignated by paragraph (2)(C)) is amended—

(A) by striking ''Nothing'' and inserting ''(1) Except as provided in paragraph (2), nothing''; and

(B) by adding at the end the following new paragraph:

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Patient Protection Act of 1998 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.''.

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of an association health plan under part 8.''.

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: ''An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.''.

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(f) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''Sec. 801. Association health plans.
''Sec. 802. Certification of association health plans.
''Sec. 803. Requirements relating to sponsors and boards of trustees.
''Sec. 804. Participation and coverage requirements.
''Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.
''Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
''Sec. 807. Requirements for application and related requirements.
''Sec. 808. Notice requirements for voluntary termination.

''Sec. 809. Corrective actions and mandatory termination.
''Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
''Sec. 811. State assessment authority.
''Sec. 812. Special rules for church plans.
''Sec. 813. Definitions and rules of construction.''.

SEC. 1303. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting ''for any plan year of any such plan, or any fiscal year of any such other arrangement;'' after ''single employer'', and by inserting ''during such year or at any time during the preceding 1-year period'' after ''control group'';

(2) in clause (iii)—

(A) by striking ''common control shall not be based on an interest of less than 25 percent'' and inserting ''an interest of greater than 25 percent may not be required as the minimum interest necessary for common control''; and

(B) by striking ''similar to'' and inserting ''consistent and coextensive with'';

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement,''.

SEC. 1304. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

''(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E),''.

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

''(C) For purposes of subparagraph (A)(i)(II), a plan or other arrangement shall be treated as established or maintained in accordance with this subparagraph only if the following requirements are met:

''(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

''(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement; or

''(II) pay a commission or any other type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations of the Secretary), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement;

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

''(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are identified to the plan or arrangement and who are neither—

''(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit); nor

''(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment);

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Small Business Affordable Health Coverage Act of 1998 and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

''(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary that the plan or other arrangement meets the requirements of clauses (i) and (ii).

''(D) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

''(i) all of the benefits provided under the plan or arrangement consist of health insurance coverage; or

''(ii)(I) the plan or arrangement is a multiemployer plan; and

''(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

''(E) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

''(i) the plan or arrangement is in effect as of the date of the enactment of the Small Business Affordable Health Coverage Act of 1998, or

''(ii) the employee organization or other entity sponsoring the plan or arrangement—

''(I) has been in existence for at least 3 years or is affiliated with another employee organization which has been in existence for at least 3 years, or

''(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement.''.

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: ''Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii).''.

SEC. 1305. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting ''(a)'' after ''SEC. 501.''; and

(2) by adding at the end the following new subsection:

''(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

''(1) being an association health plan which has been certified under part 8;

''(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

''(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met;

shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.''.

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

''(n)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

''(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

''(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

''(2) Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

''(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

''(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

''(3) The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.''.

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) (as amended by title I) is amended by adding at the end the following new subsection:

''(c) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.''.

SEC. 1306. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(c) RESPONSIBILITY OF STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8,

''(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8, or

''(C) any combination of the Secretary's authority authorized to be delegated under subparagraphs (A) and (B).

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

''(3) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular association health plan, as the State to which all authority has been delegated pursuant to such agreements in connection with such plan. In carrying out this paragraph, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.''.

SEC. 1307. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by sections 1302, 1305, and 1306 shall take effect on January 1, 2000. The amendments made by sections 1303 and 1304 shall take effect on the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this Act before January 1, 2000.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 1302) does not apply in connection with an association health plan (certified under part 8 of subtitle B of title I of such Act) existing on April 1, 1997, if no benefits provided thereunder as of the date of the enactment of this Act consist of health insurance coverage (as defined in section 733(b)(1) of such Act).

(c) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 813(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this Act)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act,

(B) the requirements of sections 801(a)(1) and 803(a)(1) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement,

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote, and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement,

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement,

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan,'' ''medical care,'' and ''participating employer'' shall have the meanings provided in section 813 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''association health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

(d) PILOT PROGRAM FOR SELF-INSURED ASSOCIATION HEALTH PLANS.—

(1) IN GENERAL.—During the pilot program period, association health plans which offer benefit options which do not consist of health insurance coverage may be certified under part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 only if such plans consist of the following:

(A) plans which offered such coverage on the date of the enactment of this Act,

(B) plans under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

(C) plans whose eligible participating employers represent one or more trades or businesses, or one or more industries, which have been indicated as having average or above-average health insurance risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, and other means demonstrated by such plans in accordance with regulations which the Secretary shall prescribe, including (but not limited to) the following: agriculture; automobile dealerships; barbering and cosmetology; child care; construction; dance, theatrical, and orchestra productions; disinfecting and pest control; eating and drinking establishments; fishing; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; sanitary services; transportation (local and freight); and warehousing.

(2) PILOT PROGRAM PERIOD.—For purposes of this subsection, the term ''pilot program period'' means the 5-year period beginning on January 1, 1999.

TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

SEC. 2001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2706. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

''(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

''(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan, the plan or issuer with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan or health insurance coverage offered in connection with the plan.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, 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 group health plan 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) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

''(1) IN GENERAL.—To the extent that the group health plan (or health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974), except for items or services specifically excluded—

''(A) the plan or issuer shall provide 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 in order to determine whether emergency medical care (as so defined) is required, and

''(B) the plan or issuer shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in section 503(b)(9)(I) of such Act.

''(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), 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 section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974) provided to such similarly situated participants and beneficiaries under the plan.

''(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan)—

''(A) provides benefits under the terms of the plan consisting of—

''(i) routine gynecological care (such as preventive women's health examinations), or

''(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

''(B) the plan 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, then the plan (or issuer) shall meet the requirements of paragraph (2).

''(2) REQUIREMENTS.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan (or issuer)—

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

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

''(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

''(d) PATIENT ACCESS TO PEDIATRIC CARE.—

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

''(e) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.''.

(c) EFFECTIVE DATE AND RELATED RULES.—

(1) IN GENERAL.—The amendments made by this section 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, except that the Secretary of Health and Human Services may issue regulations before such date under such amendments. The Secretary shall first issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

(2) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer 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 or issuer has sought to comply in good faith with such requirement.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this paragraph, any plan amendments made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 2002. REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO OFFER OPTION OF POINT-OF-SERVICE COVERAGE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act is amended by inserting after section 2713 the following new section:

''SEC. 2714. REQUIRING OFFERING OF OPTION OF POINT-OF-SERVICE COVERAGE.

''(a) REQUIREMENT TO OFFER COVERAGE OPTION TO CERTAIN EMPLOYERS.—Except as provided in subsection (c), any health insurance issuer which—

''(1) is a health maintenance organization (as defined in section 2791(b)(3)), and

''(2) which provides for coverage of services of one or more classes of health care professionals under health insurance coverage offered in connection with a group health plan only if such services are furnished exclusively through health care professionals within such class or classes who are members of a closed panel of health care professionals,

the issuer shall make available to the plan sponsor in connection with such a plan a coverage option which provides for coverage of such services which are furnished through such class (or classes) of health care professionals regardless of whether or not the professionals are members of such panel.

''(b) REQUIREMENT TO OFFER SUPPLEMENTAL COVERAGE TO PARTICIPANTS IN CERTAIN CASES.—Except as provided in subsection (c), if a health insurance issuer makes available a coverage option under and described in subsection (a) to a plan sponsor of a group health plan and the sponsor declines to contract for such coverage option, then the issuer shall make available in the individual insurance market to each participant in the group health plan optional separate supplemental health insurance coverage in the individual health insurance market which consists of services identical to those provided under such coverage provided through the closed panel under the group health plan but are furnished exclusively by health care professionals who are not members of such a closed panel.

''(c) EXCEPTIONS.—

''(1) OFFERING OF NON-PANEL OPTION.—Subsections (a) and (b) shall not apply with respect to a group health plan if the plan offers a coverage option that provides coverage for services that may be furnished by a class or classes of health care professionals who are not in a closed panel. This paragraph shall be applied separately to distinguishable groups of employees under the plan.

''(2) AVAILABILITY OF COVERAGE THROUGH HEALTHMART.—Subsections (a) and (b) shall not apply to a group health plan if the health insurance coverage under the plan is made available through a HealthMart (as defined in section 2801) and if any health insurance coverage made available through the HealthMart provides for coverage of the services of any class of health care professionals other than through a closed panel of professionals.

''(3) RELICENSURE EXEMPTION.—Subsections (a) and (b) shall not apply to a health maintenance organization in a State in any case in which—

''(A) the organization demonstrates to the applicable authority that the organization has made a good faith effort to obtain (but has failed to obtain) a contract between the organization and any other health insurance issuer providing for the coverage option or supplemental coverage described in subsection (a) or (b), as the case may be, within the applicable service area of the organization, and

''(B) the State requires the organization to receive or qualify for a separate license, as an indemnity insurer or otherwise, in order to offer such coverage option or supplemental coverage, respectively.

The applicable authority may require that the organization demonstrate that it meets the requirements of the previous sentence no more frequently that once every two years.

''(4) INCREASED COSTS.—Subsections (a) and (b) shall not apply to a health maintenance organization if the organization demonstrates to the applicable authority, in accordance with generally accepted actuarial practice, that, on either a prospective or retroactive basis, the premium for the coverage option or supplemental coverage required to be made available under such respective subsection exceeds by more than 1 percent the premium for the coverage consisting of services which are furnished through a closed panel of health care professionals in the

class or classes involved. The applicable authority may require that the organization demonstrate such an increase no more frequently that once every two years. This paragraph shall be applied on an average per enrollee or similar basis.

''(5) COLLECTIVE BARGAINING AGREEMENTS.—Subsections (a) and (b) shall not apply in connection with a group health plan if the plan is established or maintained pursuant to one or more collective bargaining agreements.

''(d) DEFINITIONS.—For purposes of this section:

''(1) COVERAGE THROUGH CLOSED PANEL.—Health insurance coverage for a class of health care professionals shall be treated as provided through a closed panel of such professionals only if such coverage consists of coverage of items or services consisting of professionals services which are reimbursed for or provided only within a limited network of such professionals.

''(2) HEALTH CARE PROFESSIONAL.—The term 'health care professional' has the meaning given such term in section 2706(a)(2).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to coverage offered on or after January 1 of the second calendar year following the date of the enactment of this Act.

Subtitle B—Patient Access to Information

SEC. 2101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (as amended by subtitle A of this title) is amended further by adding at the end the following new section:

''SEC. 2707. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

''(a) DISCLOSURE REQUIREMENT.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator of such plan on a timely basis with the information necessary to enable the administrator to include in the summary plan description of the plan required under section 102 of the Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act for different options of coverage) the information required under subsections (b), (c), (d), and (e)(2)(A). To the extent that any such issuer provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the coverage includes emergency medical care (including the extent to which the coverage provides for access to urgent care centers), and any definitions provided under in connection with such coverage for the relevant coverage terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the coverage includes benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used in connection with such coverage for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided in connection with such coverage for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided in connection with such coverage for the relevant coverage terminology referring to such limited or excluded care.

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the coverage, in including emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such coverage.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted in connection with such coverage pursuant to section 503(b) of the Employee Retirement Income Security Act of 1974, including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications, and

''(ii) the actual plan provisions setting forth the benefits available under the plan,

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

''(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or

programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.''.

SEC. 2102. REPORTING ON FRAUD AND ABUSE ENFORCEMENT ACTIVITIES.

The General Accounting Office shall—

(1) monitor—

(A) the compliance of the Department of Justice and all United States Attorneys–with the guideline entitled ''Guidance on the Use of the False Claims Act in Civil Health Care Matters'' issued by the Department on June 3, 1998, including any revisions to such guideline, and

(B) the compliance of the Office of the Inspector General of the Department of Health and Human Services with the protocols and guidelines entitled ''National Project Protocols—Best Practice Guidelines'' issued by the Inspector General on June 3, 1998, including any revisions to such protocols and guidelines, and

(2) submit a report on such compliance to the Committee on Commerce of the House of Representatives not later than February 1, 1999, and every year thereafter for a period of four years ending February 1, 2002.

SEC. 2103. EFFECTIVE DATE.

(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 first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

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

Subtitle C—HealthMarts

SEC. 2201. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Health Care Consumer Empowerment Act of 1998''.

SEC. 2202. EXPANSION OF CONSUMER CHOICE THROUGH HEALTHMARTS.

The Public Health Service Act is amended by adding at the end the following new title:

''TITLE XXVIII—HEALTHMARTS

''SEC. 2801. DEFINITION OF HEALTHMART.

''(a) IN GENERAL.—For purposes of this title, the term 'HealthMart' means a legal entity that meets the following requirements:

''(1) ORGANIZATION.—The HealthMart is a nonprofit organization operated under the direction of a board of directors which is composed of representatives of not fewer than 2 and in equal numbers from each of the following:

''(A) Small employers.

''(B) Employees of small employers.

''(C) Health care providers, which may be physicians, other health care professionals, health care facilities, or any combination thereof.

''(D) Entities, such as insurance companies, health maintenance organizations, and licensed provider-sponsored organizations, that underwrite or administer health benefits coverage.

''(2) OFFERING HEALTH BENEFITS COVERAGE.—

''(A) IN GENERAL.—The HealthMart, in conjunction with those health insurance issuers that offer health benefits coverage through the HealthMart, makes available health benefits coverage in the manner described in subsection (b) to all small employers and eligible employees in the manner described in subsection (c)(2) at rates (including employer's and employee's share) that are established by the health insurance issuer on a policy or product specific basis and that may vary only as permissible under State law. A HealthMart is deemed to be a group health plan for purposes of applying section 702 of the Employee Retirement Income Security Act of 1974, section 2702 of this Act, and section 9802(b) of the Internal Revenue Code of 1986 (which limit variation among similarly situated individuals of required premiums for health benefits coverage on the basis of health status-related factors).

''(B) NONDISCRIMINATION IN COVERAGE OFFERED.—

''(i) IN GENERAL.—Subject to clause (ii), the HealthMart may not offer health benefits coverage to an eligible employee in a geographic area (as specified under paragraph (3)(A)) unless the same coverage is offered to all such employees in the same geographic area. Section 2711(a)(1)(B) of this Act limits denial of enrollment of certain eligible individuals under health benefits coverage in the small group market.

''(ii) CONSTRUCTION.—Nothing in this title shall be construed as requiring or permitting a health insurance issuer to provide coverage outside the service area of the issuer, as approved under State law.

''(C) NO FINANCIAL UNDERWRITING.—The HealthMart provides health benefits coverage only through contracts with health insurance issuers and does not assume insurance risk with respect to such coverage.

(D) MINIMUM COVERAGE.—By the end of the first year of its operation and thereafter, the HealthMart maintains not fewer than 10 purchasers and 100 members.

''(3) GEOGRAPHIC AREAS.—

''(A) SPECIFICATION OF GEOGRAPHIC AREAS.—The HealthMart shall specify the geographic area (or areas) in which it makes available health benefits coverage offered by health insurance issuers to small employers. Such an area shall encompass at least one entire county or equivalent area.

''(B) MULTISTATE AREAS.—In the case of a HealthMart that serves more than one State, such geographic areas may be areas that include portions of two or more contiguous States.

''(C) MULTIPLE HEALTHMARTS PERMITTED IN SINGLE GEOGRAPHIC AREA.—Nothing in this

title shall be construed as preventing the establishment and operation of more than one HealthMart in a geographic area or as limiting the number of HealthMarts that may operate in any area.

''(4) PROVISION OF ADMINISTRATIVE SERVICES TO PURCHASERS.—

''(A) IN GENERAL.—The HealthMart provides administrative services for purchasers. Such services may include accounting, billing, enrollment information, and employee coverage status reports.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a HealthMart from serving as an administrative service organization to any entity.

''(5) DISSEMINATION OF INFORMATION.—The HealthMart collects and disseminates (or arranges for the collection and dissemination of) consumer-oriented information on the scope, cost, and enrollee satisfaction of all coverage options offered through the HealthMart to its members and eligible individuals. Such information shall be defined by the HealthMart and shall be in a manner appropriate to the type of coverage offered. To the extent practicable, such information shall include information on provider performance, locations and hours of operation of providers, outcomes, and similar matters. Nothing in this section shall be construed as preventing the dissemination of such information or other information by the HealthMart or by health insurance issuers through electronic or other means.

''(6) FILING INFORMATION.—The HealthMart—

''(A) files with the applicable Federal authority information that demonstrates the HealthMart's compliance with the applicable requirements of this title; or

''(B) in accordance with rules established under section 2803(a), files with a State such information as the State may require to demonstrate such compliance.

''(b) HEALTH BENEFITS COVERAGE REQUIREMENTS.—

''(1) COMPLIANCE WITH CONSUMER PROTECTION REQUIREMENTS.—Any health benefits coverage offered through a HealthMart shall—

''(A) be underwritten by a health insurance issuer that—

''(i) is licensed (or otherwise regulated) under State law (or is a community health organization that is offering health insurance coverage pursuant to section 330B(a)),

''(ii) meets all applicable State standards relating to consumer protection, subject to section 2802(b), and

''(iii) offers the coverage under a contract with the HealthMart;

''(B) subject to paragraph (2), be approved or otherwise permitted to be offered under State law; and

''(C) provide full portability of creditable coverage for individuals who remain members of the same HealthMart notwithstanding that they change the employer through which they are members in accordance with the provisions of the parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and titles XXII and XXVII of this Act, so long as both employers are purchasers in the HealthMart.

''(2) ALTERNATIVE PROCESS FOR APPROVAL OF HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMINATION OR DELAY.—

''(A) IN GENERAL.—The requirement of paragraph (1)(B) shall not apply to a policy or product of health benefits coverage offered in a State if the health insurance issuer seeking to offer such policy or product files an application to waive such requirement with the applicable Federal authority, and the authority determines, based on the application and other evidence presented to the authority, that—

''(i) either (or both) of the grounds described in subparagraph (B) for approval of the application has been met; and

''(ii) the coverage meets the applicable State standards (other than those that have been preempted under section 2802).

''(B) GROUNDS.—The grounds described in this subparagraph with respect to a policy or product of health benefits coverage are as follows:

''(i) FAILURE TO ACT ON POLICY, PRODUCT, OR RATE APPLICATION ON A TIMELY BASIS.—The State has failed to complete action on the policy or product (or rates for the policy or product) within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

''(ii) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The State has denied such an application and—

''(I) the standards or review process imposed by the State as a condition of approval of the policy or product imposes either any material requirements, procedures, or standards to such policy or product that are not generally applicable to other policies and products offered or any requirements that are preempted under section 2802; or

''(II) the State requires the issuer, as a condition of approval of the policy or product, to offer any policy or product other than such policy or product.

''(C) ENFORCEMENT.—In the case of a waiver granted under subparagraph (A) to an issuer with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an issuer and its health insurance coverage with the applicable State standards described in subparagraph (A)(ii). Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other health insurance issuers and plans, without discrimination based on the type of issuer to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under subparagraph (A).

''(3) EXAMPLES OF TYPES OF COVERAGE.—The health benefits coverage made available through a HealthMart may include, but is not limited to, any of the following if it meets the other applicable requirements of this title:

''(A) Coverage through a health maintenance organization.

''(B) Coverage in connection with a preferred provider organization.

''(C) Coverage in connection with a licensed provider-sponsored organization.

''(D) Indemnity coverage through an insurance company.

''(E) Coverage offered in connection with a contribution into a medical savings account or flexible spending account.

''(F) Coverage that includes a point-of-service option.

''(G) Coverage offered by a community health organization (as defined in section 330B(e)).

''(H) Any combination of such types of coverage.

''(4) WELLNESS BONUSES FOR HEALTH PROMOTION.—Nothing in this title shall be construed as precluding a health insurance issuer offering health benefits coverage through a HealthMart from establishing premium discounts or rebates for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention so long as such programs are agreed to in advance by the HealthMart and comply with all other provisions of this title and do not discriminate among similarly situated members.

''(c) PURCHASERS; MEMBERS; HEALTH INSURANCE ISSUERS.—

''(1) PURCHASERS.—

''(A) IN GENERAL.—Subject to the provisions of this title, a HealthMart shall permit any small employer to contract with the HealthMart for the purchase of health benefits coverage for its employees and dependents of those employees and may not vary conditions of eligibility (including premium rates and membership fees) of a small employer to be a purchaser.

''(B) ROLE OF ASSOCIATIONS, BROKERS, AND LICENSED HEALTH INSURANCE AGENTS.—Nothing in this section shall be construed as preventing an association, broker, licensed health insurance agent, or other entity from assisting or representing a HealthMart or small employers from entering into appropriate arrangements to carry out this title.

''(C) PERIOD OF CONTRACT.—The HealthMart may not require a contract under subparagraph (A) between a HealthMart and a purchaser to be effective for a period of longer than 12 months. The previous sentence shall not be construed as preventing such a contract from being extended for additional 12-month periods or preventing the purchaser from voluntarily electing a contract period of longer than 12 months.

''(D) EXCLUSIVE NATURE OF CONTRACT.—Such a contract shall provide that the purchaser agrees not to obtain or sponsor health benefits coverage, on behalf of any eligible employees (and their dependents), other than through the HealthMart. The previous sentence shall not apply to an eligible individual who resides in an area for which no coverage is offered by any health insurance issuer through the HealthMart.

''(2) MEMBERS.—

''(A) IN GENERAL.—Under rules established to carry out this title, with respect to a small employer that has a purchaser contract with a HealthMart, individuals who are employees of the employer may enroll for health benefits coverage (including coverage for dependents of such enrolling employees) offered by a health insurance issuer through the HealthMart.

''(B) NONDISCRIMINATION IN ENROLLMENT.—A HealthMart may not deny enrollment as a member to an individual who is an employee (or dependent of such an employee) eligible to be so enrolled based on health status-related factors, except as may be permitted consistent with section 2742(b).

''(C) ANNUAL OPEN ENROLLMENT PERIOD.—In the case of members enrolled in health benefits coverage offered by a health insurance issuer through a HealthMart, subject to subparagraph (D), the HealthMart shall provide for an annual open enrollment period of 30 days during which such members may change the coverage option in which the members are enrolled.

''(D) RULES OF ELIGIBILITY.—Nothing in this paragraph shall preclude a HealthMart from establishing rules of employee eligibility for enrollment and reenrollment of members during the annual open enrollment period under subparagraph (C). Such rules shall be applied consistently to all purchasers and members within the HealthMart and shall not be based in any manner on health status-related factors and may not conflict with sections 2701 and 2702 of this Act.

''(3) HEALTH INSURANCE ISSUERS.—

''(A) PREMIUM COLLECTION.—The contract between a HealthMart and a health insurance issuer shall provide, with respect to a

member enrolled with health benefits coverage offered by the issuer through the HealthMart, for the payment of the premiums collected by the HealthMart (or the issuer) for such coverage (less a pre-determined administrative charge negotiated by the HealthMart and the issuer) to the issuer.

''(B) SCOPE OF SERVICE AREA.—Nothing in this title shall be construed as requiring the service area of a health insurance issuer with respect to health insurance coverage to cover the entire geographic area served by a HealthMart.

''(C) AVAILABILITY OF COVERAGE OPTIONS.—A HealthMart shall enter into contracts with one or more health insurance issuers in a manner that assures that at least 2 health insurance coverage options are made available in the geographic area specified under subsection (a)(3)(A).

''(d) PREVENTION OF CONFLICTS OF INTEREST.—

''(1) FOR BOARDS OF DIRECTORS.—A member of a board of directors of a HealthMart may not serve as an employee or paid consultant to the HealthMart, but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or committees thereof.

''(2) FOR BOARDS OF DIRECTORS OR EMPLOYEES.—An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a HealthMart or as an employee of the HealthMart, if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in a organization from whom the HealthMart receives contributions, grants, or other funds not connected with a contract for coverage through the HealthMart.

''(3) EMPLOYMENT AND EMPLOYEE REPRESENTATIVES.—

''(A) IN GENERAL.—An individual who is serving on a board of directors of a HealthMart as a representative described in subparagraph (A) or (B) of section 2801(a)(1) shall not be employed by or affiliated with a health insurance issuer or be licensed as or employed by or affiliated with a health care provider.

''(B) CONSTRUCTION.—For purposes of subparagraph (A), the term ''affiliated'' does not include membership in a health benefits plan or the obtaining of health benefits coverage offered by a health insurance issuer.

''(e) CONSTRUCTION.—

''(1) NETWORK OF AFFILIATED HEALTHMARTS.—Nothing in this section shall be construed as preventing one or more HealthMarts serving different areas (whether or not contiguous) from providing for some or all of the following (through a single administrative organization or otherwise):

''(A) Coordinating the offering of the same or similar health benefits coverage in different areas served by the different HealthMarts.

''(B) Providing for crediting of deductibles and other cost-sharing for individuals who are provided health benefits coverage through the HealthMarts (or affiliated HealthMarts) after—

''(i) a change of employers through which the coverage is provided, or

''(ii) a change in place of employment to an area not served by the previous HealthMart.

''(2) PERMITTING HEALTHMARTS TO ADJUST DISTRIBUTIONS AMONG ISSUERS TO REFLECT RELATIVE RISK OF ENROLLEES.—Nothing in this section shall be construed as precluding a HealthMart from providing for adjustments in amounts distributed among the health insurance issuers offering health benefits coverage through the HealthMart based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.

''(3) APPLICATION OF UNIFORM MINIMUM PARTICIPATION AND CONTRIBUTION RULES.—Nothing in this section shall be construed as precluding a HealthMart from establishing minimum participation and contribution rules (described in section 2711(e)(1)) for small employers that apply to become purchasers in the HealthMart, so long as such rules are applied uniformly for all health insurance issuers.

''SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIREMENTS.

''(a) AUTHORITY OF STATES.—Nothing in this section shall be construed as preempting State laws relating to the following:

''(1) The regulation of underwriters of health coverage, including licensure and solvency requirements.

''(2) The application of premium taxes and required payments for guaranty funds or for contributions to high-risk pools.

''(3) The application of fair marketing requirements and other consumer protections (other than those specifically relating to an item described in subsection (b)).

''(4) The application of requirements relating to the adjustment of rates for health insurance coverage.

''(b) TREATMENT OF BENEFIT AND GROUPING REQUIREMENTS.—State laws insofar as they relate to any of the following are superseded and shall not apply to health benefits coverage made available through a HealthMart:

''(1) Benefit requirements for health benefits coverage offered through a HealthMart, including (but not limited to) requirements relating to coverage of specific providers, specific services or conditions, or the amount, duration, or scope of benefits, but not including requirements to the extent required to implement title XXVII or other Federal law and to the extent the requirement prohibits an exclusion of a specific disease from such coverage.

''(2) Requirements (commonly referred to as fictitious group laws) relating to grouping and similar requirements for such coverage to the extent such requirements impede the establishment and operation of HealthMarts pursuant to this title.

''(3) Any other requirements (including limitations on compensation arrangements) that, directly or indirectly, preclude (or have the effect of precluding) the offering of such coverage through a HealthMart, if the HealthMart meets the requirements of this title.

Any State law or regulation relating to the composition or organization of a HealthMart is preempted to the extent the law or regulation is inconsistent with the provisions of this title.

''(c) APPLICATION OF ERISA FIDUCIARY AND DISCLOSURE REQUIREMENTS.—The board of directors of a HealthMart is deemed to be a plan administrator of an employee welfare benefit plan which is a group health plan for purposes of applying parts 1 and 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and those provisions of part 5 of such subtitle which are applicable to enforcement of such parts 1 and 4, and the HealthMart shall be treated as such a plan and the enrollees shall be treated as participants and beneficiaries for purposes of applying such provisions pursuant to this subsection.

''(d) APPLICATION OF ERISA RENEWABILITY PROTECTION.—A HealthMart is deemed to be group health plan that is a multiple employer welfare arrangement for purposes of applying section 703 of the Employee Retirement Income Security Act of 1974.

''(e) APPLICATION OF RULES FOR NETWORK PLANS AND FINANCIAL CAPACITY.—The provisions of subsections (c) and (d) of section 2711 apply to health benefits coverage offered by a health insurance issuer through a HealthMart.

''(f) CONSTRUCTION RELATING TO OFFERING REQUIREMENT.—Nothing in section 2711(a) of this Act or 703 of the Employee Retirement Income Security Act of 1974 shall be construed as permitting the offering outside the HealthMart of health benefits coverage that is only made available through a HealthMart under this section because of the application of subsection (b).

''(g) APPLICATION TO GUARANTEED RENEWABILITY REQUIREMENTS IN CASE OF DISCONTINUATION OF AN ISSUER.—For purposes of applying section 2712 in the case of health insurance coverage offered by a health insurance issuer through a HealthMart, if the contract between the HealthMart and the issuer is terminated and the HealthMart continues to make available any health insurance coverage after the date of such termination, the following rules apply:

''(1) RENEWABILITY.—The HealthMart shall fulfill the obligation under such section of the issuer renewing and continuing in force coverage by offering purchasers (and members and their dependents) all available health benefits coverage that would otherwise be available to similarly-situated purchasers and members from the remaining participating health insurance issuers in the same manner as would be required of issuers under section 2712(c).

''(2) APPLICATION OF ASSOCIATION RULES.—The HealthMart shall be considered an association for purposes of applying section 2712(e).

''(h) CONSTRUCTION IN RELATION TO CERTAIN OTHER LAWS.—Nothing in this title shall be construed as modifying or affecting the applicability to HealthMarts or health benefits coverage offered by a health insurance issuer through a HealthMart of parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 or titles XXII and XXVII of this Act.

''SEC. 2803. ADMINISTRATION.

''(a) IN GENERAL.—The applicable Federal authority shall administer this title through the division established under subsection (b) and is authorized to issue such regulations as may be required to carry out this title. Such regulations shall be subject to Congressional review under the provisions of chapter 8 of title 5, United States Code. The applicable Federal authority shall incorporate the process of 'deemed file and use' with respect to the information filed under section 2801(a)(6)(A) and shall determine whether information filed by a HealthMart demonstrates compliance with the applicable requirements of this title. Such authority shall exercise its authority under this title in a manner that fosters and promotes the development of HealthMarts in order to improve access to health care coverage and services.

''(b) ADMINISTRATION THROUGH HEALTH CARE MARKETPLACE DIVISION.—

''(1) IN GENERAL.—The applicable Federal authority shall carry out its duties under this title through a separate Health Care Marketplace Division, the sole duty of which (including the staff of which) shall be to administer this title.

''(2) ADDITIONAL DUTIES.—In addition to other responsibilities provided under this title, such Division is responsible for—

''(A) oversight of the operations of HealthMarts under this title; and

''(B) the periodic submittal to Congress of reports on the performance of HealthMarts under this title under subsection (c).

''(c) PERIODIC REPORTS.—The applicable Federal authority shall submit to Congress a report every 30 months, during the 10-year period beginning on the effective date of the

rules promulgated by the applicable Federal authority to carry out this title, on the effectiveness of this title in promoting coverage of uninsured individuals. Such authority may provide for the production of such reports through one or more contracts with appropriate private entities.

"SEC. 2804. DEFINITIONS.

''For purposes of this title:

''(1) APPLICABLE FEDERAL AUTHORITY.—The term 'applicable Federal authority' means the Secretary of Health and Human Services.

''(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—The term 'eligible' means, with respect to an employee or other individual and a HealthMart, an employee or individual who is eligible under section 2801(c)(2) to enroll or be enrolled in health benefits coverage offered through the HealthMart.

''(3) EMPLOYER; EMPLOYEE; DEPENDENT.—Except as the applicable Federal authority may otherwise provide, the terms 'employer', 'employee', and 'dependent', as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meanings applied to such terms with respect to such coverage under the laws of the State relating to such coverage and such an issuer.

''(4) HEALTH BENEFITS COVERAGE.—The term 'health benefits coverage' has the meaning given the term group health insurance coverage in section 2791(b)(4).

''(5) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2) and includes a community health organization that is offering coverage pursuant to section 330B(a).

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning given such term in section 2791(d)(9).

''(7) HEALTHMART.—The term 'HealthMart' is defined in section 2801(a).

''(8) MEMBER.—The term 'member'' means, with respect to a HealthMart, an individual enrolled for health benefits coverage through the HealthMart under section 2801(c)(2).

''(9) PURCHASER.—The term 'purchaser' means, with respect to a HealthMart, a small employer that has contracted under section 2801(c)(1)(A) with the HealthMart for the purchase of health benefits coverage.

''(10) SMALL EMPLOYER.—The term 'small employer' has the meaning given such term for purposes of title XXVII.''.

Subtitle D—Community Health Organizations

SEC. 2301. PROMOTION OF PROVISION OF INSURANCE BY COMMUNITY HEALTH ORGANIZATIONS.

(a) WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES.—Subpart I of part D of title III of the Public Health Service Act is amended by adding at the end the following new section:

''WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES

''SEC. 330B. (a) WAIVER AUTHORIZED.—

''(1) IN GENERAL.—A community health organization may offer health insurance coverage in a State notwithstanding that it is not licensed in such a State to offer such coverage if—

''(A) the organization files an application for waiver of the licensure requirement with the Secretary of Health and Human Services (in this section referred to as the 'Secretary') by not later than November 1, 2003, and

''(B) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (A), (B), or (C) of paragraph (2) has been met.

''(2) GROUNDS FOR APPROVAL OF WAIVER.—

''(A) FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.—The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

''(B) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and the standards or review process imposed by the State as a condition of approval of the license or as the basis for such denial by the State imposes any material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business.

''(C) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—With respect to waiver applications filed on or after the date of publication of solvency standards established by the Secretary under subsection (d), the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable State solvency requirements and such requirements are not the same as the solvency standards established by the Secretary. For purposes of this subparagraph, the term solvency requirements means requirements relating to solvency and other matters covered under the standards established by the Secretary under subsection (d).

''(3) TREATMENT OF WAIVER.—In the case of a waiver granted under this subsection for a community health organization with respect to a State—

''(A) LIMITATION TO STATE.—The waiver shall be effective only with respect to that State and does not apply to any other State.

''(B) LIMITATION TO 36-MONTH PERIOD.—The waiver shall be effective only for a 36-month period but may be renewed for up to 36 additional months if the Secretary determines that such an extension is appropriate.

''(C) CONDITIONED ON COMPLIANCE WITH CONSUMER PROTECTION AND QUALITY STANDARDS.—The continuation of the waiver is conditioned upon the organization's compliance with the requirements described in paragraph (5).

''(D) PREEMPTION OF STATE LAW.—Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing health insurance coverage shall be superseded.

''(4) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

''(5) APPLICATION AND ENFORCEMENT OF STATE CONSUMER PROTECTION AND QUALITY STANDARDS.—A waiver granted under this subsection to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards—

''(A) would apply in the State to the community health organization if it were licensed as an entity offering health insurance coverage under State law; and

''(B) are generally applicable to other risk-bearing managed care organizations and plans in the State.

''(6) REPORT.—By not later than December 31, 2002, the Secretary shall submit to the Committee on Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report regarding whether the waiver process under this subsection should be continued after December 31, 2003.

''(b) ASSUMPTION OF FULL FINANCIAL RISK.—To qualify for a waiver under subsection (a), the community health organization shall assume full financial risk on a prospective basis for the provision of covered health care services, except that the organization—

''(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time;

''(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization;

''(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 105 percent of its income for such fiscal year; and

''(4) may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of health services by the physicians or other health professionals or through the institutions.

''(c) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED CHOS.—

''(1) IN GENERAL.—Each community health organization that is not licensed by a State and for which a waiver application has been approved under subsection (a)(1), shall meet standards established by the Secretary under subsection (d) relating to the financial solvency and capital adequacy of the organization.

''(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR CHOS.—The Secretary shall establish a process for the receipt and approval of applications of a community health organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such a certification application not later than 60 days after the date the application has been received.

''(d) ESTABLISHMENT OF SOLVENCY STANDARDS FOR COMMUNITY HEALTH ORGANIZATIONS.—

''(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and by rule pursuant to section 553 of title 5, United States Code and through the Health Resources and Services Administration, standards described in subsection (c)(1) (relating to financial solvency and capital adequacy) that entities must meet to obtain a waiver under subsection (a)(2)(C). In establishing such standards, the Secretary shall consult with interested organizations, including the National Association of Insurance Commissioners, the Academy of Actuaries, and organizations representing Federally qualified health centers.

''(2) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards for community health organizations under paragraph (1), the Secretary shall take into account—

''(A) the delivery system assets of such an organization and ability of such an organization to provide services to enrollees;

''(B) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care; and

''(C) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

''(3) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the organization's debts in the event of the organization's insolvency.

''(4) DEADLINE.—Such standards shall be promulgated in a manner so they are first effective by not later than April 1, 1999.

''(e) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH ORGANIZATION.—The term 'community health organization ' means an organization that is a Federally-qualified health center or is controlled by one or more Federally-qualified health centers.

''(2) FEDERALLY-QUALIFIED HEALTH CENTER.—The term 'Federally-qualified health center' has the meaning given such term in section 1905(l)(2)(B) of the Social Security Act.

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 2791(b)(1).

''(4) CONTROL.—The term 'control' means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.''.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subtitle A—Patient Protections

SEC. 3001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

(a) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section:

''SEC. 9813. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

''(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

''(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan, the plan with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, 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 group health plan 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) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

''(1) IN GENERAL.—To the extent that the group health plan provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974), except for items or services specifically excluded—

''(A) the plan shall provide 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 in order to determine whether emergency medical care (as so defined) is required, and

''(B) the plan shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in clause (i) of section 503(b)(9)(I) of such Act.

''(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), 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 section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974) provided to such similarly situated participants and beneficiaries under the plan.

''(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

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

''(A) provides benefits under the terms of the plan consisting of—

''(i) routine gynecological care (such as preventive women's health examinations), or

''(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

''(B) the plan 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, then the plan shall meet the requirements of paragraph (2).

''(2) REQUIREMENTS.—A group health plan meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan—

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

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

''(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

''(d) PATIENT ACCESS TO PEDIATRIC CARE.—

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

''(e) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.''.

(b) CLERICAL AMENDMENT.—The table of sections of such subchapter of such chapter is amended by adding at the end the following new item:

''Sec. 9813. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.''

SEC. 3002. 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, except that the Secretary of the Treasury may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON PENALTY FOR CERTAIN FAILURES.—No penalty shall be imposed on any failure to comply with any requirement imposed by the amendments made by section 3101 to the extent such failure occurs 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.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the provisions of subsections (b), (c), and (d) of section 9813 of

the Internal Revenue Code of 1986 (as added by this subtitle) shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle B—Patient Access to Information

SEC. 3101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section:

"SEC. 9814. DISCLOSURE BY GROUP HEALTH PLANS.

''(a) DISCLOSURE REQUIREMENT.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 of Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act for different options of coverage) contains the information required under subsections (b), (c), (d), and (e)(2)(A). To the extent that any health insurance issuer offering health insurance coverage in connection with such plan provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the requirements under section 4980B.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503(b) of Employee Retirement Income Security Act of 1974, including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—A group health plan shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications; and

''(ii) the actual plan provisions setting forth the benefits available under the plan

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan shall provide the following information to a participant or beneficiary on request:

''(i) NETWORK CHARACTERISTICS.—If the plan (or a health insurance issuer offering health insurance coverage in connection with the plan) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any

preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan shall, upon written request (made not more frequently than annually), make available to a participant in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.''.

(b) CLERICAL AMENDMENT.—The table of sections of such subchapter of such chapter is amended by adding at the end the following new item:

''Sec. 9814. Disclosure by group health plans.''

SEC. 3102. REPORTING ON FRAUD AND ABUSE ENFORCEMENT ACTIVITIES.

The General Accounting Office shall—

(1) monitor—

(A) the compliance of the Department of Justice and all United States Attorneys–with the guideline entitled ''Guidance on the Use of the False Claims Act in Civil Health Care Matters'' issued by the Department on June 3, 1998, including any revisions to that guideline, and

(B) the compliance of the Office of the Inspector General of the Department of Health and Human Services with the protocols and guidelines entitled ''National Project Protocols—Best Practice Guidelines'' issued by the Inspector General on June 3, 1998, including any revisions to such protocols and guidelines, and

(2) submit a report on such compliance to the Committee on the Judiciary and the Committee on Ways and Means of the House of Representatives and the Committee on the Judiciary and the Committee on Finance of the Senate not later than February 1, 1999, and every year thereafter for a period of four years ending February 1, 2002.

SEC. 3103. EFFECTIVE DATE.

(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 of the Treasury or the Secretary's delegate shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(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 final regulations issued in connection with such requirement, if the plan has sought to comply in good faith with such requirement.

Subtitle C—Medical Savings Accounts

SEC. 3201. EXPANSION OF AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(b) ALL EMPLOYERS MAY OFFER MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subclause (I) of section 220(c)(1)(A)(iii) of such Code (defining eligible individual) is amended by striking ''and such employer is a small employer''.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (C).

(B) Subsection (c) of section 220 of such Code is amended by striking paragraph (4) and by redesignating paragraph (5) as paragraph (4).

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:

''(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of the annual deductible (as of the first day of such month) of the taxpayer's coverage under the high deductible health plan.''

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking ''75 percent of''.

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (5) of section 220(b) of such Code is amended to read as follows:

''(5) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includible in the taxpayer's gross income for such taxable year.''

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking ''$1,500'' and inserting ''$1,000'', and

(B) by striking ''$3,000'' and inserting ''$2,000''.

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended—

(A) by striking ''1998'' and inserting ''1999'', and

(B) by striking ''1997'' and inserting ''1998''.

(f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by striking ''106(b),''.

(g) INDIVIDUALS RECEIVING IMMEDIATE FEDERAL ANNUITIES ELIGIBLE FOR MEDICAL SAVINGS ACCOUNTS.—Paragraph (1) of section 220(c) of such Code (defining eligible individual), as amended by subsections (a) and (b), is amended by adding at the end the following new subparagraph:

''(C) SPECIAL RULES FOR INDIVIDUALS RECEIVING IMMEDIATE FEDERAL ANNUITIES.—

''(i) IN GENERAL.—Subparagraph (A)(iii) and subsection (b)(4) shall not apply for any month to an individual—

''(I) who, as of the 1st day of such month, is enrolled in a high deductible health plan under chapter 89 of title 5, United States Code, and

''(II) who is entitled to receive for such month any amount by reason of being an annuitant (as defined in section 8901(3) of such title 5).

''(ii) SPECIAL RULE FOR SPOUSE OF ANNUITANT.—In the case of the spouse of an individual described in clause (i) who is not also described in clause (i), subsection (b)(4) shall not apply to such spouse if such individual and spouse have family coverage under the same plan described in clause (i)(I).''

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 3202. EXCEPTION FROM INSURANCE LIMITATION IN CASE OF MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 220(d)(2)(B) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

''(iii) INSURANCE OFFERED BY COMMUNITY HEALTH CENTERS.—

''(I) IN GENERAL.—Subject to clauses (II) and (III), clause (i) shall not apply to any expense for coverage under insurance offered by a health center (as defined in section 330(a)(1) of the Public Health Service Act) if the coverage consists solely of coverage for required primary health benefits (as defined

in section 330(b)(1)(A) of such Act) provided on a capitated basis.

''(II) INCOME LIMITATION.—Subclause (I) shall only apply to expenses for coverage of an individual who, in the taxable year involved, has income that is less than 200 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(III) LIMITATION ON NUMBER OF CONTRACTS.—For a taxable year ending in a calendar year, subclause (I) shall apply only to expenses for coverage for the first 15,000 individuals enrolled in insurance described in such subclause in the year.''.

(b) REPORTS ON ENROLLMENT.—Section 330(j)(3) of the Public Health Service Act (42 U.S.C. 254c(j)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (K),

(2) by striking the period at the end of subparagraph (L) and inserting ''; and'', and

(3) by inserting after subparagraph (L) the following new subparagraph:

''(M) if the center offers insurance coverage to an individual with a medical savings account under subclause (I) of section 220(d)(2)(B)(iii), the center shall provide such reports in such time and manner as may be required by the Secretary and the Secretary of the Treasury in order to carry out subclause (III) of such section.''.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

SEC. 4001. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This title shall apply with respect to any health care liability action brought in any State or Federal court, except that this title shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action, or

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(b) PREEMPTION.—This title shall preempt any State law to the extent such law is inconsistent with the limitations contained in this title. This title shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this title or otherwise imposes greater restrictions than those provided in this title.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this title applies and which is brought under section 1332 of title 28, United States Code, the amount of non-economic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this title shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 4002. DEFINITIONS.

As used in this title:

(1) ACTUAL DAMAGES.—The term ''actual damages'' means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term ''collateral source payments'' means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term ''drug'' has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term ''economic loss'' means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term ''harm'' means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract, or

(D) a Medicare+Choice plan (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court against—

(A) a health care provider,

(B) an entity which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or

(C) the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product,

in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or contribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(12) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) HEALTH CARE SERVICE.—The term ''health care service'' means any service eligible for payment under a health benefit plan, including services related to the delivery or administration of such service.

(14) MEDICAL DEVICE.—The term ''medical device'' has the meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(15) NON-ECONOMIC DAMAGES.—The term ''non-economic damages'' means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(16) PERSON.—The term ''person'' means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(17) PRODUCT SELLER.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''product seller'' means a person who, in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or is otherwise involved in placing, a product in the stream of commerce, or

(ii) installs, repairs, or maintains the harm-causing aspect of a product.

(B) EXCLUSION.—Such term does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(18) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter

such person or others from engaging in similar behavior in the future.

(19) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 4003. EFFECTIVE DATE.

This title will apply to—

(1) any health care liability action brought in a Federal or State court, and

(2) any health care liability claim subject to an alternative dispute resolution system,

that is initiated on or after the date of enactment of this title, except that any health care liability claim or action arising from an injury occurring before the date of enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle B—Uniform Standards for Health Care Liability Actions

SEC. 4011. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 4012. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NON-ECONOMIC DAMAGES.—

(1) LIMITATION ON NON-ECONOMIC DAMAGES.—The total amount of non-economic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury. The limitation under this paragraph shall not apply to an action for damages based solely on intentional denial of medical treatment necessary to preserve a patient's life that the patient is otherwise qualified to receive, against the wishes of a patient, or if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's present or predicated age, disability, degree of medical dependency, or quality of life.

(2) LIMIT.—If, after the date of the enactment of this Act, a State enacts a law which prescribes the amount of non-economic damages which may be awarded in a health care liability action which is different from the amount prescribed by section 4012(a)(1), the State amount shall apply in lieu of the amount prescribed by such section. If, after the date of the enactment of this Act, a State enacts a law which limits the amount of recovery in a health care liability action without delineating between economic and non-economic damages, the State amount shall apply in lieu of the amount prescribed by such section.

(3) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of non-economic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for non-economic damages shall be several and not joint and a separate judgment shall be rendered against each defendant for the amount allocated to such defendant.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) APPLICABILITY.—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(3) BIFURCATION.—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(4) DRUGS AND DEVICES.—

(A) IN GENERAL.—

(i) PUNITIVE DAMAGES.—Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(ii) APPLICATION.—Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and non-economic loss exceeds $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 4013. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are consistent with the provisions relating to such matters in this title.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

SEC. 5001. CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

''PART D—CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

''INSPECTION AND COPYING OF PROTECTED HEALTH INFORMATION

''SEC. 1181. (a) IN GENERAL.—Subject to the succeeding provisions of this section, upon the request of an individual who is the subject of protected health information, a person who is a health care provider, health plan, employer, health or life insurer, or educational institution shall make available to the individual (or, in the discretion of the person, to a health care provider designated by the individual), for inspection and copying, protected health information concerning the individual that the person maintains, including records created under section 1182.

''(b) ACCESS THROUGH ORIGINATING PROVIDER.—Protected health information that is created by an originating provider, and subsequently received by another health care provider or a health plan as part of treatment or payment activities, shall be made available for inspection and copying as provided in this section through the originating provider, rather than the receiving health care provider or health plan, unless the originating provider does not maintain the information.

''(c) INVESTIGATIONAL INFORMATION.—With respect to protected health information that

was created as part of the requesting individual's participation in a clinical trial monitored by an institutional review board established to review health research with respect to potential risks to human subjects pursuant to Federal regulations adopted under section 1802(b) of the Public Health Service Act (42 U.S.C. 300v–1(b)) and the notice (informally referred to as the 'Common Rule') promulgated in the Federal Register at 56 Fed. Reg. 28003), a request under subsection (a) shall be granted only to the extent and in a manner consistent with such regulations.

''(d) OTHER EXCEPTIONS.—Unless ordered by a court of competent jurisdiction, a person to whom a request under subsection (a) is made is not required to grant the request, if—

''(1) the person determines that the disclosure of the information could reasonably be expected to endanger the life or physical safety of, or cause substantial harm to, any individual; or

''(2) the information is compiled principally—

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

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

''(e) DENIAL OF REQUEST FOR INSPECTION OR COPYING.—If a person to whom a request under subsection (a) is made denies a request for inspection or copying pursuant to this section, the person shall inform the individual making the request, in writing, of—

''(1) the reasons for the denial of the request;

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

''(3) the individual's right to file with the person a concise statement setting forth the request.

''(f) STATEMENT REGARDING REQUEST.—If an individual has filed with a person a statement under subsection (e)(3) with respect to protected health information, the person, in any subsequent disclosure of the information—

''(1) shall include a notation concerning the individual's statement; and

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

''(g) PROCEDURES.—A person providing access to protected health information for inspection or copying under this section 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.

''(h) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A person to whom a request under subsection (a) is made shall permit the inspection and copying of any reasonably segregable portion of a record after deletion of any portion that the person is not required to disclose under this section.

''(i) DEADLINE.—A person described in subsection (a) shall comply with or deny, in accordance with this section, a request for inspection or copying of protected health information under this section not later than 30 days after the date on which the person receives the request.

''(j) RULES GOVERNING AGENTS.—An agent of a person 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 been asked by the person to fulfill the requirements of this section.

''SUPPLEMENTATION OF PROTECTED HEALTH INFORMATION

''SEC. 1182. (a) IN GENERAL.—Subject to subsection (b), not later than 45 days after the date on which a person who is a health care provider, health plan, employer, health or life insurer, or educational institution receives, from an individual who is a subject of protected health information that is maintained by the person, a request in writing to amend the information by adding a concise written supplement to it, the person—

''(1) shall make the amendment requested;

''(2) shall inform the individual of the amendment that has been made; and

''(3) shall make reasonable efforts to inform any person who is identified by the individual, who is not an officer, employer, or agent of the person receiving the request, and to whom the unamended portion of the information was disclosed during the preceding year, by sending a notice to the person's last known address that an amendment, consisting of the addition of a supplement, has been made to the protected health information of the individual.

''(b) REFUSAL TO AMEND.—If a person described in subsection (a) refuses to make an amendment requested by an individual under such subsection, the person 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 person 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 with a person under subsection (b)(3), the person, in any subsequent disclosure of the disputed portion of the information—

''(1) shall include a notation that such individual has filed a statement of disagreement; and

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

''(d) RULES GOVERNING AGENTS.—The agent of a person described in subsection (a) shall not be required to make amendments to individually identifiable health information, except where—

''(1) the information is retained by the agent; and

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

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

''(f) RULE OF CONSTRUCTION.—This section shall not be construed—

''(1) to permit an individual to modify statements in his or her record that document the factual observations of another individual or state the results of diagnostic tests; or

''(2) to permit an individual to amend his or her record as to the type, duration, or quality of treatment the individual believes he or she should have been provided.

''NOTICE OF CONFIDENTIALITY PRACTICES

''SEC. 1183. (a) PREPARATION OF WRITTEN NOTICE.—A person who is a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall post or provide, in writing and in a clear and conspicuous manner, notice of the person's protected health information confidentiality practices. The notice shall include—

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

''(2) the intended uses and disclosures of protected health information;

''(3) the procedures established by the person for the exercise of an individual's rights with respect to protected health information; and

''(4) the procedures established by the person for obtaining copies of the notice.

''(b) MODEL NOTICE.—The Secretary, after notice and opportunity for public comment, and based on the advice of the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)), shall develop and disseminate, not later than 6 months after the date of the enactment of the Patient Protection Act of 1998, model notices of confidentiality practices, for use under this section. Use of a model notice developed by the Secretary shall serve as a complete defense in any civil action to an allegation that a violation of this section has occurred.

''ESTABLISHMENT OF SAFEGUARDS

''SEC. 1184. (a) IN GENERAL.—A person who is a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall establish, maintain, and enforce reasonable and 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 the person.

''(b) FACTORS TO BE CONSIDERED.—A person subject to subsection (a) shall consider the following factors in establishing safeguards under such subsection:

''(1) The need for protected health information.

''(2) The categories of personnel who will have access to protected health information.

''(3) The feasibility of limiting access to individual identifiers.

''(4) The appropriateness of the policy or procedure to the person, and to the medium in which protected health information is stored and transmitted.

''(5) The value of audit trails in computerized records.

''(c) RELATIONSHIP TO PART C REQUIREMENT.—Any safeguard established under this section shall be consistent with the requirement in section 1173(d)(2).

''(d) CONVERSION TO NONIDENTIFIABLE HEALTH INFORMATION.—A person subject to subsection (a) shall, to the extent practicable and consistent with the purpose for which protected health information is maintained, convert such information into nonidentifiable health information.

''AVAILABILITY OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF HEALTH CARE OPERATIONS

''SEC. 1185. DISCLOSURE.—Any person who maintains protected health information may disclose the information to a health care provider or a health plan for the purpose of permitting the provider or plan to conduct health care operations.

''(b) USE.—A health care provider or a health plan that maintains protected health information may use it for the purposes described in subsection (a).

''RELATIONSHIP TO OTHER LAWS

''SEC. 1186. (a) STATE LAW.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the provisions of this part shall preempt a provision of State law to the extent that such provision—

''(A) otherwise would be preempted as inconsistent with this part under article VI of the Constitution of the United States;

''(B) relates to authorization for the use or disclosure of—

''(i) protected health information for health care operations; or

''(ii) nonidentifiable health information; or

''(C) relates to any of the following:

''(i) Inspection or copying of protected health information by a person who is a subject of the information.

''(ii) Amendment of protected health information by a person who is a subject of the information.

''(iii) Notice of confidentiality practices with respect to protected health information.

''(iv) Establishment of safeguards for protected health information.

''(2) EXCEPTIONS.—Nothing in this part shall be construed to preempt or modify a provision of State law to the extent that such provision relates to protected health information and—

''(A) the confidentiality of the records maintained by a licensed mental health professional;

''(B) the provision of health care to a minor, or the disclosure of information about a minor to a parent or guardian of the minor;

''(C) condition-specific limitations on disclosure;

''(D) the use or disclosure of information for use in legally authorized—

''(i) disease or injury reporting;

''(ii) public health surveillance, investigation, or intervention;

''(iii) vital statistics reporting, such as reporting of birth or death information;

''(iv) reporting of abuse or neglect information;

''(v) reporting of information concerning a communicable disease status; or

''(vi) reporting concerning the safety or effectiveness of a biological product regulated under section 351 of the Public Health Service Act (42 U.S.C. 262) or a drug or device regulated under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.);

''(E) the disclosure to a person by a health care provider of information about an individual, in any case in which the provider has determined—

''(i) in the provider's reasonable medical judgment, that the individual is unconscious, incompetent, or otherwise incapable of deciding whether to authorize disclosure of the protected health information; and

''(ii) in the provider's reasonable judgment, that the person is a spouse, relative, guardian, or close friend of the individual's; or

''(F) the use of information by, or the disclosure of information to, a person holding a valid and applicable power of attorney that includes the authority to make health care decisions on behalf of an individual who is a subject of the information.

''(3) PRIVILEGES.—Nothing in this part shall be construed to preempt or modify a provision of State law to the extent that such provision relates to a privilege of a witness or other person in a court of that State.

''(b) FEDERAL LAW.—Nothing in this part shall be construed to preempt, modify, or repeal a provision of any other Federal law relating to protected health information or relating to an individual's access to protected health information or health care services. Nothing in this part shall be construed to preempt, modify, or repeal a provision of Federal law to the extent that such provision relates to a privilege of a witness or other person in a court of the United States.

''CIVIL PENALTIES

''SEC. 1187. (a) VIOLATION.—A person who the Secretary determines has substantially and materially failed to comply with this part shall be subject, in addition to any other penalties that may be prescribed by law—

''(1) in a case in which the violation relates to section 1181 or 1182, to a civil penalty of not more than $500 for each such violation but not to exceed $5,000 in the aggregate for all violations of an identical requirement or prohibition during a calendar year;

''(2) in the case in which the violation relates to section 1183 or 1184, to a civil penalty of not more than $10,000 for each such violation, but not to exceed $50,000 in the aggregate for all violations of an identical requirement or prohibition during a calendar year; or

''(3) in a case in which the Secretary finds that such violations have occurred with such frequency as to constitute a general business practice, to a civil penalty of not more than $100,000.

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

''DEFINITIONS

''SEC. 1188. As used in this part:

''(1) AGENT.—The term 'agent' means a person, including a contractor, 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.

''(2) CONDITION-SPECIFIC LIMITATIONS ON DISCLOSURE.—The term 'condition-specific limitations on disclosure' means State laws that prohibit the disclosure of protected health information relating to a health condition or disease that has been identified by the Secretary as posing a public health threat.

''(3) DISCLOSE.—The term 'disclose' means to release, transfer, provide access to, or otherwise divulge protected health information to any person other than an individual who is the subject of such information.

''(4) EDUCATIONAL INSTITUTION.—The term 'educational institution' means an institution or place accredited or licensed for purposes of providing 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.

''(5) 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 two or more employees.

''(6) HEALTH CARE.—The term 'health care' means—

''(A) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, including appropriate assistance with disease or symptom management and maintenance, counseling, service, or procedure—

''(i) with respect to the physical or mental condition of an individual; or

''(ii) affecting the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs, or any other tissue; or

''(B) any sale or dispensing, pursuant to a prescription or medical order, of a drug, device, equipment, or other health care-related item to an individual, or for the use of an individual.

''(7) HEALTH CARE OPERATIONS.—The term 'health care operations' means services, provided directly by or on behalf of a health plan or health care provider or by its agent, for any of the following purposes:

''(A) Coordinating health care, including health care management of the individual through risk assessment, case management, and disease management.

''(B) Conducting quality assessment and improvement activities, including outcomes evaluation, clinical guideline development and improvement, and health promotion.

''(C) Carrying out utilization review activities, including precertification and preauthorization of services, and health plan rating activities, including underwriting and experience rating.

''(D) Conducting or arranging for auditing services.

''(8) 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 or any other privately-sponsored program that directly provides items or services that constitute health care to beneficiaries; or

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

''(9) HEALTH OR LIFE INSURER.—The term 'health or life insurer' means a health insurance issuer, as defined in section 9832(b)(2) of the Internal Revenue Code of 1986, or a life insurance company, as defined in section 816 of such Code.

''(10) HEALTH PLAN.—The term 'health plan' means any health insurance plan, including any hospital or medical service plan, dental or other health service plan, health maintenance organization plan, plan offered by a provider-sponsored organization (as defined in section 1855(d)), or other program providing or arranging for the provision of health benefits.

''(11) HEALTH RESEARCHER.—The term 'health researcher' means a person (or an officer, employee, or agent of a person) who is engaged in systematic investigation, including research development, testing, data analysis, and evaluation, designed to develop or contribute to generalizable knowledge relating to basic biomedical processes, health, health care, health care delivery, or health care cost.

''(12) NONIDENTIFIABLE HEALTH INFORMATION.—The term 'nonidentifiable health information' means protected health information from which personal identifiers that reveal the identity of the individual who is the subject of such information or provide a direct means of identifying the individual (such as name, address, and social security number) have been removed, encrypted, or replaced with a code, such that the identity of the individual is not evident without (in the case of encrypted or coded information) use of a key.

''(13) ORIGINATING PROVIDER.—The term 'originating provider', when used with respect to protected health information, means the health care provider who takes an action that initiates the treatment episode to which that information relates, such as prescribing a drug, ordering a diagnostic test, or admitting an individual to a health care facility. A hospital or nursing facility is the originating provider with respect to protected health information created or received as part of inpatient or outpatient treatment provided in the hospital or facility.

''(14) PAYMENT ACTIVITIES.—The term 'payment activities' means—

''(A) activities undertaken—

''(i) by, or on behalf of, a health plan to determine its responsibility for coverage under the plan; or

''(ii) by a health care provider to obtain payment for items or services provided to an individual, provided under a health plan, or provided based on a determination by the health plan of responsibility for coverage under the plan; and

''(B) includes the following activities, when performed in a manner consistent with subparagraph (A):

''(i) Billing, claims management, medical data processing, other administrative services, and actual payment.

''(ii) Determinations of coverage or adjudication of health benefit or subrogation claims.

''(iii) Review of health care services with respect to coverage under a health plan or justification of charges.

''(15) PERSON.—The term 'person' means—

''(A) a natural person;

''(B) a government or governmental subdivision, agency, or authority;

''(C) a company, corporation, estate, firm, trust, partnership, association, joint venture, society, or joint stock company; or

''(D) any other legal entity.

''(16) PROTECTED HEALTH INFORMATION.—The term 'protected health information', when used with respect to an individual who is a subject of information means any information (including genetic information) that identifies the individual, whether oral or recorded in any form or medium, and that—

''(A) is created or received by a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, or educational institution;

''(B) relates to the past, present, or future physical or mental health or condition of an individual (including individual cells and their components);

''(C) is derived from—

''(i) the provision of health care to an individual; or

''(ii) payment for the provision of health care to an individual; and

''(D) is not nonidentifiable health information.

''(17) STATE.—The term 'State' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

''(18) TREATMENT.—The term 'treatment' means the provision of health care by a health care provider.

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

(b) ENFORCEMENT OF PROVISIONS THROUGH CONDITIONS ON PARTICIPATION.—

(1) PARTICIPATING PHYSICIANS AND SUPPLIERS.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following:

''(9) The Secretary may refuse to enter into an agreement with a physician or supplier under this subsection, or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been found to have violated a provision of part D of title XI.''.

(2) MEDICARE+CHOICE ORGANIZATIONS.—Section 1852(h) of the Social Security Act (42 U.S.C. 1395w–22(h)) is amended—

(A) in the matter preceding paragraph (1), by striking ''procedures—'' and inserting ''procedures, consistent with sections 1181 through 1185—''; and

(B) in paragraph (1), by striking ''privacy of any individually identifiable enrollee information;'' and inserting ''confidentiality of protected health information concerning enrollees;''.

(3) MEDICARE PROVIDERS.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by inserting a semicolon at the end of subparagraph (R);

(B) by striking the period at the end of subparagraph (S) and inserting ''; and''; and

(C) by inserting immediately after subparagraph (S) the following new subparagraph:

''(T) to comply with sections 1181 through 1184.''.

(4) HEALTH MAINTENANCE ORGANIZATIONS WITH RISK-SHARING CONTRACTS.—Section 1876(k)(4) of the Social Security Act (42 U.S.C. 1395mm(k)(4)) of the Social Security Act is amended by adding at the end the following:

''(E) The confidentiality and accuracy procedure requirements under section 1852(h).''.

(c) CONFORMING AMENDMENTS.—

(1) TITLE HEADING.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by striking the title heading and inserting the following:

''TITLE XI—GENERAL PROVISIONS, PEER REVIEW, ADMINISTRATIVE SIMPLIFICATION, AND CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION''.

(2) NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS.—Section 306(k)(5) of the Public Health Service Act (42 U.S.C. 242(k)(5)) is amended—

(A) in subparagraphs (A)(viii) and (D), by striking ''part C'' and inserting ''parts C and D'';

(B) in subparagraph (C), by striking ''and'' at the end;

(C) in subparagraph (D), by striking the period at the end and inserting ''; and''; and

(D) by adding at the end the following:

''(E) shall study the issues relating to section 1184 of the Social Security Act (as added by the Patient Protection Act of 1998), and, not later than 1 year after the date of the enactment of the Patient Protection Act of 1998, shall report to the Congress on such section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 1 year after the date of the enactment of this Act, except that subsection (c)(2), and section 1183(b) of the Social Security Act (as added by subsection (a)), shall take effect on the date of the enactment of this Act.

SEC. 5002. STUDY AND REPORT ON EFFECT OF STATE LAW ON HEALTH-RELATED RESEARCH.

Not later than one year after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study on the effect of State laws on health-related research subject to review by an institutional review board or institutional review committee with respect to the protection of human subjects.

SEC. 5003. STUDY AND REPORT ON STATE LAW ON PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Not later than 9 months after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study—

(1) compiling State laws on the confidentiality of protected health information (as defined in section 1188 of the Social Security Act, as added by section 5001 of this Act); and

(2) analyzing the effect of such laws on the provision of health care and securing payment for such care.

(b) MODIFICATION OF DEADLINE.—Section 264(c)(1) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) is amended by striking ''36 months after the date of the enactment of this Act,'' and inserting ''6 months after the date on which the Comptroller General of the United States submits to the Congress a report under section 5003(a) of the Patient Protection Act of 1998,''.

SEC. 5004. PROTECTION FOR CERTAIN INFORMATION DEVELOPED TO REDUCE MORTALITY OR MORBIDITY OR FOR IMPROVING PATIENT CARE AND SAFETY.

(a) PROTECTION OF CERTAIN INFORMATION.—Notwithstanding any other provision of Federal or State law, health care response information shall be exempt from any disclosure requirement (regardless of whether the requirement relates to subpoenas, discovery, introduction of evidence, testimony, or any other form of disclosure), in connection with a civil or administrative proceeding under Federal or State law, to the same extent as information developed by a health care provider with respect to any of the following:

(1) Peer review.

(2) Utilization review.

(3) Quality management or improvement.

(4) Quality control.

(5) Risk management.

(6) Internal review for purposes of reducing mortality, morbidity, or for improving patient care or safety.

(b) NO WAIVER OF PROTECTION THROUGH INTERACTION WITH ACCREDITING BODY.—Notwithstanding any other provision of Federal or State law, the protection of health care response information from disclosure provided under subsection (a) shall not be deemed to be modified or in any way waived by—

(1) the development of such information in connection with a request or requirement of an accrediting body; or

(2) the transfer of such information to an accrediting body.

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

(1) The term ''accrediting body'' means a national, not-for-profit organization that—

(A) accredits health care providers; and

(B) is recognized as an accrediting body by statute or by a Federal or State agency that regulates health care providers.

(2) The term ''health care provider'' has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

(3) The term ''health care response information'' means information (including any data, report, record, memorandum, analysis, statement, or other communication) developed by, or on behalf of, a health care provider in response to a serious, adverse, patient-related event—

(A) during the course of analyzing or studying the event and its causes; and

(B) for purposes of—

(i) reducing mortality or morbidity; or

(ii) improving patient care or safety (including the provider's notification to an accrediting body and the provider's plans of action in response to such event).

(5) The term ''State'' has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

TITLE VI—MEDICAL SAVINGS ACCOUNTS FOR FEDERAL EMPLOYEES

SEC. 6001. MEDICAL SAVINGS ACCOUNTS FOR FEDERAL EMPLOYEES.

(a) MEDICAL SAVINGS ACCOUNTS.—

(1) CONTRIBUTIONS.—Title 5, United States Code, is amended by redesignating section 8906a as section 8906c and by inserting after section 8906 the following:

"§ 8906a. Government contributions to medical savings accounts

''(a) An employee or annuitant enrolled in a high deductible health plan is entitled, in addition to the Government contribution under section 8906(b) toward the subscription charge for such plan, to have a Government contribution made, in accordance with succeeding provisions of this section, to a medical savings account of such employee or annuitant.

''(b)(1) The biweekly Government contribution under this section shall, in the case of any such employee or annuitant, be equal to the amount by which—

''(A) the biweekly equivalent of the maximum Government contribution for the contract year involved (as defined by paragraph (2)), exceeds (if at all)

''(B) the amount of the biweekly Government contribution payable on such employee's or annuitant's behalf under section 8906(b) for the period involved.

''(2) For purposes of this section, the term 'maximum Government contribution' means, with respect to a contract year, the maximum Government contribution that could be made for health benefits for an employee or annuitant for such contract year, as determined under section 8906(b) (disregarding paragraph (2) thereof)).

''(3) Notwithstanding any other provision of this section, no contribution under this section shall be payable to any medical savings account of an employee or annuitant for any period—

''(A) if, as of the first day of the month before the month in which such period commences, such employee or annuitant (or the spouse of such employee or annuitant, if coverage is for self and family) is entitled to benefits under part A of title XVIII of the Social Security Act;

''(B) to the extent that such contribution, when added to previous contributions made under this section for that same year with respect to such employee or annuitant, would cause the total to exceed—

''(i) the highest annual limit deductible permitted under clause (i) or (ii) of section 220(c)(2)(A) of the Internal Revenue Code of 1986, as appropriate (determined taking into account any changes in coverage that may occur), for the calendar year in which such period commences; or

''(ii) such lower amount (relative to the limitation that would otherwise apply under clause (i)) as the employee or annuitant may specify in accordance with regulations of the Office, including an election not to receive contributions under this section for a year or the remainder of a year; or

''(C) for which any information (or documentation) under subsection (d) that is needed in order to make such contribution has not been timely submitted.

''(4) Notwithstanding any other provision of this section, no contribution under this section shall be payable to any medical savings account of an employee for any period in a contract year unless that employee was enrolled in a health benefits plan under this chapter as an employee for not less than—

''(A) the 1 year of service immediately before the start of such contract year, or

''(B) the full period or periods of service between the last day of the first period, as prescribed by regulations of the Office of Personnel Management, in which he is eligible to enroll in the plan and the day before the start of such contract year,

whichever is shorter.

''(5) The Office shall provide for the conversion of biweekly rates of contributions specified by paragraph (1) to rates for employees and annuitants whose pay or annuity is provided on other than a biweekly basis, and for this purpose may provide for the adjustment of the converted rate to the nearest cent.

''(c) A Government contribution under this section—

''(1) shall be made at the same time that, and the same frequency with which, Government contributions under section 8906(b) are made for the benefit of the employee or annuitant involved; and

''(2) shall be payable from the same appropriation, fund, account, or other source as would any Government contributions under section 8906(b) with respect to the employee or annuitant involved.

''(d) The Office shall by regulation prescribe the time, form, and manner in which an employee or annuitant shall submit any information (and supporting documentation) necessary to identify any medical savings account to which contributions under this section are requested to be made.

''(e) Nothing in this section shall be considered to entitle an employee or annuitant to any Government contribution under this section with respect to any period for which such employee or annuitant is ineligible for a Government contribution under section 8906(b).

"§ 8906b. Individual contributions to medical savings accounts

''(a) Upon the written request of an employee or annuitant enrolled in a high deductible health plan, there shall be withheld from the pay or annuity of such employee or annuitant and contributed to the medical savings account identified by such employee or annuitant in accordance with applicable regulations under subsection (c) such amount as the employee or annuitant may specify.

''(b) Notwithstanding subsection (a), no withholding under this section may be made from the pay or annuity of an employee or annuitant for any period—

''(1) if, or to the extent that, a Government contribution for such period under section 8906a would not be allowable by reason of subparagraph (A) or (B)(i) of subsection (b)(3) thereof;

''(2) for which any information (or documentation) that is needed in order to make such contribution has not been timely submitted; or

''(3) if the employee or annuitant submits a request for termination of withholdings, beginning on or after the effective date of the request and before the end of the year.

''(c) The Office of Personnel Management shall prescribe any regulations necessary to carry out this section, including provisions relating to the time, form, and manner in which any request for withholdings under this section may be made, changed, or terminated.''.

(2) RULES OF CONSTRUCTION.—Nothing in this section or in any amendment made by this section shall be considered—

(A) to permit or require that any contributions to a medical savings account (whether by the Government or through withholdings from pay or annuity) be paid into the Employees Health Benefits Fund; or

(B) to affect any authority under section 1005(f) of title 39, United States Code, to vary, add to, or substitute for any provision of chapter 89 of title 5, United States Code, as amended by this section.

(3) CONFORMING AMENDMENTS.—

(A) The table of sections at the beginning of chapter 89 of title 5, United States Code, is amended by striking the item relating to section 8906a and inserting the following:

''8906a. Government contributions to medical savings accounts.

''8906b. Individual contributions to medical savings accounts.

''8906c. Temporary employees.''.

(B) Section 8913(b)(4) of title 5, United States Code, is amended by striking ''8906a(a)'' and inserting ''8906c(a)''.

(b) INFORMATIONAL REQUIREMENTS.—Section 8907 of title 5, United States Code, is amended by adding at the end the following:

''(c) In addition to any information otherwise required under this section, the Office shall make available to all employees and annuitants eligible to enroll in a high deductible health plan, information relating to—

''(1) the conditions under which Government contributions under section 8906a shall be made to a medical savings account;

''(2) the amount of any Government contributions under section 8906a to which an employee or annuitant may be entitled (or how such amount may be ascertained);

''(3) the conditions under which contributions to a medical savings account may be made under section 8906b through withholdings from pay or annuity; and

''(4) any other matter the Office considers appropriate in connection with medical savings accounts.''.

(c) HIGH DEDUCTIBLE HEALTH PLAN AND MEDICAL SAVINGS ACCOUNT DEFINED.—Section 8901 of title 5, United States Code, is amended—

(1) in paragraph (10) by striking ''and'' after the semicolon;

(2) in paragraph (11) by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

''(12) the term 'high deductible health plan' means a plan described by section 8903(5) or section 8903a(d); and

''(13) the term 'medical savings account' has the meaning given such term by section 220(d) of the Internal Revenue Code of 1986.''.

(d) AUTHORITY TO CONTRACT FOR HIGH DEDUCTIBLE HEALTH PLANS.—Section 8902 of title 5, United States Code, is amended by adding at the end the following:

''(p)(1) The Office shall contract under this chapter for a high deductible health plan with any qualified carrier that offers such a plan and, as of the date of enactment of the Federal Employees Health Care Freedom of Choice Act, offers a health benefits plan under this chapter.

''(2) The Office may contract under this chapter for a high deductible health plan with any qualified carrier that offers such a plan, but does not, as of the date of enactment of the Federal Employees Health Care Freedom of Choice Act, offer a health benefits plan under this chapter.''.

(e) DESCRIPTION OF HIGH DEDUCTIBLE HEALTH PLANS AND BENEFITS TO BE PROVIDED THEREUNDER.—

(1) IN GENERAL.—Section 8903 of title 5, United States Code, is amended by adding at the end the following:

''(5) HIGH DEDUCTIBLE HEALTH PLANS.—(A) One or more plans described by paragraph (1), (2), (3), or (4), which—

''(i) are high deductible health plans (as defined by section 220(c)(2) of the Internal Revenue Code of 1986); and

''(ii) provide benefits of the types referred to by section 8904(a)(5).

''(B) Nothing in this section shall be considered—

''(i) to prevent a carrier from simultaneously offering a plan described by subparagraph (A) and a plan described by paragraph (1) or (2); or

''(ii) to require that a high deductible health plan offer two levels of benefits.''.

(2) TYPES OF BENEFITS.—Section 8904(a) of title 5, United States Code, is amended by inserting after paragraph (4) the following:

''(5) HIGH DEDUCTIBLE HEALTH PLANS.—Benefits of the types named under paragraph (1) or (2) of this subsection or both.''.

(3) CONFORMING AMENDMENTS.—

(A) Section 8903a of title 5, United States Code, is amended by redesignating subsection (d) as subsection (e) and by inserting after subsection (c) the following:

''(d) The plans under this section may include one or more plans, otherwise allowable under this section, that satisfy the requirements of clauses (i) and (ii) of section 8903(5)(A).''.

(B) Section 8909(d) of title 5, United States Code, is amended by striking ''8903a(d)'' and inserting ''8903a(e)''.

(4) REFERENCES.—Section 8903 of title 5, United States Code, is amended by adding after paragraph (5) (as added by paragraph (1) of this subsection) as a flush left sentence, the following:

''The Office shall prescribe regulations in accordance with which the requirements of section 8902(c), 8902(n), 8909(e), and any other provision of this chapter that applies with respect to a plan described by paragraph (1), (2), (3), or (4) of this section shall apply with respect to the corresponding plan under paragraph (5) of this section. Similar regulations shall be prescribed with respect to any plan under section 8903a(d).''.

SEC. 6002. EFFECTIVE DATE.

The amendments made by this title shall apply with respect to contract years beginning on or after January 1, 2000. The Office of Personnel Management shall take appropriate measures to ensure that coverage under a high deductible health plan under chapter 89 of title 5, United States Code (as amended by this section) shall be available as of the beginning of the first contract year described in the preceding sentence.

The SPEAKER pro tempore. Pursuant to House Resolution 509, the amendments printed in House Report 105–643 are adopted.

The text of H.R. 4250, as amended pursuant to House Resolution 509, is as follows:

H.R. 4250

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

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—The Act may be cited as the ''Patient Protection Act of 1998''.

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

Sec. 1. Short title and table of contents.

TITLE I—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Subtitle A—Patient Protections.

Sec. 1001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.

Sec. 1002. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 1101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 1102. Effective date.

Subtitle C—New Procedures and Access to Courts for Grievances Arising under Group Health Plans

Sec. 1201. Special rules for group health plans.

Sec. 1202. Effective date.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

Sec. 1301. Short title of subtitle.

Sec. 1302. Rules governing association health plans.

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''Sec. 801. Association health plans.

''Sec. 802. Certification of association health plans.

''Sec. 803. Requirements relating to sponsors and boards of trustees.

''Sec. 804. Participation and coverage requirements.

''Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.

''Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.

''Sec. 807. Requirements for application and related requirements.

''Sec. 808. Notice requirements for voluntary termination.

''Sec. 809. Corrective actions and mandatory termination.

''Sec. 810. Trusteeship by the secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.

''Sec. 811. State assessment authority.

''Sec. 812. Special rules for church plans.

''Sec. 813. Definitions and rules of construction.

Sec. 1303. Clarification of treatment of single employer arrangements.

Sec. 1304. Clarification of treatment of certain collectively bargained arrangements.

Sec. 1305. Enforcement provisions relating to association health plans.

Sec. 1306. Cooperation between Federal and State authorities.

Sec. 1307. Effective date and transitional and other rules.

TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

Sec. 2001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.

Sec. 2002. Requiring health maintenance organizations to offer option of point-of-service coverage.

Subtitle B—Patient Access to Information

Sec. 2101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 2102. Effective date.

Subtitle C—HealthMarts

Sec. 2201. Short title of subtitle.

Sec. 2202. Expansion of consumer choice through HealthMarts.

''TITLE XXVIII—HEALTHMARTS

''Sec. 2801. Definition of HealthMart.

''Sec. 2802. Application of certain laws and requirements.

''Sec. 2803. Administration.

''Sec. 2804. Definitions.

SUBTITLE D—COMMUNITY HEALTH ORGANIZATIONS

Sec. 2301. Promotion of provision of insurance by community health organizations.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subtitle A—Patient Protections

Sec. 3001. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.

Sec. 3002. Effective date and related rules.

Subtitle B—Patient Access to Information

Sec. 3101. Patient access to information regarding plan coverage, managed care procedures, health care providers, and quality of medical care.

Sec. 3102. Effective date.

Subtitle C—Medical Savings Accounts

Sec. 3201. Expansion of availability of medical savings accounts.

Sec. 3202. Exception from insurance limitation in case of medical savings accounts.

Sec. 3203. Sense of the House of Representatives.

Subtitle D—Revenue Offsets

Sec. 3301. Clarification of definition of specified liability loss.

Sec. 3302. Property subject to a liability treated in same manner as assumption of liability.

Sec. 3303. Limitation on required accrual of amounts received for performance of certain personal services.

Sec. 3304. Returns relating to cancellations of indebtedness by organizations lending money.

Sec. 3305. Clarifications and expansion of mathematical error assessment procedures.

Sec. 3306. Inclusion of rotavirus gastroenteritis as a taxable vaccine.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

Sec. 4001. Federal reform of health care liability actions.

Sec. 4002. Definitions.

Sec. 4003. Effective date.

Subtitle B—Uniform Standards for Health Care Liability Actions

Sec. 4011. Statute of limitations.

Sec. 4012. Calculation and payment of damages.

Sec. 4013. Alternative dispute resolution.

Sec. 4014. Reporting on fraud and abuse enforcement activities.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

Sec. 5001. Confidentiality of protected health information.

''PART D—CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

''Sec. 1181. Inspection and copying of protected health information.

''Sec. 1182. Supplementation of protected health information.

''Sec. 1183. Notice of confidentiality practices.

''Sec. 1184. Establishment of safeguards.

''Sec. 1185. Availability of protected health information for purposes of health care operations.

''Sec. 1186. Relationship to other laws.

''Sec. 1187. Civil penalties.

''Sec. 1188. Definitions.

Sec. 5002. Study and report on effect of State law on health-related research.

Sec. 5003. Study and report on State law on protected health information.

Sec. 5004. Protection for certain information developed to reduce mortality or morbidity or for improving patient care and safety.

Sec. 5005. Effective date for standards governing unique health identifiers for individuals.

TITLE I—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Subtitle A—Patient Protections

SEC. 1001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, AND PEDIATRIC CARE.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended further by adding at the end the following new section:

"SEC. 713. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

''(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

''(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan, the plan or issuer with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition or restriction with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan or health insurance coverage offered in connection with the plan.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, 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 group health plan 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) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

''(1) IN GENERAL.—To the extent that the group health plan (or health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I)), except for items or services specifically excluded—

''(A) the plan or issuer shall provide benefits, without requiring preauthorization and without regard to otherwise applicable network limitations, 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 in order to determine whether emergency medical care (as so defined) is required, and

''(B) the plan or issuer shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in section 503(b)(9)(I).

''(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), 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 section 503(b)(9)(I)) provided to such similarly situated participants and beneficiaries under the plan.

''(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan)—

''(A) provides benefits under the terms of the plan consisting of—

''(i) routine gynecological care (such as preventive women's health examinations), or

''(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

''(B) the plan 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, then the plan (or issuer) shall meet the requirements of paragraph (2).

''(2) REQUIREMENTS.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan (or issuer)—

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

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

''(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

''(d) PATIENT ACCESS TO PEDIATRIC CARE.—

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

''(e) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.''.

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

''Sec. 713. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, and pediatric care.''.

SEC. 1002. 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, except that the Secretary of Labor may issue regulations before such date under such amendments. The Secretary shall first issue 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 or health insurance issuer 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 or issuer has sought to comply in good faith with such requirement.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the provisions of subsections (b), (c), and (d) of section 713 of the Employee Retirement Income Security Act of 1974 (as added by this subtitle) shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

(d) ASSURING COORDINATION.—The Secretary of Labor, the Secretary of the Treasury, and the Secretary of Health and Human Services shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this subtitle, section 2101, and subtitle A of title III (and the amendments made thereby) are administered so as to have the same effect at all times, and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

(e) TREATMENT OF RELIGIOUS NONMEDICAL PROVIDERS.—

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

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

(B) require such plans or issuers to—

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

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

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

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

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

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

Subtitle B—Patient Access to Information

SEC. 1101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended—

(1) by redesignating section 111 as section 112; and

(2) by inserting after section 110 the following new section:

''DISCLOSURE BY GROUP HEALTH PLANS

''SEC. 111. (a) DISCLOSURE REQUIREMENT.—

''(1) GROUP HEALTH PLANS.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 for different options of coverage) contains, among any information otherwise required under this part, the information required under subsections (b), (c), (d), and (e)(2)(A).

''(2) HEALTH INSURANCE ISSUERS.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator on a timely basis with the information necessary to enable the administrator to comply with the requirements of paragraph (1). To the extent that any such issuer provides on a timely basis to plan participants and beneficiaries information otherwise required under this part to be included in the summary plan description, the requirements of sections 101(a)(1) and 104(b) shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the plan pursuant to part 6.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503(b), including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—In addition to the information required to be provided under section 104(b)(4), a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications; and

''(ii) the actual plan provisions setting forth the benefits available under the plan

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

''(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or

issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(ix) INFORMATION RELATING TO EXTERNAL REVIEWS.—The number of external reviews under section 503(b)(4) that have been completed during the prior plan year and the number of such reviews in which the recommendation reported under section 503(b)(4)(C)(iii) includes a recommendation for modification or reversal of an internal review decision under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant (and an employee who, under the terms of the plan, is eligible for coverage, but not enrolled) in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.

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

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided such term under section 503(b)(6).

''(2) MEDICAL CARE.—The term 'medical care' has the meaning provided such term under section 733(a)(2).

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term under section 733(b)(1).

''(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term under section 733(b)(2).''.

(b) CONFORMING AMENDMENTS.—

(1) Section 102(b) of such Act (29 U.S.C. 1022(b)) is amended—

(A) by striking ''section 733(a)(1)'' each place it appears and inserting ''section 503(b)(6)''; and

(B) by inserting before the period at the end the following: ''; and, in the case of a group health plan (as defined in section 111(h)(1)), the information required to be included under section 111(a)''.

(2) The table of contents in section 1 of such Act is amended by striking the item relating to section 111 and inserting the following new items:

''Sec. 111. Disclosure by group health plans.
''Sec. 112. Repeal and effective date.''.

SEC. 1102. 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 first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

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

(c) ASSURING COORDINATION.—The Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under the provisions of this subtitle, subtitle B of title II, and subtitle B of title III (and the amendments made thereby) are administered so as to have the same effect at all times, and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

Subtitle C—New Procedures and Access to Courts for Grievances Arising Under Group Health Plans

SEC. 1201. SPECIAL RULES FOR GROUP HEALTH PLANS.

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

(1) by inserting ''(a) IN GENERAL.—'' after ''SEC. 503.'';

(2) by inserting ''(other than a group health plan)'' after ''employee benefit plan''; and

(3) by adding at the end the following new subsection:

''(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

''(1) COVERAGE DETERMINATIONS.—Every group health plan shall—

''(A) provide adequate notice in writing in accordance with this subsection to any participant or beneficiary of any adverse coverage decision with respect to benefits of such participant or beneficiary under the plan, setting forth the specific reasons for such coverage decision and any rights of review provided under the plan, written in a manner calculated to be understood by the participant,

''(B) provide such notice in writing also to any treating medical care provider of such participant or beneficiary, if such provider has claimed reimbursement for any item or service involved in such coverage decision, or if a claim submitted by the provider initiated the proceedings leading to such decision,

''(C) afford a reasonable opportunity to any participant or beneficiary who is in receipt of the notice of such adverse coverage decision, and who files a written request for review of the initial coverage decision within 180 days after receipt of the notice of the initial decision, for a full and fair de novo review of the decision by an appropriate named

fiduciary who did not make the initial decision, and

''(D) meet the additional requirements of this subsection.

''(2) TIME LIMITS FOR MAKING INITIAL COVERAGE DECISIONS FOR BENEFITS AND COMPLETING INTERNAL APPEALS.—

''(A) TIME LIMITS FOR DECIDING REQUESTS FOR BENEFIT PAYMENTS, REQUESTS FOR ADVANCE DETERMINATION OF COVERAGE, AND REQUESTS FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—Except as provided in subparagraph (B)—

''(i) INITIAL DECISIONS.—If a request for benefit payments, a request for advance determination of coverage, or a request for required determination of medical necessity is submitted to a group health plan in such reasonable form as may be required under the plan, the plan shall issue in writing an initial coverage decision on the request before the end of the initial decision period under paragraph (9)(J) following the filing completion date. Failure to issue a coverage decision on such a request before the end of the period required under this clause shall be treated as an adverse coverage decision for purposes of internal review under clause (ii).

''(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for such decision, before the end of the internal review period following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of such period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration under paragraph (4).

''(B) TIME LIMITS FOR MAKING COVERAGE DECISIONS RELATING TO URGENT AND EMERGENCY MEDICAL CARE AND FOR COMPLETING INTERNAL APPEALS.—

''(i) INITIAL DECISIONS.—A group health plan shall issue in writing an initial coverage decision on any request for expedited advance determination of coverage or for expedited required determination of medical necessity submitted, in such reasonable form as may be required under the plan—

''(I) before the end of the urgent decision period under paragraph (9)(L), in cases involving urgent medical care but not involving emergency medical care, or

''(II) before the end of the emergency decision period under paragraph (9)(M), in cases involving emergency medical care,

following the filing completion date. Failure to approve or deny such a request before the end of the applicable decision period shall be treated as a denial of the request for purposes of internal review under clause (ii).

''(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial converge decision, setting forth the grounds for the decision—

''(I) before the end of the urgent decision period under paragraph (9)(L), in cases involving urgent medical care but not involving emergency medical care, or

''(II) before the end of the emergency decision period under paragraph (9)(M), in cases involving emergency medical care,

following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of the applicable decision period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision, subject to any applicable reconsideration under paragraph (4).

''(3) PHYSICIANS MUST REVIEW INITIAL COVERAGE DECISIONS INVOLVING MEDICAL APPROPRIATENESS OR NECESSITY OR EXPERIMENTAL TREATMENT.—If an initial coverage decision under paragraph (2)(A)(i) or (2)(B)(i) is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service does not meet the plan's requirements for medical appropriateness or necessity or would constitute experimental treatment or technology, the review under paragraph (2)(A)(ii) or (2)(B)(ii), to the extent that it relates to medical appropriateness or necessity or to experimental treatment or technology, shall be conducted by a physician who is selected to serve as an appropriate named fiduciary under the plan and who did not make the initial denial.

''(4) ELECTIVE EXTERNAL REVIEW BY INDEPENDENT MEDICAL EXPERT AND RECONSIDERATION OF INITIAL REVIEW DECISION.—

''(A) IN GENERAL.—The requirements of subparagraphs (B), (C) and (D) shall apply—

''(i) in the case of any failure to timely issue a coverage decision upon internal review which is deemed to be an adverse coverage decision under paragraph (2)(A)(ii) or (2)(B)(ii) (thereby failing to constitute a coverage decision for which specific reasons have been set forth as required under paragraph (1)(A)), and

''(ii) in the case of any adverse coverage decision which is not reversed upon a review conducted pursuant to paragraph (1)(C) (including any review pursuant to paragraph (2)(A)(ii) or (2)(B)(ii)), if such coverage decision is based on a determination that provision of a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service—

''(I) does not meet the plan's requirements for medical appropriateness or necessity, or

''(II) would constitute experimental treatment or technology.

''(B) LIMITS ON ALLOWABLE ADVANCE PAYMENTS.—The review under this paragraph in connection with an adverse coverage decision shall be available subject to any requirement of the plan (unless waived by the plan for financial or other reasons) for payment in advance to the plan by the participant or beneficiary seeking review of an amount not to exceed the greater of—

''(i) the lesser of $100 or 10 percent of the cost of the medical care involved in the decision, or

''(ii) $25,

with each such dollar amount subject to compounded annual adjustments in the same manner and to the same extent as apply under section 215(i) of the Social Security Act, except that, for any calendar year, such amount as so adjusted shall be deemed, solely for such calendar year, to be equal to such amount rounded to the nearest $10. No such payment may be required in the case of any participant or beneficiary whose enrollment under the plan is paid for, in whole or in part, under a State plan under title XIX or XXI of the Social Security Act. Any such advance payment shall be subject to reimbursement if the recommendation of the independent medical expert or experts under subparagraph (C)(iii) is to reverse or modify the coverage decision.

''(C) RECONSIDERATION OF INITIAL REVIEW DECISION.—In any case in which a participant or beneficiary who has received an adverse decision of the plan upon initial review of the coverage decision and who has not commenced review of the initial coverage decision under section 502 makes a request in writing, within 30 days after the date of such review decision, for reconsideration of such review decision, the terms of the plan shall provide for a procedure for such reconsideration under which—

''(i) one or more independent medical experts will be selected in accordance with subparagraph (E) to review the coverage decision described in subparagraph (A) to determine whether such decision was in accordance with the terms of the plan and this title,

''(ii) the record for review (including a specification of the terms of the plan and other criteria serving as the basis for the initial review decision) will be presented to such expert or experts and maintained in a manner which will ensure confidentiality of such record,

''(iii) such expert or experts will report in writing to the plan their recommendation, based on the determination made under clause (i), as to whether such coverage decision should be affirmed, modified, or reversed, setting forth the grounds (including the clinical basis) for the recommendation, and

''(iv) a physician who did not make the initial review decision will reconsider the initial review decision to determine whether such decision was in accordance with the terms of the plan and this title and will issue a written decision affirming, modifying, or reversing the initial review decision, taking into account any recommendations reported to the plan pursuant to clause (iii), and setting forth the grounds for the decision.

''(D) TIME LIMITS FOR RECONSIDERATION.—Any review under this paragraph shall be completed before the end of the reconsideration period (as defined in paragraph (9)(O)) following the review filing date in connection with such review. The decision under this paragraph affirming, reversing, or modifying the initial review decision of the plan shall be the final decision of the plan. Failure to issue a written decision before the end of the reconsideration period in any reconsideration requested under this paragraph shall be treated as a final decision affirming the initial review decision of the plan.

''(E) INDEPENDENT MEDICAL EXPERTS.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'independent medical expert' means, in connection with any coverage decision by a group health plan, a professional—

''(I) who is a physician or, if appropriate, another medical professional,

''(II) who has appropriate credentials and has attained recognized expertise in the applicable medical field,

''(III) who was not involved in the initial decision or any earlier review thereof, and

''(IV) who is selected in accordance with clause (ii) and meets the requirements of clause (iii).

''(ii) SELECTION OF MEDICAL EXPERTS.—An independent medical expert is selected in accordance with this clause if—

''(I) the expert is selected by an intermediary which itself meets the requirements of clause (iii), by means of a method which ensures that the identity of the expert is not disclosed to the plan, any health insurance issuer offering health insurance coverage to the aggrieved participant or beneficiary in

connection with the plan, and the aggrieved participant or beneficiary under the plan, and the identities of the plan, the issuer, and the aggrieved participant or beneficiary are not disclosed to the expert,

''(II) the expert is selected, by an appropriately credentialed panel of physicians meeting the requirements of clause (iii) established by a fully accredited teaching hospital meeting such requirements,

''(III) the expert is selected by an organization described in section 1152(1)(A) of the Social Security Act which meets the requirements of clause (iii),

''(IV) the expert is selected by an external review organization which meets the requirements of clause (iii) and is accredited by a private standard-setting organization meeting such requirements and recognized as such by the Secretary, or

''(V) the expert is selected, by an intermediary or otherwise, in a manner that is, under regulations issued pursuant to negotiated rulemaking, sufficient to ensure the expert's independence,

and the method of selection is devised to reasonably ensure that the expert selected meets the independence requirements of clause (iii).

''(iii) INDEPENDENCE REQUIREMENTS.—An independent medical expert or another entity described in clause (ii) meets the independence requirements of this clause if—

''(I) the expert or entity is not affiliated with any related party,

''(II) any compensation received by such expert or entity in connection with the external review is reasonable and not contingent on any decision rendered by the expert or entity,

''(III) under the terms of the plan and any health insurance coverage offered in connection with the plan, the plan and the issuer (if any) have no recourse against the expert or entity in connection with the external review, and

''(IV) the expert or entity does not otherwise have a conflict of interest with a related party as determined under any regulations which the Secretary may prescribe.

''(iv) RELATED PARTY.—For purposes of clause (ii)(I), the term 'related party' means—

''(I) the plan or any health insurance issuer offering health insurance coverage in connection with the plan (or any officer, director, or management employee of such plan or issuer),

''(II) the physician or other medical care provider that provided the medical care involved in the coverage decision,

''(III) the institution at which the medical care involved in the coverage decision is provided,

''(IV) the manufacturer of any drug or other item that was included in the medical care involved in the coverage decision, or

''(V) any other party determined under any regulations which the Secretary may prescribe to have a substantial interest in the coverage decision .

''(v) AFFILIATED.—For purposes of clause (iii)(I), the term 'affiliated' means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

''(F) INAPPLICABILITY WITH RESPECT TO ITEMS AND SERVICES SPECIFICALLY EXCLUDED FROM COVERAGE.—An adverse coverage decision based on a determination that an item or service is excluded from coverage under the terms of the plan shall not be subject to review under this paragraph, unless such determination is found in such decision to be based solely on the fact that the item or service—

''(i) does not meet the plan's requirements for medical appropriateness or necessity, or

''(ii) would constitute experimental treatment or technology (as defined under the plan).

''(5) PERMITTED ALTERNATIVES TO REQUIRED INTERNAL REVIEW.—

''(A) IN GENERAL.—A group health plan shall not be treated as failing to meet the requirements under paragraphs (2)(A)(ii) and (2)(B)(ii) relating to review of initial coverage decisions for benefits, if—

''(i) in lieu of the procedures relating to review under paragraphs (2)(A)(ii) and (2)(B)(ii) and in accordance with such regulations (if any) as may be prescribed by the Secretary—

''(I) the aggrieved participant or beneficiary elects in the request for the review an alternative dispute resolution procedure which is available under the plan with respect to similarly situated participants and beneficiaries, or

''(II) in the case of any such plan or portion thereof which is established and maintained pursuant to a bona fide collective bargaining agreement, the plan provides for a procedure by which such disputes are resolved by means of any alternative dispute resolution procedure,

''(ii) the time limits not exceeding the time limits otherwise applicable under paragraphs (2)(A)(ii) and (2)(B)(ii) are incorporated in such alternative dispute resolution procedure,

''(iii) any applicable requirement for review by a physician under paragraph (3), unless waived by the participant or beneficiary (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures), is incorporated in such alternative dispute resolution procedure, and

''(iv) the plan meets the additional requirements of subparagraph (B).

In any case in which a procedure described in subclause (I) or (II) of clause (i) is utilized and an alternative dispute resolution procedure is voluntarily elected by the aggrieved participant or beneficiary, the plan may require or allow (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) the aggrieved participant or beneficiary to waive review of the coverage decision under paragraph (3), to waive further review of the coverage decision under paragraph (4) or section 502, and to elect an alternative means of external review (other than review under paragraph (4)).

''(B) ADDITIONAL REQUIREMENTS.—The requirements of this subparagraph are met if the means of resolution of dispute allow for adequate presentation by the aggrieved participant or beneficiary of scientific and medical evidence supporting the position of such participant or beneficiary.

''(6) PERMITTED ALTERNATIVES TO REQUIRED EXTERNAL REVIEW.—A group health plan shall not be treated as failing to meet the requirements of this subsection in connection with review of coverage decisions under paragraph (4) if the aggrieved participant or beneficiary elects to utilize a procedure in connection with such review which is made generally available under the plan (in a manner consistent with such regulations as the Secretary may prescribe to ensure equitable procedures) under which—

''(A) the plan agrees in advance of the recommendations of the independent medical expert or experts under paragraph (4)(C)(iii) to render a final decision in accordance with such recommendations, and

''(B) the participant or beneficiary waives in advance any right to review of the final decision under section 502.

''(7) SPECIAL RULE FOR ACCESS TO SPECIALTY CARE.— In the case of a request for advance determination of coverage consisting of a request by a physician for a determination of coverage of the services of a specialist with respect to any condition, if coverage of the services of such specialist for such condition is otherwise provided under the plan, the initial coverage decision referred to in subparagraph (A)(i) or (B)(i) of paragraph (2) shall be issued within the specialty decision period. For purposes of this paragraph, the term 'specialist' means, with respect to a condition, a physician who has a high level of expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to treat the condition.

''(8) GROUP HEALTH PLAN DEFINED.—For purposes of this section—

''(A) IN GENERAL.—The term 'group health plan' shall have the meaning provided in section 733(a).

''(B) TREATMENT OF PARTNERSHIPS.—The provisions of paragraphs (1), (2), and (3) of section 732(d) shall apply.

''(9) OTHER DEFINITIONS.—For purposes of this subsection—

''(A) REQUEST FOR BENEFIT PAYMENTS.—The term 'request for benefit payments' means a request, for payment of benefits by a group health plan for medical care, which is made by or on behalf of a participant or beneficiary after such medical care has been provided.

''(B) REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'required determination of medical necessity' means a determination required under a group health plan solely that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's requirements for medical appropriateness or necessity (which may be subject to exceptions under the plan for fraud or misrepresentation), irrespective of whether the proposed medical care otherwise meets other terms and conditions of coverage, but only if such determination does not constitute an advance determination of coverage (as defined in subparagraph (C)).

''(C) ADVANCE DETERMINATION OF COVERAGE.—The term 'advance determination of coverage' means a determination under a group health plan that proposed medical care meets, under the facts and circumstances at the time of the determination, the plan's terms and conditions of coverage (which may be subject to exceptions under the plan for fraud or misrepresentation).

''(D) REQUEST FOR ADVANCE DETERMINATION OF COVERAGE.—The term 'request for advance determination of coverage' means a request for an advance determination of coverage of medical care which is made by or on behalf of a participant or beneficiary before such medical care is provided.

''(E) REQUEST FOR EXPEDITED ADVANCE DETERMINATION OF COVERAGE.—The term 'request for expedited advance determination of coverage' means a request for advance determination of coverage, in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

''(F) REQUEST FOR REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for required determination of medical necessity' means a request for a required determination of medical necessity for medical care which is made by or on behalf of a participant or beneficiary before the medical care is provided.

''(G) REQUEST FOR EXPEDITED REQUIRED DETERMINATION OF MEDICAL NECESSITY.—The term 'request for expedited required determination of medical necessity' means a request for required determination of medical necessity in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

''(H) URGENT MEDICAL CARE.—The term 'urgent medical care' means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary) that failure to provide the participant or beneficiary with such medical care within 45 days can reasonably be expected to result in either—

''(i) the imminent death of the participant or beneficiary, or

''(ii) the immediate, serious, and irreversible deterioration of the health of the participant or beneficiary which will significantly increase the likelihood of death of, or irreparable harm to, the participant or beneficiary.

''(I) EMERGENCY MEDICAL CARE.—The term 'emergency medical care' means medical care in any case in which an appropriate physician has certified in writing (or as otherwise provided in regulations of the Secretary)—

''(i) that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in—

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

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

''(III) serious dysfunction of any bodily organ or part,

or

''(ii) that immediate provision of the care is necessary because the participant or beneficiary has made or is at serious risk of making an attempt to harm himself or herself or another individual.

''(J) INITIAL DECISION PERIOD.—The term 'initial decision period' means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

''(K) INTERNAL REVIEW PERIOD.—The term 'internal review period' means a period of 30 days, or such longer period as may be prescribed in regulations of the Secretary.

''(L) URGENT DECISION PERIOD.—The term 'urgent decision period' means a period of 10 days, or such longer period as may be prescribed in regulations of the Secretary.

''(M) EMERGENCY DECISION PERIOD.—The term 'emergency decision period' means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

''(N) SPECIALTY DECISION PERIOD.—The term 'specialty decision period' means a period of 72 hours, or such longer period as may be prescribed in regulations of the Secretary.

''(O) RECONSIDERATION PERIOD.—The term 'reconsideration period' means a period of 25 days, or such longer period as may be prescribed in regulations of the Secretary, except that—

''(i) in the case of a decision involving urgent medical care, such term means the urgent decision period, and

''(ii) in the case of a decision involving emergency medical care, such term means the emergency decision period.

''(P) FILING COMPLETION DATE.—The term 'filing completion date' means, in connection with a group health plan, the date as of which the plan is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make an initial coverage decision.

''(Q) REVIEW FILING DATE.—The term 'review filing date' means, in connection with a group health plan, the date as of which the appropriate named fiduciary (or the independent medical expert or experts in the case of a review under paragraph (4)) is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make a decision to affirm, modify, or reverse a coverage decision.

''(R) MEDICAL CARE.—The term 'medical care' has the meaning provided such term by section 733(a)(2).

''(S) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided such term by section 733(b)(1).

''(T) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided such term by section 733(b)(2).

''(U) WRITTEN OR IN WRITING.—

''(i) IN GENERAL.—A request or decision shall be deemed to be 'written' or 'in writing' if such request or decision is presented in a generally recognized printable or electronic format. The Secretary may by regulation provide for presentation of information otherwise required to be in written form in such other forms as may be appropriate under the circumstances.

''(ii) MEDICAL APPROPRIATENESS OR EXPERIMENTAL TREATMENT DETERMINATIONS.—For purposes of this subparagraph, in the case of a request for advance determination of coverage, a request for expedited advance determination of coverage, a request for required determination of medical necessity, or a request for expedited required determination of medical necessity, if the decision on such request is conveyed to the provider of medical care or to the participant or beneficiary by means of telephonic or other electronic communications, such decision shall be treated as a written decision.''.

(b) CIVIL PENALTIES.—

(1) IN GENERAL.—Section 502(c) of such Act (29 U.S.C. 1132(c)) is amended by redesignating paragraphs (6) and (7) as paragraphs (7) and (8), respectively, and by inserting after paragraph (5) the following new paragraph:

''(6)(A)(i) In any case in which—

''(I) a benefit under a group health plan (as defined in section 503(b)(8)) is not timely provided to a participant or beneficiary pursuant to a final decision of the plan which was not in accordance with the terms of the plan or this title, and

''(II) such final decision of the plan is contrary to a recommendation described in section 503(b)(4)(C)(iii),

any person acting in the capacity of a fiduciary of such plan so as to cause such failure may, in the court's discretion, be liable to the aggrieved participant or beneficiary for a civil penalty.

''(ii) Such civil penalty shall be in the amount of up to $500 a day (or up to $1,000 a day in case of a bad faith failure) from the date on which the recommendation was made to the plan until the date the failure to provide benefits is corrected, up to a total amount not to exceed $250,000.

''(B) In any action commenced under subsection (a) by a participant or beneficiary with respect to a group health plan (as defined in section 503(b)(8)) in which the plaintiff alleges that a person, in the capacity of a fiduciary and in violation of the terms of the plan or this title, has taken an action resulting in an adverse coverage decision in violation of the terms of the plan, or has failed to take an action for which such person is responsible under the plan and which is necessary under the plan for a favorable coverage decision, upon finding in favor of the plaintiff, if such action was commenced after a final decision of the plan upon review which included a review under section 503(b)(4) or such action was commenced under subsection (b)(4) of this section, the court shall cause to be served on the defendant an order requiring the defendant—

''(i) to cease and desist from the alleged action or failure to act, and

''(ii) to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

The remedies provided under this subparagraph shall be in addition to remedies otherwise provided under this section.

''(C)(i) The Secretary may assess a civil penalty against a person acting in the capacity of a fidicuary of one or more group health plans (as defined in section 503(b)(8)) for—

''(I) any pattern or practice of repeated adverse coverage decisions in violation of the terms of the plan or plans or this title, or

''(II) any pattern or practice of repeated violations of the requirements of section 503 with respect to such plan or plans.

Such penalty shall be payable only upon proof by clear and convincing evidence of such pattern or practice.

''(ii) Such penalty shall be in an amount not to exceed the lesser of—

''(I) 5 percent of the aggregate value of benefits shown by the Secretary to have not been provided, or unlawfully delayed in violation of section 503, under such pattern or practice, or

''(II) $100,000.

''(iii) Any person acting in the capacity of a fiduciary of a group health plan or plans who has engaged in any such pattern or practice with respect to such plans, upon the petition of the Secretary, may be removed by the court from that position, and from any other involvement, with respect to such plan or plans, and may be precluded from returning to any such position or involvement for a period determined by the court.''.

(2) CONFORMING AMENDMENT.—Section 502(a)(6) of such Act (29 U.S.C. 1132(a)(6)) is amended by striking '', or (6)'' and inserting '', (6), or (7)''.

(c) EXPEDITED COURT REVIEW.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(1) in subsection (a)(8), by striking ''or'' at the end;

(2) in subsection (a)(9), by striking the period and inserting ''; or'';

(3) by adding at the end of subsection (a) the following new paragraph:

''(10) by a participant or beneficiary for appropriate relief under subsection (b)(4).''.

(4) by adding at the end of subsection (b) the following new paragraph:

''(4) In any case in which exhaustion of administrative remedies in accordance with paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) otherwise necessary for an action for relief under paragraph (1)(B) or (3) of subsection (a) has not been obtained and it is demonstrated to the court by means of certification by an appropriate physician that such exhaustion is not reasonably attainable under the facts and circumstances without undue risk of irreparable harm to the health of the participant or beneficiary, a civil action may be brought by a participant or beneficiary to obtain appropriate equitable relief. Any determinations made under paragraph (2)(A)(ii) or (2)(B)(ii) of section 503(b) made while an action under this paragraph is pending shall be given due consideration by the court in any such action.''.

(d) STANDARD OF REVIEW UNAFFECTED.—The standard of review under section 502 of the Employee Retirement Income Security Act of 1974 (as amended by this section) shall continue on and after the date of the enactment of this Act to be the standard of review which was applicable under such section as of immediately before such date.

(e) CONCURRENT JURISDICTION.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)(1)) is amended—

(1) in the first sentence, by striking ''under subsection (a)(1)(B) of this section'' and inserting ''under subsection (a)(1)(A) for relief

under subsection (c)(6), under subsection (a)(1)(B), and under subsection (b)(4)''; and

(2) in the last sentence, by striking ''of actions under paragraphs (1)(B) and (7) of subsection (a) of this section'' and inserting ''of actions under paragraph (1)(A) of subsection (a) for relief under subsection (c)(6) and of actions under paragraphs (1)(B) and (7) of subsection (a) and paragraph (4) of subsection (b)''.

SEC. 1202. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this subtitle shall apply with respect to grievances arising in 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 first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

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

(c) COLLECTIVE BARGAINING AGREEMENTS.—Any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

SEC. 1301. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Small Business Affordable Health Coverage Act of 1998''.

SEC. 1302. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''SEC. 801. ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a group health plan—

''(1) whose sponsor is (or is deemed under this part to be) described in subsection (b), and

''(2) under which at least one option of health insurance coverage offered by a health insurance issuer (which may include, among other options, managed care options, point of service options, and preferred provider options) is provided to participants and beneficiaries, unless, for any plan year, such coverage remains unavailable to the plan despite good faith efforts exercised by the plan to secure such coverage.

''(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a trade association, an industry association (including a rural electric cooperative association or a rural telephone cooperative association), a professional association, or a chamber of commerce (or similar business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care,

''(2) is established as a permanent entity which receives the active support of its members and collects from its members on a periodic basis dues or payments necessary to maintain eligibility for membership in the sponsor, and

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1) and (2) shall be deemed to be a sponsor described in this subsection.

''SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

''(a) IN GENERAL.—The applicable authority shall prescribe by regulation a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

''(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), the applicable authority shall certify an association health plan as meeting the requirements of this part only if the applicable authority is satisfied that—

''(1) such certification—

''(A) is administratively feasible,

''(B) is not adverse to the interests of the individuals covered under the plan, and

''(C) is protective of the rights and benefits of the individuals covered under the plan, and

''(2) the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

''(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of association health plans under this part, including requirements relating to commencement of new benefit options by plans which do not consist of health insurance coverage.

''(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

''SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

''(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if—

''(1) the sponsor (together with its immediate predecessor, if any) has met (or is deemed under this part to have met) for a continuous period of not less than 3 years ending with the date of the application for certification under this part, the requirements of paragraphs (1) and (2) of section 801(b), and

''(2) the sponsor meets (or is deemed under this part to meet) the requirements of section 801(b)(3).

''(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

''(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

''(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(B) LIMITATION.—

''(i) GENERAL RULE.—Except as provided in clauses (ii) and (iii), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

''(ii) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(iii) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, clause (i) shall not apply in the case of any service provider described in subparagraph (A) who is a provider of medical care under the plan.

''(C) SOLE AUTHORITY.—The board has sole authority to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

''(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

''(1) the requirements of subsection (a) and section 801(a)(1) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b), and

''(2) the requirements of section 804(a)(1) shall be deemed met.

''(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

''(1) IN GENERAL.—In the case of a group health plan described in paragraph (2)—

''(A) the requirements of subsection (a) and section 801(a)(1) shall be deemed met,

''(B) the joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection (b) are met, and

''(C) the requirements of section 804 shall be deemed met.

''(2) REQUIREMENTS.—A group health plan is described in this paragraph if—

''(A) the plan is a multiemployer plan, or

''(B) the plan is in existence on April 1, 1997, and would be described in section

3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii).

"SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

''(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

''(1) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer, and

''(2) all individuals commencing coverage under the plan after certification under this part must be—

''(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers, or

''(B) the beneficiaries of individuals described in subparagraph (A).

''(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—

''(1) IN GENERAL.—Subject to paragraph (2), the requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no affiliated member of the sponsor may be offered coverage under the plan as a participating employer, unless—

''(A) the affiliated member was an affiliated member on the date of certification under this part, or

''(B) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

''(2) LIMITATION.—The requirements of this subsection shall apply only in the case of plans which were in existence on the date of the enactment of the Small Business Affordable Health Coverage Act of 1998.

''(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

''(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

''(1) under the terms of the plan, no employer meeting the preceding requirements of this section is excluded as a participating employer, unless participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met with respect to the excluded employer,

''(2) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan, and

''(3) applicable benefit options under the plan are actively marketed to all eligible participating employers.

"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

''(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)), and

''(C) incorporates the requirements of section 806.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) The contribution rates for any participating small employer do not vary on the basis of the claims experience of such employer and do not vary on the basis of the type of business or industry in which such employer is engaged.

''(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from

''(i) setting contribution rates based on the claims experience of the plan, or

''(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market,

subject to the requirements of section 702(b) relating to contribution rates.

''(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

''(4) MARKETING REQUIREMENTS.—

''(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

''(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

''(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority may prescribe by regulation as necessary to carry out the purposes of this part.

''(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of any law to the extent that it (1) prohibits an exclusion of a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to matters governed by section 711 or 712.

"SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—

''(1) the benefits under the plan consist solely of health insurance coverage, or

''(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

''(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

''(i) a reserve sufficient for unearned contributions,

''(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities,

''(iii) a reserve sufficient for any other obligations of the plan, and

''(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan, and

''(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

''(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary (but not more than $200,000). The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

''(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

''(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—The requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to $2,000,000, reduced in accordance with a scale, prescribed in regulations of the applicable authority to an amount not less than $500,000, based on the level of aggregate and specific excess/stop loss insurance provided with respect to such plan.

''(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements

relating to reserves and excess/stop loss insurance as the applicable authority considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any such plan or any class of such plans.

''(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

''(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

''(f) MEASURES TO ENSURE CONTINUED PAYMENT OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

''(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

''(B) PENALTIES FOR FAILURE TO MAKE PAYMENTS.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment which was not timely paid shall be payable by the plan to the Fund.

''(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

''(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS STOP/LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be, (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2), or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

''(3) ASSOCIATION HEALTH PLAN FUND.—

''(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the 'Association Health Plan Fund'. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B), and earnings on investments of amounts of the Fund under subparagraph (B).

''(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

''(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

''(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term 'aggregate excess/stop loss insurance' means, in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract,

''(B) which is guaranteed renewable, and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term 'specific excess/stop loss insurance' means , in connection with an association health plan, a contract—

''(A) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in such contract in connection with such covered individual,

''(B) which is guaranteed renewable, and

''(C) which allows for payment of premiums by any third party on behalf of the insured plan.

''(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term 'indemnification insurance' means, in connection with an association health plan, a contract—

''(1) under which an insurer (meeting such minimum standards as may be prescribed in regulations of the applicable authority) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination),

''(2) which is guaranteed renewable and noncancellable for any reason (except as may be provided in regulations of the applicable authority), and

''(3) which allows for payment of premiums by any third party on behalf of the insured plan.

''(i) RESERVES.—For purposes of this section, the term 'reserves' means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as may be prescribed in regulations of the applicable authority.

''(j) REGULATIONS PRESCRIBED UNDER NEGOTIATED RULEMAKING.—The regulations under this section shall be prescribed under negotiated rulemaking in accordance with subchapter III of chapter 5 of title 5, United States Code, except that, in establishing the negotiated rulemaking committee for purposes of such rulemaking, the applicable authority shall include among persons invited to membership on the committee at least one of each of the following:

''(1) a representative of the National Association of Insurance Commissioners,

''(2) a representative of the American Academy of Actuaries,

''(3) a representative of the State governments, or their interests,

''(4) a representative of existing self-insured arrangements, or their interests,

''(5) a representative of associations of the type referred to in section 801(b)(1), or their interests, and

''(6) a representative of multiemployer plans that are group health plans, or their interests.

''SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form prescribed in regulations of the applicable authority, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor, and

''(B) the members of the board of trustees of the plan.

''(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

''(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

''(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

''(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

''(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

''(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

''(E) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the applicable authority as necessary to carry out the purposes of this part.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed in regulations of the applicable authority. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority).

''(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

''(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations, and

''(2) represent such actuary's best estimate of anticipated experience under the plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

''SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

''Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees—

''(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date,

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated, and

''(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed in regulations of the applicable authority.

''SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

''(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

''(b) MANDATORY TERMINATION.—In any case in which—

''(1) the applicable authority has been notified under subsection (a) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements, and

''(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

''SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

''(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition as defined in regulations of such Secretary, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

''(b) POWERS AS TRUSTEE.—The Secretary, upon appointment as trustee under subsection (a), shall have the power—

''(1) to do any act authorized by the plan, this title, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan,

''(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee,

''(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations of the Secretary, and applicable provisions of law,

''(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan,

''(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship,

''(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan,

''(7) to issue, publish, or file such notices, statements, and reports as may be required under regulations of the Secretary or by any order of the court,

''(8) to terminate the plan (or provide for its termination accordance with section 809(b)) and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship,

''(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options, and

''(10) to do such other acts as may be necessary to comply with this title or any order

of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

''(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

''(1) the sponsor and plan administrator,

''(2) each participant,

''(3) each participating employer, and

''(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

''(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

''(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

''(f) JURISDICTION OF COURT.—

''(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

''(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

''(g) PERSONNEL.—In accordance with regulations of the Secretary, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

''SEC. 811. STATE ASSESSMENT AUTHORITY.

''(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Affordable Health Coverage Act of 1998.

''(b) CONTRIBUTION TAX.—For purposes of this section, the term 'contribution tax' imposed by a State on an association health plan means any tax imposed by such State if—

''(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals covered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals,

''(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan,

''(3) such tax is otherwise nondiscriminatory, and

''(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

''SEC. 812. SPECIAL RULES FOR CHURCH PLANS.

''(a) ELECTION FOR CHURCH PLANS.—Notwithstanding section 4(b)(2), if a church, a convention or association of churches, or an organization described in section 3(33)(C)(i) maintains a church plan which is a group health plan (as defined in section 733(a)(1)), and such church, convention, association, or organization makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulation prescribe), then the provisions of this section shall apply to such plan, with respect to benefits provided under such plan consisting of medical care, as if section 4(b)(2) did not contain an exclusion for church plans. Nothing in this subsection shall be construed to render any other section of this title applicable to church plans, except to the extent that such other section is incorporated by reference in this section.

''(b) EFFECT OF ELECTION.—

''(1) PREEMPTION OF STATE INSURANCE LAWS REGULATING COVERED CHURCH PLANS.—Subject to paragraphs (2) and (3), this section shall supersede any and all State laws which regulate insurance insofar as they may now or hereafter regulate church plans to which this section applies or trusts established under such church plans.

''(2) GENERAL STATE INSURANCE REGULATION UNAFFECTED.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (3), nothing in this section shall be construed to exempt or relieve any person from any provision of State law which regulates insurance.

''(B) CHURCH PLANS NOT TO BE DEEMED INSURANCE COMPANIES OR INSURERS.—Neither a church plan to which this section applies, nor any trust established under such a church plan, shall be deemed to be an insurance company or other insurer or to be engaged in the business of insurance for purposes of any State law purporting to regulate insurance companies or insurance contracts.

''(3) PREEMPTION OF CERTAIN STATE LAWS RELATING TO PREMIUM RATE REGULATION AND BENEFIT MANDATES.—The provisions of subsections (a)(2)(B) and (b) of section 805 shall apply with respect to a church plan to which this section applies in the same manner and to the same extent as such provisions apply with respect to association health plans.

''(4) DEFINITIONS.—For purposes of this subsection—

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

''(B) STATE.—The term 'State' includes a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of church plans covered by this section.

''(c) REQUIREMENTS FOR COVERED CHURCH PLANS.—

''(1) FIDUCIARY RULES AND EXCLUSIVE PURPOSE.—A fiduciary shall discharge his duties with respect to a church plan to which this section applies—

''(A) for the exclusive purpose of:

''(i) providing benefits to participants and their beneficiaries; and

''(ii) defraying reasonable expenses of administering the plan;

''(B) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

''(C) in accordance with the documents and instruments governing the plan.

The requirements of this paragraph shall not be treated as not satisfied solely because the plan assets are commingled with other church assets, to the extent that such plan assets are separately accounted for.

''(2) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every church plan to which this section applies shall—

''(A) 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;

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

''(C) provide a written statement to each participant describing the procedures established pursuant to this paragraph.

''(3) ANNUAL STATEMENTS.—In accordance with regulations of the Secretary, every church plan to which this section applies shall file with the Secretary an annual statement—

''(A) stating the names and addresses of the plan and of the church, convention, or association maintaining the plan (and its principal place of business);

''(B) certifying that it is a church plan to which this section applies and that it complies with the requirements of paragraphs (1) and (2);

''(C) identifying the States in which participants and beneficiaries under the plan are or likely will be located during the 1-year period covered by the statement; and

''(D) containing a copy of a statement of actuarial opinion signed by a qualified actuary that the plan maintains capital, reserves, insurance, other financial arrangements, or any combination thereof adequate to enable the plan to fully meet all of its financial obligations on a timely basis.

''(4) DISCLOSURE.—At the time that the annual statement is filed by a church plan with the Secretary pursuant to paragraph (3), a copy of such statement shall be made available by the Secretary to the State insurance commissioner (or similar official) of any State. The name of each church plan and sponsoring organization filing an annual statement in compliance with paragraph (3) shall be published annually in the Federal Register.

''(c) ENFORCEMENT.—The Secretary may enforce the provisions of this section in a manner consistent with section 502, to the extent applicable with respect to actions under section 502(a)(5), and with section 3(33)(D), except that, other than for the purpose of seeking a temporary restraining order, a civil action may be brought with respect to the plan's failure to meet any requirement of this section only if the plan fails to correct its failure within the correction period described in section 3(33)(D). The other provisions of part 5 (except sections 501(a), 503, 512, 514, and 515) shall apply with respect to the enforcement and administration of this section.

''(d) DEFINITIONS AND OTHER RULES.—For purposes of this section—

''(1) IN GENERAL.—Except as otherwise provided in this section, any term used in this section which is defined in any provision of this title shall have the definition provided such term by such provision.

''(2) SEMINARY STUDENTS.—Seminary students who are enrolled in an institution of higher learning described in section 3(33)(C)(iv) and who are treated as participants under the terms of a church plan to which this section applies shall be deemed to be employees as defined in section 3(6) if the number of such students constitutes an insignificant portion of the total number of individuals who are treated as participants under the terms of the plan.

''SEC. 813. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(2) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

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

''(5) APPLICABLE AUTHORITY.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'applicable authority' means, in connection with an association health plan—

''(i) the State recognized pursuant to subsection (c) of section 506 as the State to which authority has been delegated in connection with such plan, or

''(ii) if there if no State referred to in clause (i), the Secretary.

''(B) EXCEPTIONS.—

''(i) JOINT AUTHORITIES.—Where such term appears in section 808(3), section 807(e) (in the first instance), section 809(a) (in the second instance), section 809(a) (in the fourth instance), and section 809(b)(1), such term means, in connection with an association health plan, the Secretary and the State referred to in subparagraph (A)(i) (if any) in connection with such plan.

''(ii) REGULATORY AUTHORITIES.—Where such term appears in section 802(a) (in the first instance), section 802(d), section 802(e), section 803(d), section 805(a)(5), section 806(a)(2), section 806(b), section 806(c), section 806(d), paragraphs (1)(A) and (2)(A) of section 806(g), section 806(h), section 806(i), section 807(a) (in the second instance), section 807(b), section 807(d), section 807(e) (in the second instance), section 808 (in the matter after paragraph (3)), and section 809(a) (in the third instance), such term means, in connection with an association health plan, the Secretary.

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning provided in section 733(d)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(9) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(10) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation.

''(11) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor, a person eligible to be a member of the sponsor or, in the case of a sponsor with member associations, a person who is a member, or is eligible to be a member, of a member association.

''(12) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

''(13) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

''(b) RULES OF CONSTRUCTION.—

''(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(A) in the case of a partnership, the term 'employer' (as defined in section (3)(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section (3)(6)) includes any partner in relation to the partnership, and

''(B) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

''(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

''(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.''.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

''(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

''(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

''(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

''(B) In any case in which health insurance coverage of any policy type is offered under an association health plan in a State and the filing, with the applicable State authority, of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

''(3) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

''(4) For purposes of this subsection, the term 'association health plan' has the meaning provided in section 801(a), and the terms

'health insurance coverage', 'participating employer', and 'health insurance issuer' have the meanings provided such terms in section 811, respectively.''.

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking ''and'' at the end;

(B) in clause (ii), by inserting ''and which does not provide medical care (within the meaning of section 733(a)(2)),'' after ''arrangement,'', and by striking ''title.'' and inserting ''title, and''; and

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

''(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.''.

(4) Section 514(e) of such Act (as redesignated by paragraph (2)(C)) is amended—

(A) by striking ''Nothing'' and inserting ''(1) Except as provided in paragraph (2), nothing''; and

(B) by adding at the end the following new paragraph:

''(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Patient Protection Act of 1998 shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.''.

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of an association health plan under part 8.''.

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: ''An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.''.

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(f) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

''PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

''Sec. 801. Association health plans.
''Sec. 802. Certification of association health plans.
''Sec. 803. Requirements relating to sponsors and boards of trustees.
''Sec. 804. Participation and coverage requirements.
''Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.
''Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
''Sec. 807. Requirements for application and related requirements.
''Sec. 808. Notice requirements for voluntary termination.
''Sec. 809. Corrective actions and mandatory termination.
''Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
''Sec. 811. State assessment authority.
''Sec. 812. Special rules for church plans.
''Sec. 813. Definitions and rules of construction.''.

SEC. 1303. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting ''for any plan year of any such plan, or any fiscal year of any such other arrangement;'' after ''single employer'', and by inserting ''during such year or at any time during the preceding 1-year period'' after ''control group'';

(2) in clause (iii)—

(A) by striking ''common control shall not be based on an interest of less than 25 percent'' and inserting ''an interest of greater than 25 percent may not be required as the minimum interest necessary for common control''; and

(B) by striking ''similar to'' and inserting ''consistent and coextensive with'';

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

''(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement,''.

SEC. 1304. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

''(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E),''.

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

''(C) For purposes of subparagraph (A)(i)(II), a plan or other arrangement shall be treated as established or maintained in accordance with this subparagraph only if the following requirements are met:

''(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

''(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement; or

''(II) pay a commission or any other type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations of the Secretary), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement;

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

''(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are identified to the plan or arrangement and who are neither—

''(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit); nor

''(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment);

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Small Business Affordable Health Coverage Act of 1998 and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

''(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary that the plan or other arrangement meets the requirements of clauses (i) and (ii).

''(D) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

''(i) all of the benefits provided under the plan or arrangement consist of health insurance coverage; or

''(ii)(I) the plan or arrangement is a multiemployer plan; and

''(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

''(E) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

''(i) the plan or arrangement is in effect as of the date of the enactment of the Small Business Affordable Health Coverage Act of 1998, or

''(ii) the employee organization or other entity sponsoring the plan or arrangement—

''(I) has been in existence for at least 3 years or is affiliated with another employee organization which has been in existence for at least 3 years, or

''(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement.''.

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: ''Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii).''.

SEC. 1305. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting ''(a)'' after ''SEC. 501.''; and

(2) by adding at the end the following new subsection:

''(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

''(1) being an association health plan which has been certified under part 8;

''(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

''(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met;

shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.''.

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

''(n)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

''(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

''(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

''(2) Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

''(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

''(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

''(3) The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.''.

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) (as amended by title I) is amended by adding at the end the following new subsection:

''(c) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.''.

SEC. 1306. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(c) RESPONSIBILITY OF STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8,

''(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8, or

''(C) any combination of the Secretary's authority authorized to be delegated under subparagraphs (A) and (B).

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

''(3) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular association health plan, as the State to which all authority has been delegated pursuant to such agreements in connection with such plan. In carrying out this paragraph, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.''.

SEC. 1307. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by sections 1302, 1305, and 1306 shall take effect on January 1, 2000. The amendments made by sections 1303 and 1304 shall take effect on the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this subtitle before January 1, 2000.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 1302) does not apply in connection with an association health plan (certified under part 8 of subtitle B of title I of such Act) existing on April 1, 1997, if no benefits provided thereunder as of the date of the enactment of this Act consist of health insurance coverage (as defined in section 733(b)(1) of such Act).

(c) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 813(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this Act)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act,

(B) the requirements of sections 801(a)(1) and 803(a)(1) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement,

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote, and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement,

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement,

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan,'' ''medical care,'' and ''participating employer'' shall have the meanings provided in section 813 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''association health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

(d) PILOT PROGRAM FOR SELF-INSURED ASSOCIATION HEALTH PLANS.—

(1) IN GENERAL.—During the pilot program period, association health plans which offer benefit options which do not consist of health insurance coverage may be certified under part 8 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 only if such plans consist of the following:

(A) plans which offered such coverage on the date of the enactment of this Act,

(B) plans under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

(C) plans whose eligible participating employers represent one or more trades or businesses, or one or more industries, which have been indicated as having average or above-average health insurance risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, and other means demonstrated by such plans in accordance with regulations which the Secretary shall prescribe, including (but not limited to) the following: agriculture; automobile dealerships; barbering and cosmetology; child care; construction; dance, theatrical, and orchestra productions; disinfecting and pest control; eating and drinking establishments; fishing; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; sanitary services; transportation (local and freight); and warehousing.

(2) PILOT PROGRAM PERIOD.—For purposes of this subsection, the term ''pilot program period'' means the 5-year period beginning on January 1, 1999.

TITLE II—AMENDMENTS TO PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements

SEC. 2001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2706. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

''(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

''(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan or a health insurance issuer offering health insurance coverage in connection with a group health plan, the plan or issuer with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition or restriction with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan or health insurance coverage offered in connection with the plan.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, 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 group health plan 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) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

''(1) IN GENERAL.—To the extent that the group health plan (or health insurance issuer offering health insurance coverage in connection with the plan) provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974), except for items or services specifically excluded—

''(A) the plan or issuer shall provide benefits, and without regard to otherwise applicable network limitations, without requiring preauthorization and without regard to otherwise applicable network limitations, 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 in order to determine whether emergency medical care (as so defined) is required, and

''(B) the plan or issuer shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in section 503(b)(9)(I) of such Act.

''(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan or issuer from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), 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 section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974) provided to such similarly situated participants and beneficiaries under the plan.

''(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan)—

''(A) provides benefits under the terms of the plan consisting of—

''(i) routine gynecological care (such as preventive women's health examinations), or

''(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

''(B) the plan 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, then the plan (or issuer) shall meet the requirements of paragraph (2).

''(2) REQUIREMENTS.—A group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan (or issuer)—

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

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

''(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

''(d) PATIENT ACCESS TO PEDIATRIC CARE.—

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

''(e) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.''.

(c) EFFECTIVE DATE AND RELATED RULES.—

(1) IN GENERAL.—The amendments made by this section 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, except that the Secretary of Health and Human Services may issue regulations before such date under such amendments. The Secretary shall first issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

(2) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer 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 or issuer has sought to comply in good faith with such requirement.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this paragraph, any plan amendments made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

SEC. 2002. REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO OFFER OPTION OF POINT-OF-SERVICE COVERAGE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act is amended by inserting after section 2713 the following new section:

''SEC. 2714. REQUIRING OFFERING OF OPTION OF POINT-OF-SERVICE COVERAGE.

''(a) REQUIREMENT TO OFFER COVERAGE OPTION TO CERTAIN EMPLOYERS.—Except as provided in subsection (c), any health insurance issuer which—

''(1) is a health maintenance organization (as defined in section 2791(b)(3)), and

''(2) which provides for coverage of services of one or more classes of health care professionals under health insurance coverage offered in connection with a group health plan only if such services are furnished exclusively through health care professionals within such class or classes who are members of a closed panel of health care professionals,

the issuer shall make available to the plan sponsor in connection with such a plan a

coverage option which provides for coverage of such services which are furnished through such class (or classes) of health care professionals regardless of whether or not the professionals are members of such panel.

''(b) REQUIREMENT TO OFFER SUPPLEMENTAL COVERAGE TO PARTICIPANTS IN CERTAIN CASES.—Except as provided in subsection (c), if a health insurance issuer makes available a coverage option under and described in subsection (a) to a plan sponsor of a group health plan and the sponsor declines to contract for such coverage option, then the issuer shall make available in the individual insurance market to each participant in the group health plan optional separate supplemental health insurance coverage in the individual health insurance market which consists of services identical to those provided under such coverage provided through the closed panel under the group health plan but are furnished exclusively by health care professionals who are not members of such a closed panel.

''(c) EXCEPTIONS.—

''(1) OFFERING OF NON-PANEL OPTION.—Subsections (a) and (b) shall not apply with respect to a group health plan if the plan offers a coverage option that provides coverage for services that may be furnished by a class or classes of health care professionals who are not in a closed panel. This paragraph shall be applied separately to distinguishable groups of employees under the plan.

''(2) AVAILABILITY OF COVERAGE THROUGH HEALTHMART.—Subsections (a) and (b) shall not apply to a group health plan if the health insurance coverage under the plan is made available through a HealthMart (as defined in section 2801) and if any health insurance coverage made available through the HealthMart provides for coverage of the services of any class of health care professionals other than through a closed panel of professionals.

''(3) RELICENSURE EXEMPTION.—Subsections (a) and (b) shall not apply to a health maintenance organization in a State in any case in which—

''(A) the organization demonstrates to the applicable authority that the organization has made a good faith effort to obtain (but has failed to obtain) a contract between the organization and any other health insurance issuer providing for the coverage option or supplemental coverage described in subsection (a) or (b), as the case may be, within the applicable service area of the organization, and

''(B) the State requires the organization to receive or qualify for a separate license, as an indemnity insurer or otherwise, in order to offer such coverage option or supplemental coverage, respectively.

The applicable authority may require that the organization demonstrate that it meets the requirements of the previous sentence no more frequently that once every two years.

''(4) INCREASED COSTS.—Subsections (a) and (b) shall not apply to a health maintenance organization if the organization demonstrates to the applicable authority, in accordance with generally accepted actuarial practice, that, on either a prospective or retroactive basis, the premium for the coverage option or supplemental coverage required to be made available under such respective subsection exceeds by more than 1 percent the premium for the coverage consisting of services which are furnished through a closed panel of health care professionals in the class or classes involved. The applicable authority may require that the organization demonstrate such an increase no more frequently that once every two years. This paragraph shall be applied on an average per enrollee or similar basis.

''(5) COLLECTIVE BARGAINING AGREEMENTS.—Subsections (a) and (b) shall not apply in connection with a group health plan if the plan is established or maintained pursuant to one or more collective bargaining agreements.

''(d) DEFINITIONS.—For purposes of this section:

''(1) COVERAGE THROUGH CLOSED PANEL.—Health insurance coverage for a class of health care professionals shall be treated as provided through a closed panel of such professionals only if such coverage consists of coverage of items or services consisting of professionals services which are reimbursed for or provided only within a limited network of such professionals.

''(2) HEALTH CARE PROFESSIONAL.—The term 'health care professional' has the meaning given such term in section 2706(a)(2).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to coverage offered on or after January 1 of the second calendar year following the date of the enactment of this Act.

Subtitle B—Patient Access to Information

SEC. 2101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (as amended by subtitle A of this title) is amended further by adding at the end the following new section:

''SEC. 2707. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

''(a) DISCLOSURE REQUIREMENT.—Each health insurance issuer offering health insurance coverage in connection with a group health plan shall provide the administrator of such plan on a timely basis with the information necessary to enable the administrator to include in the summary plan description of the plan required under section 102 of the Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act for different options of coverage) the information required under subsections (b), (c), (d), and (e)(2)(A). To the extent that any such issuer provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the coverage includes emergency medical care (including the extent to which the coverage provides for access to urgent care centers), and any definitions provided under in connection with such coverage for the relevant coverage terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the coverage includes benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the benefits available under the coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used in connection with such coverage for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided in connection with such coverage for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided in connection with such coverage for the relevant coverage terminology referring to such limited or excluded care.

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the coverage, in including emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such coverage.

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted in connection with such coverage pursuant to section 503(b) of the Employee Retirement Income Security Act of 1974, including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—A group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications, and

''(ii) the actual plan provisions setting forth the benefits available under the plan,

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS AND ISSUERS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall provide the following information to a participant or beneficiary on request:

''(i) NETWORK CHARACTERISTICS.—If the plan (or issuer) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(ix) INFORMATION RELATING TO EXTERNAL REVIEWS.—The number of external reviews under section 503(b)(4) of the Employee Retirement Income Security Act of 1974 that have been completed during the prior plan year and the number of such reviews in which the recommendation reported under section 503(b)(4)(C)(iii) of such Act includes a recommendation for modification or reversal of an internal review decision under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan (and a health insurance issuer offering health insurance coverage in connection with a group health plan) shall, upon written request (made not more frequently than annually), make available to a participant and an employee who, under the terms of the plan, is eligible for coverage but not enrolled in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.''.

SEC. 2102. EFFECTIVE DATE.

(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 first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

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

Subtitle C—HealthMarts

SEC. 2201. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Health Care Consumer Empowerment Act of 1998''.

SEC. 2202. EXPANSION OF CONSUMER CHOICE THROUGH HEALTHMARTS.

(a) IN GENERAL.—The Public Health Service Act is amended by adding at the end the following new title:

''TITLE XXVIII—HEALTHMARTS

''SEC. 2801. DEFINITION OF HEALTHMART.

''(a) IN GENERAL.—For purposes of this title, the term 'HealthMart' means a legal entity that meets the following requirements:

''(1) ORGANIZATION.—The HealthMart is a nonprofit organization operated under the direction of a board of directors which is composed of representatives of not fewer than 2 and in equal numbers from each of the following:

''(A) Small employers.

''(B) Employees of small employers.

''(C) Health care providers, which may be physicians, other health care professionals, health care facilities, or any combination thereof.

''(D) Entities, such as insurance companies, health maintenance organizations, and licensed provider-sponsored organizations, that underwrite or administer health benefits coverage.

''(2) OFFERING HEALTH BENEFITS COVERAGE.—

''(A) IN GENERAL.—The HealthMart, in conjunction with those health insurance issuers that offer health benefits coverage through the HealthMart, makes available health benefits coverage in the manner described in subsection (b) to all small employers and eligible employees in the manner described in subsection (c)(2) at rates (including employer's and employee's share) that are established by the health insurance issuer on a policy or product specific basis and that may vary only as permissible under State law. A HealthMart is deemed to be a group health plan for purposes of applying section 702 of the Employee Retirement Income Security Act of 1974, section 2702 of this Act, and section 9802(b) of the Internal Revenue Code of 1986 (which limit variation among similarly situated individuals of required premiums for health benefits coverage on the basis of health status-related factors).

''(B) NONDISCRIMINATION IN COVERAGE OFFERED.—

''(i) IN GENERAL.—Subject to clause (ii), the HealthMart may not offer health benefits coverage to an eligible employee in a geographic area (as specified under paragraph (3)(A)) unless the same coverage is offered to all such employees in the same geographic area. Section 2711(a)(1)(B) of this Act limits denial of enrollment of certain eligible individuals under health benefits coverage in the small group market.

''(ii) CONSTRUCTION.—Nothing in this title shall be construed as requiring or permitting a health insurance issuer to provide coverage outside the service area of the issuer, as approved under State law.

''(C) NO FINANCIAL UNDERWRITING.—The HealthMart provides health benefits coverage only through contracts with health insurance issuers and does not assume insurance risk with respect to such coverage.

''(D) MINIMUM COVERAGE.—By the end of the first year of its operation and thereafter, the HealthMart maintains not fewer than 10 purchasers and 100 members.

''(3) GEOGRAPHIC AREAS.—

''(A) SPECIFICATION OF GEOGRAPHIC AREAS.—The HealthMart shall specify the geographic area (or areas) in which it makes available health benefits coverage offered by health insurance issuers to small employers. Such an area shall encompass at least one entire county or equivalent area.

''(B) MULTISTATE AREAS.—In the case of a HealthMart that serves more than one State, such geographic areas may be areas that include portions of two or more contiguous States.

''(C) MULTIPLE HEALTHMARTS PERMITTED IN SINGLE GEOGRAPHIC AREA.—Nothing in this title shall be construed as preventing the establishment and operation of more than one HealthMart in a geographic area or as limiting the number of HealthMarts that may operate in any area.

''(4) PROVISION OF ADMINISTRATIVE SERVICES TO PURCHASERS.—

''(A) IN GENERAL.—The HealthMart provides administrative services for purchasers. Such services may include accounting, billing, enrollment information, and employee coverage status reports.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a HealthMart from serving as an administrative service organization to any entity.

''(5) DISSEMINATION OF INFORMATION.—The HealthMart collects and disseminates (or arranges for the collection and dissemination of) consumer-oriented information on the scope, cost, and enrollee satisfaction of all coverage options offered through the HealthMart to its members and eligible individuals. Such information shall be defined by the HealthMart and shall be in a manner appropriate to the type of coverage offered. To the extent practicable, such information shall include information on provider performance, locations and hours of operation of providers, outcomes, and similar matters. Nothing in this section shall be construed as preventing the dissemination of such information or other information by the HealthMart or by health insurance issuers through electronic or other means.

''(6) FILING INFORMATION.—The HealthMart—

''(A) files with the applicable Federal authority information that demonstrates the HealthMart's compliance with the applicable requirements of this title; or

''(B) in accordance with rules established under section 2803(a), files with a State such information as the State may require to demonstrate such compliance.

''(b) HEALTH BENEFITS COVERAGE REQUIREMENTS.—

''(1) COMPLIANCE WITH CONSUMER PROTECTION REQUIREMENTS.—Any health benefits coverage offered through a HealthMart shall—

''(A) be underwritten by a health insurance issuer that—

''(i) is licensed (or otherwise regulated) under State law (or is a community health organization that is offering health insurance coverage pursuant to section 330B(a)),

''(ii) meets all applicable State standards relating to consumer protection, subject to section 2802(b), and

''(iii) offers the coverage under a contract with the HealthMart;

''(B) subject to paragraph (2), be approved or otherwise permitted to be offered under State law; and

''(C) provide full portability of creditable coverage for individuals who remain members of the same HealthMart notwithstanding that they change the employer through which they are members in accordance with the provisions of the parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and titles XXII and XXVII of this Act, so long as both employers are purchasers in the HealthMart.

''(2) ALTERNATIVE PROCESS FOR APPROVAL OF HEALTH BENEFITS COVERAGE IN CASE OF DISCRIMINATION OR DELAY.—

''(A) IN GENERAL.—The requirement of paragraph (1)(B) shall not apply to a policy or product of health benefits coverage offered in a State if the health insurance issuer seeking to offer such policy or product files an application to waive such requirement with the applicable Federal authority, and the authority determines, based on the application and other evidence presented to the authority, that—

''(i) either (or both) of the grounds described in subparagraph (B) for approval of the application has been met; and

''(ii) the coverage meets the applicable State standards (other than those that have been preempted under section 2802).

''(B) GROUNDS.—The grounds described in this subparagraph with respect to a policy or product of health benefits coverage are as follows:

''(i) FAILURE TO ACT ON POLICY, PRODUCT, OR RATE APPLICATION ON A TIMELY BASIS.—The State has failed to complete action on the policy or product (or rates for the policy or product) within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

''(ii) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The State has denied such an application and—

''(I) the standards or review process imposed by the State as a condition of approval of the policy or product imposes either any material requirements, procedures, or standards to such policy or product that are not generally applicable to other policies and products offered or any requirements that are preempted under section 2802; or

''(II) the State requires the issuer, as a condition of approval of the policy or product, to offer any policy or product other than such policy or product.

''(C) ENFORCEMENT.—In the case of a waiver granted under subparagraph (A) to an issuer with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an issuer and its health insurance coverage with the applicable State standards described in subparagraph (A)(ii). Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other health insurance issuers and plans, without discrimination based on the type of issuer to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under subparagraph (A).

''(3) EXAMPLES OF TYPES OF COVERAGE.—The health benefits coverage made available through a HealthMart may include, but is not limited to, any of the following if it meets the other applicable requirements of this title:

''(A) Coverage through a health maintenance organization.

''(B) Coverage in connection with a preferred provider organization.

''(C) Coverage in connection with a licensed provider-sponsored organization.

''(D) Indemnity coverage through an insurance company.

''(E) Coverage offered in connection with a contribution into a medical savings account or flexible spending account.

''(F) Coverage that includes a point-of-service option.

''(G) Coverage offered by a community health organization (as defined in section 330B(e)).

''(H) Any combination of such types of coverage.

''(4) WELLNESS BONUSES FOR HEALTH PROMOTION.—Nothing in this title shall be construed as precluding a health insurance issuer offering health benefits coverage through a HealthMart from establishing premium discounts or rebates for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention so long as such programs are agreed to in advance by the HealthMart and comply with all other provisions of this title and do not discriminate among similarly situated members.

''(c) PURCHASERS; MEMBERS; HEALTH INSURANCE ISSUERS.—

''(1) PURCHASERS.—

''(A) IN GENERAL.—Subject to the provisions of this title, a HealthMart shall permit any small employer to contract with the HealthMart for the purchase of health benefits coverage for its employees and dependents of those employees and may not vary conditions of eligibility (including premium rates and membership fees) of a small employer to be a purchaser.

''(B) ROLE OF ASSOCIATIONS, BROKERS, AND LICENSED HEALTH INSURANCE AGENTS.—Nothing in this section shall be construed as preventing an association, broker, licensed health insurance agent, or other entity from assisting or representing a HealthMart or small employers from entering into appropriate arrangements to carry out this title.

''(C) PERIOD OF CONTRACT.—The HealthMart may not require a contract under subparagraph (A) between a HealthMart and a purchaser to be effective for a period of longer than 12 months. The previous sentence shall not be construed as preventing such a contract from being extended for additional 12-month periods or preventing the purchaser from voluntarily electing a contract period of longer than 12 months.

''(D) EXCLUSIVE NATURE OF CONTRACT.—Such a contract shall provide that the purchaser agrees not to obtain or sponsor health benefits coverage, on behalf of any eligible employees (and their dependents), other than through the HealthMart. The previous sentence shall not apply to an eligible individual who resides in an area for which no coverage is offered by any health insurance issuer through the HealthMart.

''(2) MEMBERS.—

''(A) IN GENERAL.—Under rules established to carry out this title, with respect to a small employer that has a purchaser contract with a HealthMart, individuals who are employees of the employer may enroll for health benefits coverage (including coverage for dependents of such enrolling employees) offered by a health insurance issuer through the HealthMart.

''(B) NONDISCRIMINATION IN ENROLLMENT.—A HealthMart may not deny enrollment as a member to an individual who is an employee (or dependent of such an employee) eligible to be so enrolled based on health status-related factors, except as may be permitted consistent with section 2742(b).

''(C) ANNUAL OPEN ENROLLMENT PERIOD.—In the case of members enrolled in health benefits coverage offered by a health insurance issuer through a HealthMart, subject to subparagraph (D), the HealthMart shall provide for an annual open enrollment period of 30 days during which such members may change the coverage option in which the members are enrolled.

''(D) RULES OF ELIGIBILITY.—Nothing in this paragraph shall preclude a HealthMart from establishing rules of employee eligibility for enrollment and reenrollment of members during the annual open enrollment period under subparagraph (C). Such rules shall be applied consistently to all purchasers and members within the HealthMart and shall not be based in any manner on health status-related factors and may not conflict with sections 2701 and 2702 of this Act.

''(3) HEALTH INSURANCE ISSUERS.—

''(A) PREMIUM COLLECTION.—The contract between a HealthMart and a health insurance issuer shall provide, with respect to a member enrolled with health benefits coverage offered by the issuer through the HealthMart, for the payment of the premiums collected by the HealthMart (or the issuer) for such coverage (less a pre-determined administrative charge negotiated by the HealthMart and the issuer) to the issuer.

''(B) SCOPE OF SERVICE AREA.—Nothing in this title shall be construed as requiring the service area of a health insurance issuer with respect to health insurance coverage to cover the entire geographic area served by a HealthMart.

''(C) AVAILABILITY OF COVERAGE OPTIONS.—A HealthMart shall enter into contracts with one or more health insurance issuers in a manner that assures that at least 2 health insurance coverage options are made available in the geographic area specified under subsection (a)(3)(A).

''(d) PREVENTION OF CONFLICTS OF INTEREST.—

''(1) FOR BOARDS OF DIRECTORS.—A member of a board of directors of a HealthMart may not serve as an employee or paid consultant to the HealthMart, but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or committees thereof.

''(2) FOR BOARDS OF DIRECTORS OR EMPLOYEES.—An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a HealthMart or as an employee of the HealthMart, if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in a organization from whom the HealthMart receives contributions, grants, or other funds not connected with a contract for coverage through the HealthMart.

''(3) EMPLOYMENT AND EMPLOYEE REPRESENTATIVES.—

''(A) IN GENERAL.—An individual who is serving on a board of directors of a HealthMart as a representative described in subparagraph (A) or (B) of section 2801(a)(1) shall not be employed by or affiliated with a health insurance issuer or be licensed as or employed by or affiliated with a health care provider.

''(B) CONSTRUCTION.—For purposes of subparagraph (A), the term ''affiliated'' does not include membership in a health benefits plan or the obtaining of health benefits coverage offered by a health insurance issuer.

''(e) CONSTRUCTION.—

''(1) NETWORK OF AFFILIATED HEALTHMARTS.—Nothing in this section shall be construed as preventing one or more HealthMarts serving different areas (whether or not contiguous) from providing for some or all of the following (through a single administrative organization or otherwise):

''(A) Coordinating the offering of the same or similar health benefits coverage in different areas served by the different HealthMarts.

''(B) Providing for crediting of deductibles and other cost-sharing for individuals who are provided health benefits coverage through the HealthMarts (or affiliated HealthMarts) after—

''(i) a change of employers through which the coverage is provided, or

''(ii) a change in place of employment to an area not served by the previous HealthMart.

''(2) PERMITTING HEALTHMARTS TO ADJUST DISTRIBUTIONS AMONG ISSUERS TO REFLECT RELATIVE RISK OF ENROLLEES.—Nothing in this section shall be construed as precluding a HealthMart from providing for adjustments in amounts distributed among the health insurance issuers offering health benefits coverage through the HealthMart based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.

''(3) APPLICATION OF UNIFORM MINIMUM PARTICIPATION AND CONTRIBUTION RULES.—Nothing in this section shall be construed as precluding a HealthMart from establishing minimum participation and contribution rules (described in section 2711(e)(1)) for small employers that apply to become purchasers in the HealthMart, so long as such rules are applied uniformly for all health insurance issuers.

''SEC. 2802. APPLICATION OF CERTAIN LAWS AND REQUIREMENTS.

''(a) AUTHORITY OF STATES.—Nothing in this section shall be construed as preempting State laws relating to the following:

''(1) The regulation of underwriters of health coverage, including licensure and solvency requirements.

''(2) The application of premium taxes and required payments for guaranty funds or for contributions to high-risk pools.

''(3) The application of fair marketing requirements and other consumer protections (other than those specifically relating to an item described in subsection (b)).

''(4) The application of requirements relating to the adjustment of rates for health insurance coverage.

''(b) TREATMENT OF BENEFIT AND GROUPING REQUIREMENTS.—State laws insofar as they relate to any of the following are superseded and shall not apply to health benefits coverage made available through a HealthMart:

''(1) Benefit requirements for health benefits coverage offered through a HealthMart, including (but not limited to) requirements relating to coverage of specific providers, specific services or conditions, or the amount, duration, or scope of benefits, but not including requirements to the extent required to implement title XXVII or other Federal law and to the extent the requirement prohibits an exclusion of a specific disease from such coverage.

''(2) Requirements (commonly referred to as fictitious group laws) relating to grouping and similar requirements for such coverage to the extent such requirements impede the establishment and operation of HealthMarts pursuant to this title.

''(3) Any other requirements (including limitations on compensation arrangements) that, directly or indirectly, preclude (or have the effect of precluding) the offering of such coverage through a HealthMart, if the HealthMart meets the requirements of this title.

Any State law or regulation relating to the composition or organization of a HealthMart is preempted to the extent the law or regulation is inconsistent with the provisions of this title.

''(c) APPLICATION OF ERISA FIDUCIARY AND DISCLOSURE REQUIREMENTS.—The board of directors of a HealthMart is deemed to be a plan administrator of an employee welfare benefit plan which is a group health plan for purposes of applying parts 1 and 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and those provisions of part 5 of such subtitle which are applicable to enforcement of such parts 1 and 4, and the HealthMart shall be treated as such a plan and the enrollees shall be treated as participants and beneficiaries for purposes of applying such provisions pursuant to this subsection.

''(d) APPLICATION OF ERISA RENEWABILITY PROTECTION.—A HealthMart is deemed to be group health plan that is a multiple employer welfare arrangement for purposes of applying section 703 of the Employee Retirement Income Security Act of 1974.

''(e) APPLICATION OF RULES FOR NETWORK PLANS AND FINANCIAL CAPACITY.—The provisions of subsections (c) and (d) of section 2711 apply to health benefits coverage offered by a health insurance issuer through a HealthMart.

''(f) CONSTRUCTION RELATING TO OFFERING REQUIREMENT.—Nothing in section 2711(a) of this Act or 703 of the Employee Retirement Income Security Act of 1974 shall be construed as permitting the offering outside the HealthMart of health benefits coverage that is only made available through a HealthMart under this section because of the application of subsection (b).

''(g) APPLICATION TO GUARANTEED RENEWABILITY REQUIREMENTS IN CASE OF DISCONTINUATION OF AN ISSUER.—For purposes of

applying section 2712 in the case of health insurance coverage offered by a health insurance issuer through a HealthMart, if the contract between the HealthMart and the issuer is terminated and the HealthMart continues to make available any health insurance coverage after the date of such termination, the following rules apply:

''(1) RENEWABILITY.—The HealthMart shall fulfill the obligation under such section of the issuer renewing and continuing in force coverage by offering purchasers (and members and their dependents) all available health benefits coverage that would otherwise be available to similarly-situated purchasers and members from the remaining participating health insurance issuers in the same manner as would be required of issuers under section 2712(c).

''(2) APPLICATION OF ASSOCIATION RULES.—The HealthMart shall be considered an association for purposes of applying section 2712(e).

''(h) CONSTRUCTION IN RELATION TO CERTAIN OTHER LAWS.—Nothing in this title shall be construed as modifying or affecting the applicability to HealthMarts or health benefits coverage offered by a health insurance issuer through a HealthMart of parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 or titles XXII and XXVII of this Act.

''SEC. 2803. ADMINISTRATION.

''(a) IN GENERAL.—The applicable Federal authority shall administer this title through the division established under subsection (b) and is authorized to issue such regulations as may be required to carry out this title. Such regulations shall be subject to Congressional review under the provisions of chapter 8 of title 5, United States Code. The applicable Federal authority shall incorporate the process of 'deemed file and use' with respect to the information filed under section 2801(a)(6)(A) and shall determine whether information filed by a HealthMart demonstrates compliance with the applicable requirements of this title. Such authority shall exercise its authority under this title in a manner that fosters and promotes the development of HealthMarts in order to improve access to health care coverage and services.

''(b) ADMINISTRATION THROUGH HEALTH CARE MARKETPLACE DIVISION.—

''(1) IN GENERAL.—The applicable Federal authority shall carry out its duties under this title through a separate Health Care Marketplace Division, the sole duty of which (including the staff of which) shall be to administer this title.

''(2) ADDITIONAL DUTIES.—In addition to other responsibilities provided under this title, such Division is responsible for—

''(A) oversight of the operations of HealthMarts under this title; and

''(B) the periodic submittal to Congress of reports on the performance of HealthMarts under this title under subsection (c).

''(c) PERIODIC REPORTS.—The applicable Federal authority shall submit to Congress a report every 30 months, during the 10-year period beginning on the effective date of the rules promulgated by the applicable Federal authority to carry out this title, on the effectiveness of this title in promoting coverage of uninsured individuals. Such authority may provide for the production of such reports through one or more contracts with appropriate private entities.

''SEC. 2804. DEFINITIONS.

''For purposes of this title:

''(1) APPLICABLE FEDERAL AUTHORITY.—The term 'applicable Federal authority' means the Secretary of Health and Human Services.

''(2) ELIGIBLE EMPLOYEE OR INDIVIDUAL.—The term 'eligible' means, with respect to an employee or other individual and a HealthMart, an employee or individual who is eligible under section 2801(c)(2) to enroll or be enrolled in health benefits coverage offered through the HealthMart.

''(3) EMPLOYER; EMPLOYEE; DEPENDENT.—Except as the applicable Federal authority may otherwise provide, the terms 'employer', 'employee', and 'dependent', as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meanings applied to such terms with respect to such coverage under the laws of the State relating to such coverage and such an issuer.

''(4) HEALTH BENEFITS COVERAGE.—The term 'health benefits coverage' has the meaning given the term group health insurance coverage in section 2791(b)(4).

''(5) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2) and includes a community health organization that is offering coverage pursuant to section 330B(a).

''(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning given such term in section 2791(d)(9).

''(7) HEALTHMART.—The term 'HealthMart' is defined in section 2801(a).

''(8) MEMBER.—The term 'member'' means, with respect to a HealthMart, an individual enrolled for health benefits coverage through the HealthMart under section 2801(c)(2).

''(9) PURCHASER.—The term 'purchaser' means, with respect to a HealthMart, a small employer that has contracted under section 2801(c)(1)(A) with the HealthMart for the purchase of health benefits coverage.

''(10) SMALL EMPLOYER.—The term 'small employer' has the meaning given such term for purposes of title XXVII.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2000. The Secretary of Health and Human Services shall first issue all regulations necessary to carry out such amendment before such date.

Subtitle D—Community Health Organizations

SEC. 2301. PROMOTION OF PROVISION OF INSURANCE BY COMMUNITY HEALTH ORGANIZATIONS.

(a) WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES.—Subpart I of part D of title III of the Public Health Service Act is amended by adding at the end the following new section:

''WAIVER OF STATE LICENSURE REQUIREMENT FOR COMMUNITY HEALTH ORGANIZATIONS IN CERTAIN CASES

''SEC. 330B. (a) WAIVER AUTHORIZED.—

''(1) IN GENERAL.—A community health organization may offer health insurance coverage in a State notwithstanding that it is not licensed in such a State to offer such coverage if—

''(A) the organization files an application for waiver of the licensure requirement with the Secretary of Health and Human Services (in this section referred to as the 'Secretary') by not later than November 1, 2003, and

''(B) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (A), (B), or (C) of paragraph (2) has been met.

''(2) GROUNDS FOR APPROVAL OF WAIVER.—

''(A) FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.—The ground for approval of such a waiver application described in this subparagraph is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of a substantially complete application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

''(B) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and the standards or review process imposed by the State as a condition of approval of the license or as the basis for such denial by the State imposes any material requirements, procedures, or standards (other than solvency requirements) to such organizations that are not generally applicable to other entities engaged in a substantially similar business.

''(C) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—With respect to waiver applications filed on or after the date of publication of solvency standards established by the Secretary under subsection (d), the ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable State solvency requirements and such requirements are not the same as the solvency standards established by the Secretary. For purposes of this subparagraph, the term solvency requirements means requirements relating to solvency and other matters covered under the standards established by the Secretary under subsection (d).

''(3) TREATMENT OF WAIVER.—In the case of a waiver granted under this subsection for a community health organization with respect to a State—

''(A) LIMITATION TO STATE.—The waiver shall be effective only with respect to that State and does not apply to any other State.

''(B) LIMITATION TO 36-MONTH PERIOD.—The waiver shall be effective only for a 36-month period but may be renewed for up to 36 additional months if the Secretary determines that such an extension is appropriate.

''(C) CONDITIONED ON COMPLIANCE WITH CONSUMER PROTECTION AND QUALITY STANDARDS.—The continuation of the waiver is conditioned upon the organization's compliance with the requirements described in paragraph (5).

''(D) PREEMPTION OF STATE LAW.—Any provisions of law of that State which relate to the licensing of the organization and which prohibit the organization from providing health insurance coverage shall be superseded.

''(4) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete waiver application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

''(5) APPLICATION AND ENFORCEMENT OF STATE CONSUMER PROTECTION AND QUALITY STANDARDS.—A waiver granted under this subsection to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards—

''(A) would apply in the State to the community health organization if it were licensed as an entity offering health insurance coverage under State law; and

''(B) are generally applicable to other risk-bearing managed care organizations and plans in the State.

''(6) REPORT.—By not later than December 31, 2002, the Secretary shall submit to the

Committee on Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate a report regarding whether the waiver process under this subsection should be continued after December 31, 2003.

''(b) ASSUMPTION OF FULL FINANCIAL RISK.—To qualify for a waiver under subsection (a), the community health organization shall assume full financial risk on a prospective basis for the provision of covered health care services, except that the organization—

''(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time;

''(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization;

''(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 105 percent of its income for such fiscal year; and

''(4) may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of health services by the physicians or other health professionals or through the institutions.

''(c) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED CHOS.—

''(1) IN GENERAL.—Each community health organization that is not licensed by a State and for which a waiver application has been approved under subsection (a)(1), shall meet standards established by the Secretary under subsection (d) relating to the financial solvency and capital adequacy of the organization.

''(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR CHOS.—The Secretary shall establish a process for the receipt and approval of applications of a community health organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such a certification application not later than 60 days after the date the application has been received.

''(d) ESTABLISHMENT OF SOLVENCY STANDARDS FOR COMMUNITY HEALTH ORGANIZATIONS.—

''(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and by rule pursuant to section 553 of title 5, United States Code and through the Health Resources and Services Administration, standards described in subsection (c)(1) (relating to financial solvency and capital adequacy) that entities must meet to obtain a waiver under subsection (a)(2)(C). In establishing such standards, the Secretary shall consult with interested organizations, including the National Association of Insurance Commissioners, the Academy of Actuaries, and organizations representing Federally qualified health centers.

''(2) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards for community health organizations under paragraph (1), the Secretary shall take into account—

''(A) the delivery system assets of such an organization and ability of such an organization to provide services to enrollees;

''(B) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care; and

''(C) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations.

''(3) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the organization's debts in the event of the organization's insolvency.

''(4) DEADLINE.—Such standards shall be promulgated in a manner so they are first effective by not later than April 1, 1999.

''(e) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH ORGANIZATION.—The term 'community health organization ' means an organization that is a Federally-qualified health center or is controlled by one or more Federally-qualified health centers.

''(2) FEDERALLY-QUALIFIED HEALTH CENTER.—The term 'Federally-qualified health center' has the meaning given such term in section 1905(l)(2)(B) of the Social Security Act.

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 2791(b)(1).

''(4) CONTROL.—The term 'control' means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.''.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subtitle A—Patient Protections

SEC. 3001. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

(a) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section:

''SEC. 9813. PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE, EMERGENCY MEDICAL CARE, OBSTETRIC AND GYNECOLOGICAL CARE, PEDIATRIC CARE.

''(a) PATIENT ACCESS TO UNRESTRICTED MEDICAL ADVICE.—

''(1) IN GENERAL.—In the case of any health care professional acting within the lawful scope of practice in the course of carrying out a contractual employment arrangement or other direct contractual arrangement between such professional and a group health plan, the plan with which such contractual employment arrangement or other direct contractual arrangement is maintained by the professional may not impose on such professional under such arrangement any prohibition or restriction with respect to advice, provided to a participant or beneficiary under the plan who is a patient, about the health status of the participant or beneficiary or the medical care or treatment for the condition or disease of the participant or beneficiary, regardless of whether benefits for such care or treatment are provided under the plan.

''(2) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, 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 group health plan 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) PATIENT ACCESS TO EMERGENCY MEDICAL CARE.—

''(1) IN GENERAL.—To the extent that the group health plan provides for any benefits consisting of emergency medical care (as defined in section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974), except for items or services specifically excluded—

''(A) the plan shall provide benefits, without requiring preauthorization and without regard to otherwise applicable network limitations, 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 in order to determine whether emergency medical care (as so defined) is required, and

''(B) the plan shall provide benefits for additional emergency medical services following an emergency medical screening examination (if determined necessary under subparagraph (A)) to the extent that a prudent emergency medical professional would determine such additional emergency services to be necessary to avoid the consequences described in clause (i) of section 503(b)(9)(I) of such Act.

''(2) UNIFORM COST-SHARING REQUIRED.—Nothing in this subsection shall be construed as preventing a group health plan from imposing any form of cost-sharing applicable to any participant or beneficiary (including coinsurance, copayments, deductibles, and any other charges) in relation to benefits described in paragraph (1), 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 section 503(b)(9)(I) of the Employee Retirement Income Security Act of 1974) provided to such similarly situated participants and beneficiaries under the plan.

''(c) PATIENT ACCESS TO OBSTETRIC AND GYNECOLOGICAL CARE.

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

''(A) provides benefits under the terms of the plan consisting of—

''(i) routine gynecological care (such as preventive women's health examinations), or

''(ii) routine obstetric care (such as routine pregnancy-related services),

provided by a participating physician who specializes in such care (or provides benefits consisting of payment for such care), and

''(B) the plan 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, then the plan shall meet the requirements of paragraph (2).

''(2) REQUIREMENTS.—A group health plan meets the requirements of this paragraph, in connection with benefits described in paragraph (1) consisting of care described in clause (i) or (ii) of paragraph (1)(A) (or consisting of payment therefor), if the plan—

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

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

''(3) CONSTRUCTION.—Nothing in paragraph (2)(B) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological or obstetric care so ordered.

''(d) PATIENT ACCESS TO PEDIATRIC CARE.—

''(1) IN GENERAL.—In any case in which a group health plan (or a health insurance issuer offering health insurance coverage in connection with the plan) provides benefits consisting of routine pediatric care provided by a participating physician who specializes in pediatrics (or consisting of payment for such care) and the plan requires or provides for designation by a participant or beneficiary of a participating primary care provider, the plan (or issuer) shall provide that such a participating physician may be designated, if available, by a parent or guardian of any beneficiary under the plan is who under 18 years of age, as the primary care provider with respect to any such benefits.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of pediatric care.

''(e) TREATMENT OF MULTIPLE COVERAGE OPTIONS.—In the case of a plan providing benefits under two or more coverage options, the requirements of subsections (c) and (d) shall apply separately with respect to each coverage option.''.

(b) CLERICAL AMENDMENT.—The table of sections of such subchapter of such chapter is amended by adding at the end the following new item:

''Sec. 9813. Patient access to unrestricted medical advice, emergency medical care, obstetric and gynecological care, pediatric care.''

SEC. 3002. 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, except that the Secretary of the Treasury may issue regulations before such date under such amendments. The Secretary shall first issue regulations necessary to carry out the amendments made by this section before the effective date thereof.

(b) LIMITATION ON PENALTY FOR CERTAIN FAILURES.—No penalty shall be imposed on any failure to comply with any requirement imposed by the amendments made by section 3101 to the extent such failure occurs 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.

(c) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the provisions of subsections (b), (c), and (d) of section 9813 of the Internal Revenue Code of 1986 (as added by this subtitle) shall not apply with respect to plan years beginning before the later of—

(1) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(2) January 1, 2001.

For purposes of this subsection, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this subtitle shall not be treated as a termination of such collective bargaining agreement.

Subtitle B—Patient Access to Information

SEC. 3101. PATIENT ACCESS TO INFORMATION REGARDING PLAN COVERAGE, MANAGED CARE PROCEDURES, HEALTH CARE PROVIDERS, AND QUALITY OF MEDICAL CARE.

(a) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section:

''SEC. 9814. DISCLOSURE BY GROUP HEALTH PLANS.

''(a) DISCLOSURE REQUIREMENT.—The administrator of each group health plan shall take such actions as are necessary to ensure that the summary plan description of the plan required under section 102 of Employee Retirement Income Security Act of 1974 (or each summary plan description in any case in which different summary plan descriptions are appropriate under part 1 of subtitle B of title I of such Act for different options of coverage) contains the information required under subsections (b), (c), (d), and (e)(2)(A). To the extent that any health insurance issuer offering health insurance coverage in connection with such plan provides such information on a timely basis to plan participants and beneficiaries, the requirements of this subsection shall be deemed satisfied in the case of such plan with respect to such information.

''(b) PLAN BENEFITS.—The information required under subsection (a) includes the following:

''(1) COVERED ITEMS AND SERVICES.—

''(A) CATEGORIZATION OF INCLUDED BENEFITS.—A description of covered benefits, categorized by—

''(i) types of items and services (including any special disease management program), and

''(ii) types of health care professionals providing such items and services.

''(B) EMERGENCY MEDICAL CARE.—A description of the extent to which the plan covers emergency medical care (including the extent to which the plan provides for access to urgent care centers), and any definitions provided under the plan for the relevant plan terminology referring to such care.

''(C) PREVENTATIVE SERVICES.—A description of the extent to which the plan provides benefits for preventative services.

''(D) DRUG FORMULARIES.—A description of the extent to which covered benefits are determined by the use or application of a drug formulary and a summary of the process for determining what is included in such formulary.

''(E) COBRA CONTINUATION COVERAGE.—A description of the requirements under section 4980B.

''(2) LIMITATIONS, EXCLUSIONS, AND RESTRICTIONS ON COVERED BENEFITS.—

''(A) CATEGORIZATION OF EXCLUDED BENEFITS.—A description of benefits specifically excluded from coverage, categorized by types of items and services.

''(B) UTILIZATION REVIEW AND PREAUTHORIZATION REQUIREMENTS.—Whether coverage for medical care is limited or excluded on the basis of utilization review or preauthorization requirements.

''(C) LIFETIME, ANNUAL, OR OTHER PERIOD LIMITATIONS.—A description of the circumstances under which, and the extent to which, coverage is subject to lifetime, annual, or other period limitations, categorized by types of benefits.

''(D) CUSTODIAL CARE.—A description of the circumstances under which, and the extent to which, the coverage of benefits for custodial care is limited or excluded, and a statement of the definition used by the plan for custodial care.

''(E) EXPERIMENTAL TREATMENTS.—Whether coverage for any medical care is limited or excluded because it constitutes experimental treatment or technology, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(F) MEDICAL APPROPRIATENESS OR NECESSITY.—Whether coverage for medical care may be limited or excluded by reason of a failure to meet the plan's requirements for medical appropriateness or necessity, and any definitions provided under the plan for the relevant plan terminology referring to such limited or excluded care.

''(G) SECOND OR SUBSEQUENT OPINIONS.—A description of the circumstances under which, and the extent to which, coverage for second or subsequent opinions is limited or excluded.

''(H) SPECIALTY CARE.—A description of the circumstances under which, and the extent to which, coverage of benefits for specialty care is conditioned on referral from a primary care provider.

''(I) CONTINUITY OF CARE.—A description of the circumstances under which, and the extent to which, coverage of items and services provided by any health care professional is limited or excluded by reason of the departure by the professional from any defined set of providers.

''(J) RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—A description of the circumstances under which, and the extent to which, the plan, in covering emergency medical care furnished to a participant or beneficiary of the plan imposes any financial responsibility described in subsection (c) on participants or beneficiaries or limits or conditions benefits for such care subject to any other term or condition of such plan

''(c) PARTICIPANT'S FINANCIAL RESPONSIBILITIES.—The information required under subsection (a) includes an explanation of—

''(1) a participant's financial responsibility for payment of premiums, coinsurance, copayments, deductibles, and any other charges, and

''(2) the circumstances under which, and the extent to which, the participant's financial responsibility described in paragraph (1) may vary, including any distinctions based on whether a health care provider from whom covered benefits are obtained is included in a defined set of providers.

''(d) DISPUTE RESOLUTION PROCEDURES.—The information required under subsection (a) includes a description of the processes adopted by the plan pursuant to section 503(b) of Employee Retirement Income Security Act of 1974, including—

''(1) descriptions thereof relating specifically to—

''(A) coverage decisions,

''(B) internal review of coverage decisions, and

''(C) any external review of coverage decisions, and

''(2) the procedures and time frames applicable to each step of the processes referred to in subparagraphs (A), (B), and (C) of paragraph (1).

''(e) INFORMATION AVAILABLE ON REQUEST.—

''(1) ACCESS TO PLAN BENEFIT INFORMATION IN ELECTRONIC FORM.—

''(A) IN GENERAL.—A group health plan shall, upon written request (made not more frequently than annually), make available to

participants and beneficiaries, in a generally recognized electronic format, the following information:

''(i) the latest summary plan description, including the latest summary of material modifications; and

''(ii) the actual plan provisions setting forth the benefits available under the plan

to the extent such information relates to the coverage options under the plan available to the participant or beneficiary. A reasonable charge may be made to cover the cost of providing such information in such generally recognized electronic format. The Secretary may by regulation prescribe a maximum amount which will constitute a reasonable charge under the preceding sentence.

''(B) ALTERNATIVE ACCESS.—The requirements of this paragraph may be met by making such information generally available (rather than upon request) on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

''(2) ADDITIONAL INFORMATION TO BE PROVIDED ON REQUEST.—

''(A) INCLUSION IN SUMMARY PLAN DESCRIPTION OF SUMMARY OF ADDITIONAL INFORMATION.—The information required under subsection (a) includes a summary description of the types of information required by this subsection to be made available to participants and beneficiaries on request.

''(B) INFORMATION REQUIRED FROM PLANS ON REQUEST.—In addition to information required to be included in summary plan descriptions under this subsection, a group health plan shall provide the following information to a participant or beneficiary on request:

''(i) NETWORK CHARACTERISTICS.—If the plan (or a health insurance issuer offering health insurance coverage in connection with the plan) utilizes a defined set of providers under contract with the plan (or issuer), a detailed list of the names of such providers and their geographic location, set forth separately with respect to primary care providers and with respect to specialists.

''(ii) CARE MANAGEMENT INFORMATION.—A description of the circumstances under which, and the extent to which, the plan has special disease management programs or programs for persons with disabilities, indicating whether these programs are voluntary or mandatory and whether a significant benefit differential results from participation in such programs.

''(iii) INCLUSION OF DRUGS AND BIOLOGICALS IN FORMULARIES.—A statement of whether a specific drug or biological is included in a formulary used to determine benefits under the plan and a description of the procedures for considering requests for any patient-specific waivers.

''(iv) PROCEDURES FOR DETERMINING EXCLUSIONS BASED ON MEDICAL NECESSITY OR EXPERIMENTAL TREATMENTS.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision based on a determination relating to medical necessity or an experimental treatment or technology, a description of the procedures and medically-based criteria used in such decision.

''(v) PREAUTHORIZATION AND UTILIZATION REVIEW PROCEDURES.—Upon receipt by the participant or beneficiary of any notification of an adverse coverage decision, a description of the basis on which any preauthorization requirement or any utilization review requirement has resulted in such decision.

''(vi) ACCREDITATION STATUS OF HEALTH INSURANCE ISSUERS AND SERVICE PROVIDERS.—A description of the accreditation and licencing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licencing authority.

''(vii) MEASURES OF ENROLLEE SATISFACTION.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to enrollee satisfaction.

''(viii) QUALITY PERFORMANCE MEASURES.—The latest information (if any) maintained by the plan, or by any health insurance issuer offering health insurance coverage in connection with the plan, relating to quality of performance of the delivery of medical care with respect to coverage options offered under the plan and of health care professionals and facilities providing medical care under the plan.

''(ix) INFORMATION RELATING TO EXTERNAL REVIEWS.—The number of external reviews under section 503(b)(4) of the Employee Retirement Income Security Act of 1974 that have been completed during the prior plan year and the number of such reviews in which the recommendation reported under section 503(b)(4)(C)(iii) of such Act includes a recommendation for modification or reversal of an internal review decision under the plan.

''(C) INFORMATION REQUIRED FROM HEALTH CARE PROFESSIONALS ON REQUEST.—Any health care professional treating a participant or beneficiary under a group health plan shall provide to the participant or beneficiary, on request, a description of his or her professional qualifications (including board certification status, licensing status, and accreditation status, if any), privileges, and experience and a general description by category (including salary, fee-for-service, capitation, and such other categories as may be specified in regulations of the Secretary) of the applicable method by which such professional is compensated in connection with the provision of such medical care.

''(D) INFORMATION REQUIRED FROM HEALTH CARE FACILITIES ON REQUEST.—Any health care facility from which a participant or beneficiary has sought treatment under a group health plan shall provide to the participant or beneficiary, on request, a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status (if any) assigned to the facility by standard-setting organizations.

''(f) ACCESS TO INFORMATION RELEVANT TO THE COVERAGE OPTIONS UNDER WHICH THE PARTICIPANT OR BENEFICIARY IS ELIGIBLE TO ENROLL.—In addition to information otherwise required to be made available under this section, a group health plan shall, upon written request (made not more frequently than annually), make available to a participant (and an employee who, under the terms of the plan, is eligible for coverage but not enrolled) in connection with a period of enrollment the summary plan description for any coverage option under the plan under which the participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

''(g) ADVANCE NOTICE OF CHANGES IN DRUG FORMULARIES.—Not later than 30 days before the effective of date of any exclusion of a specific drug or biological from any drug formulary under the plan that is used in the treatment of a chronic illness or disease, the plan shall take such actions as are necessary to reasonably ensure that plan participants are informed of such exclusion. The requirements of this subsection may be satisfied—

''(1) by inclusion of information in publications broadly distributed by plan sponsors, employers, or employee organizations,

''(2) by electronic means of communication (including the Internet or proprietary computer networks in a format which is readily accessible to participants),

''(3) by timely informing participants who, under an ongoing program maintained under the plan, have submitted their names for such notification, or

''(4) by any other reasonable means of timely informing plan participants.''.

(b) CLERICAL AMENDMENT.—The table of sections of such subchapter of such chapter is amended by adding at the end the following new item:

''Sec. 9814. Disclosure by group health plans.''

SEC. 3102. EFFECTIVE DATE.

(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 of the Treasury or the Secretary's delegate shall first issue all regulations necessary to carry out the amendments made by this subtitle before such date.

(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 final regulations issued in connection with such requirement, if the plan has sought to comply in good faith with such requirement.

Subtitle C—Medical Savings Accounts

SEC. 3201. EXPANSION OF AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(b) ALL EMPLOYERS MAY OFFER MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subclause (I) of section 220(c)(1)(A)(iii) of such Code (defining eligible individual) is amended by striking ''and such employer is a small employer''.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (C).

(B) Subsection (c) of section 220 of such Code is amended by striking paragraph (4) and by redesignating paragraph (5) as paragraph (4).

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:

''(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of the annual deductible (as of the first day of such month) of the taxpayer's coverage under the high deductible health plan.''

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking ''75 percent of''.

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (5) of section 220(b) of such Code is amended to read as follows:

''(5) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply

under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includible in the taxpayer's gross income for such taxable year.''

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking ''$1,500'' and inserting ''$1,000'', and

(B) by striking ''$3,000'' and inserting ''$2,000''.

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended—

(A) by striking ''1998'' and inserting ''1999'', and

(B) by striking ''1997'' and inserting ''1998''.

(f) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by striking ''106(b),''.

(g) INDIVIDUALS RECEIVING IMMEDIATE FEDERAL ANNUITIES ELIGIBLE FOR MEDICAL SAVINGS ACCOUNTS.—Paragraph (1) of section 220(c) of such Code (defining eligible individual), as amended by subsections (a) and (b), is amended by adding at the end the following new subparagraph:

''(C) SPECIAL RULES FOR INDIVIDUALS RECEIVING IMMEDIATE FEDERAL ANNUITIES.—

''(i) IN GENERAL.—Subparagraph (A)(iii) and subsection (b)(4) shall not apply for any month to an individual—

''(I) who, as of the 1st day of such month, is enrolled in a high deductible health plan under chapter 89 of title 5, United States Code, and

''(II) who is entitled to receive for such month any amount by reason of being an annuitant (as defined in section 8901(3) of such title 5).

''(ii) SPECIAL RULE FOR SPOUSE OF ANNUITANT.—In the case of the spouse of an individual described in clause (i) who is not also described in clause (i), subsection (b)(4) shall not apply to such spouse if such individual and spouse have family coverage under the same plan described in clause (i)(I).''

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 3202. EXCEPTION FROM INSURANCE LIMITATION IN CASE OF MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 220(d)(2)(B) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

''(iii) INSURANCE OFFERED BY COMMUNITY HEALTH CENTERS.—

''(I) IN GENERAL.—Subject to clauses (II) and (III), clause (i) shall not apply to any expense for coverage under insurance offered by a health center (as defined in section 330(a)(1) of the Public Health Service Act) if the coverage consists solely of coverage for required primary health benefits (as defined in section 330(b)(1)(A) of such Act) provided on a capitated basis.

''(II) INCOME LIMITATION.—Subclause (I) shall only apply to expenses for coverage of an individual who, in the taxable year involved, has income that is less than 200 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(III) LIMITATION ON NUMBER OF CONTRACTS.—For a taxable year ending in a calendar year, subclause (I) shall apply only to expenses for coverage for the first 15,000 individuals enrolled in insurance described in such subclause in the year.''.

(b) REPORTS ON ENROLLMENT.—Section 330(j)(3) of the Public Health Service Act (42 U.S.C. 254c(j)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (K),

(2) by striking the period at the end of subparagraph (L) and inserting ''; and'', and

(3) by inserting after subparagraph (L) the following new subparagraph:

''(M) if the center offers insurance coverage to an individual with a medical savings account under subclause (I) of section 220(d)(2)(B)(iii), the center shall provide such reports in such time and manner as may be required by the Secretary and the Secretary of the Treasury in order to carry out subclause (III) of such section.''.

SEC. 3203. SENSE OF THE HOUSE OF REPRESENTATIVES.

It is the sense of the House of Representatives that patients are best served when they are empowered to make informed choices about their own health care. The same is true regarding an individual's choice of health insurance. A system that gives people the power to choose the coverage that best meets their needs, combined with insurance market reforms, offers great promise of increased choices and greater access to health insurance for Americans.

Subtitle D—Revenue Offsets

SEC. 3301. CLARIFICATION OF DEFINITION OF SPECIFIED LIABILITY LOSS.

(a) IN GENERAL.—Subparagraph (B) of section 172(f)(1) of the Internal Revenue Code of 1986 (defining specified liability loss) is amended to read as follows:

''(B)(i) Any amount allowable as a deduction under this chapter (other than section 468(a)(1) or 468A(a)) which is in satisfaction of a liability under a Federal or State law requiring—

''(I) the reclamation of land,

''(II) the decommissioning of a nuclear power plant (or any unit thereof),

''(III) the dismantlement of a drilling platform,

''(IV) the remediation of environmental contamination, or

''(V) a payment under any workers compensation act (within the meaning of section 461(h)(2)(C)(i)).

''(ii) A liability shall be taken into account under this subparagraph only if—

''(I) the act (or failure to act) giving rise to such liability occurs at least 3 years before the beginning of the taxable year, and

''(II) the taxpayer used an accrual method of accounting throughout the period or periods during which such act (or failure to act) occurred.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to net operating losses arising in taxable years ending after the date of the enactment of this Act.

SEC. 3302. PROPERTY SUBJECT TO A LIABILITY TREATED IN SAME MANNER AS ASSUMPTION OF LIABILITY.

(a) REPEAL OF PROPERTY SUBJECT TO A LIABILITY TEST.—

(1) SECTION 357.—Section 357(a) of the Internal Revenue Code of 1986 (relating to assumption of liability) is amended by striking '', or acquires from the taxpayer property subject to a liability'' in paragraph (2).

(2) SECTION 358.—Section 358(d)(1) of such Code (relating to assumption of liability) is amended by striking ''or acquired from the taxpayer property subject to a liability''.

(3) SECTION 368.—

(A) Section 368(a)(1)(C) of such Code is amended by striking '', or the fact that property acquired is subject to a liability,''.

(B) The last sentence of section 368(a)(2)(B) of such Code is amended by striking '', and the amount of any liability to which any property acquired from the acquiring corporation is subject,''.

(b) CLARIFICATION OF ASSUMPTION OF LIABILITY.—

(1) IN GENERAL.—Section 357 of such Code is amended by adding at the end the following new subsections:

''(d) DETERMINATION OF AMOUNT OF LIABILITY ASSUMED.—

''(1) IN GENERAL.—For purposes of this section, section 358(d), section 362(d), section 368(a)(1)(C), and section 368(a)(2)(B), except as provided in regulations—

''(A) a recourse liability (or portion thereof) shall be treated as having been assumed if, as determined on the basis of all facts and circumstances, the transferee has agreed to, and is expected to, satisfy such liability (or portion), whether or not the transferor has been relieved of such liability, and

''(B) a nonrecourse liability shall be treated as having been assumed by the transferee of any asset subject to such liability.

''(2) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the purposes of this subsection and section 362(d). The Secretary may also prescribe regulations which provide that the manner in which a liability is treated as assumed under this subsection is applied, where appropriate, elsewhere in this title.''

(2) LIMITATION ON BASIS INCREASE ATTRIBUTABLE TO ASSUMPTION OF LIABILITY.—Section 362 of such Code is amended by adding at the end the following new subsection:

''(d) LIMITATION ON BASIS INCREASE ATTRIBUTABLE TO ASSUMPTION OF LIABILITY.—

''(1) IN GENERAL.—In no event shall the basis of any property be increased under subsection (a) or (b) above fair market value (determined without regard to section 7701(g)) by reason of any gain recognized to the transferor as a result of the assumption of a liability.

''(2) TREATMENT OF GAIN NOT SUBJECT TO TAX.—Except as provided in regulations, if—

''(A) gain is recognized to the transferor as a result of an assumption of a nonrecourse liability by a transferee which is also secured by assets not transferred to such transferee, and

''(B) no person is subject to tax under this title on such gain,

then, for purposes of determining basis under subsections (a) and (b), the amount of gain recognized by the transferor as a result of the assumption of the liability shall be determined as if the liability assumed by the transferee equaled such transferee's ratable portion of such liability determined on the basis of the relative fair market values (determined without regard to section 7701(g)) of all of the assets subject to such liability.''

(c) APPLICATION TO PROVISIONS OTHER THAN SUBCHAPTER C.—

(1) SECTION 584.—Section 584(h)(3) of such Code is amended—

(A) by striking '', and the fact that any property transferred by the common trust fund is subject to a liability,'' in subparagraph (A),

(B) by striking clause (ii) of subparagraph (B) and inserting:

''(ii) ASSUMED LIABILITIES.—For purposes of clause (i), the term 'assumed liabilities' means any liability of the common trust fund assumed by any regulated investment company in connection with the transfer referred to in paragraph (1)(A).

''(C) ASSUMPTION.—For purposes of this paragraph, in determining the amount of any liability assumed, the rules of section 357(d) shall apply.''.

(2) SECTION 1031.—The last sentence of section 1031(d) of such Code is amended—

(A) by striking ''assumed a liability of the taxpayer or acquired from the taxpayer property subject to a liability'' and inserting ''assumed (as determined under section 357(d)) a liability of the taxpayer'', and

(B) by striking ''or acquisition (in the amount of the liability)''.

(d) CONFORMING AMENDMENTS.—

(1) Section 351(h)(1) of such Code is amended by striking '', or acquires property subject to a liability,''.

(2) Section 357 of such Code is amended by striking ''or acquisition'' each place it appears in subsection (a) or (b).

(3) Section 357(b)(1) of such Code is amended by striking ''or acquired''.

(4) Section 357(c)(1) of such Code is amended by striking '', plus the amount of the liabilities to which the property is subject,''.

(5) Section 357(c)(3) of such Code is amended by striking ''or to which the property transferred is subject''.

(6) Section 358(d)(1) of such Code is amended by striking ''or acquisition (in the amount of the liability)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to transfers after the date of the enactment of this Act.

SEC. 3303. LIMITATION ON REQUIRED ACCRUAL OF AMOUNTS RECEIVED FOR PERFORMANCE OF CERTAIN PERSONAL SERVICES.

(a) IN GENERAL.—Paragraph (5) of section 448(d) of the Internal Revenue Code of 1986 (relating to special rule for services) is amended by inserting ''in fields referred to in paragraph (2)(A)'' after ''services by such person''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1998.

(c) COORDINATION WITH SECTION 481.—In the case of any taxpayer required by this section to change its method of accounting for any taxable year—

(1) such change shall be treated as initiated by the taxpayer,

(2) such change shall be treated as made with the consent of the Secretary of the Treasury, and

(3) the period for taking into account the adjustments under section 481 by reason of such change shall be 3 years.

SEC. 3304. RETURNS RELATING TO CANCELLATIONS OF INDEBTEDNESS BY ORGANIZATIONS LENDING MONEY.

(a) IN GENERAL.—Paragraph (2) of section 6050P(c) of the Internal Revenue Code of 1986 (relating to definitions and special rules) is amended by striking ''and'' at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting '', and'', and by inserting after subparagraph (C) the following new subparagraph:

''(D) any organization a significant trade or business of which is the lending of money.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges of indebtedness after December 31, 1998.

SEC. 3305. CLARIFICATION AND EXPANSION OF MATHEMATICAL ERROR ASSESSMENT PROCEDURES.

(a) TIN DEEMED INCORRECT IF INFORMATION ON RETURN DIFFERS WITH AGENCY RECORDS.—Section 6213(g)(2) of the Internal Revenue Code of 1986 (defining mathematical or clerical error) is amended by adding at the end the following flush sentence:

''A taxpayer shall be treated as having omitted a correct TIN for purposes of the preceding sentence if information provided by the taxpayer on the return with respect to the individual whose TIN was provided differs from the information the Secretary obtains from the person issuing the TIN.''.

(b) EXPANSION OF MATHEMATICAL ERROR PROCEDURES TO CASES WHERE TIN ESTABLISHES INDIVIDUAL NOT ELIGIBLE FOR TAX CREDIT.—Section 6213(g)(2) of such Code is amended by striking ''and'' at the end of subparagraph (J), by striking the period at the end of the subparagraph (K) and inserting '', and'', and by adding at the end the following new subparagraph:

''(L) the inclusion on a return of a TIN required to be included on the return under section 21, 24, or 32 if—

''(i) such TIN is of an individual whose age affects the amount of the credit under such section, and

''(ii) the computation of the credit on the return reflects the treatment of such individual as being of an age different from the individual's age based on such TIN.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 3306. INCLUSION OF ROTAVIRUS GASTROENTERITIS AS A TAXABLE VACCINE.

(a) IN GENERAL.—Section 4132(1) of the Internal Revenue Code of 1986 (defining taxable vaccine) is amended by adding at the end the following new subparagraph:

''(K) Any vaccine against rotavirus gastroenteritis.''.

(b) EFFECTIVE DATE.—

(1) SALES.—The amendment made by this section shall apply to sales after the date of the enactment of this Act.

(2) DELIVERIES.—For purposes of paragraph (1), in the case of sales on or before the date of the enactment of this Act for which delivery is made after such date, the delivery date shall be considered the sale date.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

SEC. 4001. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This title shall apply with respect to any health care liability action brought in any State or Federal court, except that this title shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action, or

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(b) PREEMPTION.—This title shall preempt any State law to the extent such law is inconsistent with the limitations contained in this title. This title shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this title or otherwise imposes greater restrictions than those provided in this title.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this title applies and which is brought under section 1332 of title 28, United States Code, the amount of non-economic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this title shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 4002. DEFINITIONS.

As used in this title:

(1) ACTUAL DAMAGES.—The term ''actual damages'' means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term ''collateral source payments'' means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term ''drug'' has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term ''economic loss'' means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term ''harm'' means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract, or

(D) a Medicare+Choice plan (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court against—

(A) a health care provider,

(B) an entity which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or

(C) the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product,

in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or contribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(12) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) HEALTH CARE SERVICE.—The term ''health care service'' means any service eligible for payment under a health benefit plan, including services related to the delivery or administration of such service.

(14) MEDICAL DEVICE.—The term ''medical device'' has the meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(15) NON-ECONOMIC DAMAGES.—The term ''non-economic damages'' means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(16) PERSON.—The term ''person'' means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(17) PRODUCT SELLER.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''product seller'' means a person who, in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or is otherwise involved in placing, a product in the stream of commerce, or

(ii) installs, repairs, or maintains the harm-causing aspect of a product.

(B) EXCLUSION.—Such term does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(18) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(19) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 4003. EFFECTIVE DATE.

This title will apply to—

(1) any health care liability action brought in a Federal or State court, and

(2) any health care liability claim subject to an alternative dispute resolution system,

that is initiated on or after the date of enactment of this title, except that any health care liability claim or action arising from an injury occurring before the date of enactment of this title shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

Subtitle B—Uniform Standards for Health Care Liability Actions

SEC. 4011. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 4012. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NON-ECONOMIC DAMAGES.—

(1) LIMITATION ON NON-ECONOMIC DAMAGES.—The total amount of non-economic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury. The limitation under this paragraph shall not apply to an action for damages based solely on intentional denial of medical treatment necessary to preserve a patient's life that the patient is otherwise qualified to receive, against the wishes of a patient, or if the patient is incompetent, against the wishes of the patient's guardian, on the basis of the patient's present or predicated age, disability, degree of medical dependency, or quality of life.

(2) LIMIT.—If, after the date of the enactment of this Act, a State enacts a law which prescribes the amount of non-economic damages which may be awarded in a health care liability action which is different from the amount prescribed by section 4012(a)(1), the State amount shall apply in lieu of the amount prescribed by such section. If, after the date of the enactment of this Act, a State enacts a law which limits the amount of recovery in a health care liability action without delineating between economic and non-economic damages, the State amount shall apply in lieu of the amount prescribed by such section.

(3) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of non-economic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for non-economic damages shall be several and not joint and a separate judgment shall be rendered against each defendant for the amount allocated to such defendant.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) APPLICABILITY.—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(3) BIFURCATION.—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(4) DRUGS AND DEVICES.—

(A) IN GENERAL.—

(i) PUNITIVE DAMAGES.—Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(ii) APPLICATION.—Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded

for future economic and non-economic loss exceeds $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 4013. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are consistent with the provisions relating to such matters in this title.

SEC. 4014. REPORTING ON FRAUD AND ABUSE ENFORCEMENT ACTIVITIES.

The General Accounting Office shall—

(1) monitor—

(A) the compliance of the Department of Justice and all United States Attorneys with the guideline entitled ''Guidance on the Use of the False Claims Act in Civil Health Care Matters'' issued by the Department on June 3, 1998, including any revisions to that guideline, and

(B) the compliance of the Office of the Inspector General of the Department of Health and Human Services with the protocols and guidelines entitled ''National Project Protocols—Best Practice Guidelines'' issued by the Inspector General on June 3, 1998, including any revisions to such protocols and guidelines, and

(2) submit a report on such compliance to the Committee on Commerce, the Committee on the Judiciary, and the Committee on Ways and Means of the House of Representatives and the Committee on the Judiciary and the Committee on Finance of the Senate not later than February 1, 1999, and every year thereafter for a period of four years ending February 1, 2002.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

SEC. 5001. CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

''PART D—CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

''INSPECTION AND COPYING OF PROTECTED HEALTH INFORMATION

''SEC. 1181. (a) IN GENERAL.—Subject to the succeeding provisions of this section, upon the request of an individual who is the subject of protected health information, a person who is a health care provider, health plan, employer, health or life insurer, or educational institution shall make available to the individual (or, in the discretion of the person, to a health care provider designated by the individual), for inspection and copying, protected health information concerning the individual that the person maintains, including records created under section 1182.

''(b) ACCESS THROUGH ORIGINATING PROVIDER.—Protected health information that is created by an originating provider, and subsequently received by another health care provider or a health plan as part of treatment or payment activities, shall be made available for inspection and copying as provided in this section through the originating provider, rather than the receiving health care provider or health plan, unless the originating provider does not maintain the information.

''(c) INVESTIGATIONAL INFORMATION.—With respect to protected health information that was created as part of the requesting individual's participation in a clinical trial monitored by an institutional review board established to review health research with respect to potential risks to human subjects pursuant to Federal regulations adopted under section 1802(b) of the Public Health Service Act (42 U.S.C. 300v–1(b)) and the notice (informally referred to as the 'Common Rule') promulgated in the Federal Register at 56 Fed. Reg. 28003), a request under subsection (a) shall be granted only to the extent and in a manner consistent with such regulations.

''(d) OTHER EXCEPTIONS.—Unless ordered by a court of competent jurisdiction, a person to whom a request under subsection (a) is made is not required to grant the request, if—

''(1) the person determines that the disclosure of the information could reasonably be expected to endanger the life or physical safety of, or cause substantial harm to, any individual; or

''(2) the information is compiled principally—

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

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

''(e) DENIAL OF REQUEST FOR INSPECTION OR COPYING.—If a person to whom a request under subsection (a) is made denies a request for inspection or copying pursuant to this section, the person shall inform the individual making the request, in writing, of—

''(1) the reasons for the denial of the request;

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

''(3) the individual's right to file with the person a concise statement setting forth the request.

''(f) STATEMENT REGARDING REQUEST.—If an individual has filed with a person a statement under subsection (e)(3) with respect to protected health information, the person, in any subsequent disclosure of the information—

''(1) shall include a notation concerning the individual's statement; and

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

''(g) PROCEDURES.—A person providing access to protected health information for inspection or copying under this section 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.

''(h) INSPECTION AND COPYING OF SEGREGABLE PORTION.—A person to whom a request under subsection (a) is made shall permit the inspection and copying of any reasonably segregable portion of a record after deletion of any portion that the person is not required to disclose under this section.

''(i) DEADLINE.—A person described in subsection (a) shall comply with or deny, in accordance with this section, a request for inspection or copying of protected health information under this section not later than 30 days after the date on which the person receives the request.

''(j) RULES GOVERNING AGENTS.—An agent of a person 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 been asked by the person to fulfill the requirements of this section.

''SUPPLEMENTATION OF PROTECTED HEALTH INFORMATION

''SEC. 1182. (a) IN GENERAL.—Subject to subsection (b), not later than 45 days after the date on which a person who is a health care provider, health plan, employer, health or life insurer, or educational institution receives, from an individual who is a subject of protected health information that is maintained by the person, a request in writing to amend the information by adding a concise written supplement to it, the person—

''(1) shall make the amendment requested;

''(2) shall inform the individual of the amendment that has been made; and

''(3) shall make reasonable efforts to inform any person who is identified by the individual, who is not an officer, employer, or agent of the person receiving the request, and to whom the unamended portion of the information was disclosed during the preceding year, by sending a notice to the person's last known address that an amendment, consisting of the addition of a supplement, has been made to the protected health information of the individual.

''(b) REFUSAL TO AMEND.—If a person described in subsection (a) refuses to make an amendment requested by an individual under such subsection, the person 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 person 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 with a person under subsection (b)(3), the person, in any subsequent disclosure of the disputed portion of the information—

''(1) shall include a notation that such individual has filed a statement of disagreement; and

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

''(d) RULES GOVERNING AGENTS.—The agent of a person described in subsection (a) shall not be required to make amendments to individually identifiable health information, except where—

''(1) the information is retained by the agent; and

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

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

''(f) RULE OF CONSTRUCTION.—This section shall not be construed—

''(1) to permit an individual to modify statements in his or her record that document the factual observations of another individual or state the results of diagnostic tests; or

''(2) to permit an individual to amend his or her record as to the type, duration, or quality of treatment the individual believes he or she should have been provided.

''NOTICE OF CONFIDENTIALITY PRACTICES

''SEC. 1183. (a) PREPARATION OF WRITTEN NOTICE.—A person who is a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall post or provide, in writing and in a clear and conspicuous manner, notice of the person's protected health information confidentiality practices. The notice shall include—

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

''(2) the intended uses and disclosures of protected health information;

''(3) the procedures established by the person for the exercise of an individual's rights with respect to protected health information; and

''(4) the procedures established by the person for obtaining copies of the notice.

''(b) MODEL NOTICE.—The Secretary, after notice and opportunity for public comment, and based on the advice of the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)), shall develop and disseminate, not later than 6 months after the date of the enactment of the Patient Protection Act of 1998, model notices of confidentiality practices, for use under this section. Use of a model notice developed by the Secretary shall serve as a complete defense in any civil action to an allegation that a violation of this section has occurred.

''ESTABLISHMENT OF SAFEGUARDS

''SEC. 1184. (a) IN GENERAL.—A person who is a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall establish, maintain, and enforce reasonable and 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 the person.

''(b) FACTORS TO BE CONSIDERED.—A person subject to subsection (a) shall consider the following factors in establishing safeguards under such subsection:

''(1) The need for protected health information.

''(2) The categories of personnel who will have access to protected health information.

''(3) The feasibility of limiting access to individual identifiers.

''(4) The appropriateness of the policy or procedure to the person, and to the medium in which protected health information is stored and transmitted.

''(5) The value of audit trails in computerized records.

''(c) RELATIONSHIP TO PART C REQUIREMENT.—Any safeguard established under this section shall be consistent with the requirement in section 1173(d)(2).

''(d) CONVERSION TO NONIDENTIFIABLE HEALTH INFORMATION.—A person subject to subsection (a) shall, to the extent practicable and consistent with the purpose for which protected health information is maintained, convert such information into nonidentifiable health information.

''AVAILABILITY OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF HEALTH CARE OPERATIONS

''SEC. 1185. (a) DISCLOSURE.—Any person who maintains protected health information may disclose the information to a health care provider or a health plan for the purpose of permitting the provider or plan to conduct health care operations.

''(b) USE.—A health care provider or a health plan that maintains protected health information may use it for the purposes described in subsection (a).

''(c) LIMITATION ON SALE OR BARTER.—Notwithstanding subsection (b), no health care provider or health plan may, as part of conducting health care operations, sell or barter protected health information.

''RELATIONSHIP TO OTHER LAWS

''SEC. 1186. (a) STATE LAW.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the provisions of this part shall preempt a provision of State law to the extent that such provision—

''(A) otherwise would be preempted as inconsistent with this part under article VI of the Constitution of the United States;

''(B) relates to authorization for the use or disclosure of—

''(i) protected health information for health care operations; or

''(ii) nonidentifiable health information; or

''(C) relates to any of the following:

''(i) Inspection or copying of protected health information by a person who is a subject of the information.

''(ii) Amendment of protected health information by a person who is a subject of the information.

''(iii) Notice of confidentiality practices with respect to protected health information.

''(iv) Establishment of safeguards for protected health information.

''(2) EXCEPTIONS.—Nothing in this part shall be construed to preempt or modify a provision of State law to the extent that such provision relates to protected health information and—

''(A) the confidentiality of the records maintained by a licensed mental health professional;

''(B) the provision of health care to a minor, or the disclosure of information about a minor to a parent or guardian of the minor;

''(C) condition-specific limitations on disclosure;

''(D) the use or disclosure of information for use in legally authorized—

''(i) disease or injury reporting;

''(ii) public health surveillance, investigation, or intervention;

''(iii) vital statistics reporting, such as reporting of birth or death information;

''(iv) reporting of abuse or neglect information;

''(v) reporting of information concerning a communicable disease status; or

''(vi) reporting concerning the safety or effectiveness of a biological product regulated under section 351 of the Public Health Service Act (42 U.S.C. 262) or a drug or device regulated under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.);

''(E) the disclosure to a person by a health care provider of information about an individual, in any case in which the provider has determined—

''(i) in the provider's reasonable medical judgment, that the individual is unconscious, incompetent, or otherwise incapable of deciding whether to authorize disclosure of the protected health information; and

''(ii) in the provider's reasonable judgment, that the person is a spouse, relative, guardian, or close friend of the individual's; or

''(F) the use of information by, or the disclosure of information to, a person holding a valid and applicable power of attorney that includes the authority to make health care decisions on behalf of an individual who is a subject of the information.

''(3) PRIVILEGES.—Nothing in this part shall be construed to preempt or modify a provision of State law to the extent that such provision relates to a privilege of a witness or other person in a court of that State.

''(b) FEDERAL LAW.—Nothing in this part shall be construed to preempt, modify, or repeal a provision of any other Federal law relating to protected health information or relating to an individual's access to protected health information or health care services. Nothing in this part shall be construed to preempt, modify, or repeal a provision of Federal law to the extent that such provision relates to a privilege of a witness or other person in a court of the United States.

''CIVIL PENALTIES

''SEC. 1187. (a) VIOLATION.—A person who the Secretary determines has substantially and materially failed to comply with this part shall be subject, in addition to any other penalties that may be prescribed by law—

''(1) in a case in which the violation relates to section 1181 or 1182, to a civil penalty of not more than $500 for each such violation but not to exceed $5,000 in the aggregate for all violations of an identical requirement or prohibition during a calendar year;

''(2) in the case in which the violation relates to section 1183 or 1184, to a civil penalty of not more than $10,000 for each such violation, but not to exceed $50,000 in the aggregate for all violations of an identical requirement or prohibition during a calendar year; or

''(3) in a case in which the Secretary finds that such violations have occurred with such frequency as to constitute a general business practice, to a civil penalty of not more than $100,000.

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

''DEFINITIONS

''SEC. 1188. As used in this part:

''(1) AGENT.—The term 'agent' means a person, including a contractor, 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.

''(2) CONDITION-SPECIFIC LIMITATIONS ON DISCLOSURE.—The term 'condition-specific limitations on disclosure' means State laws that prohibit the disclosure of protected health information relating to a health condition or disease that has been identified by the Secretary as posing a public health threat.

''(3) DISCLOSE.—The term 'disclose' means to release, transfer, provide access to, or otherwise divulge protected health information to any person other than an individual who is the subject of such information.

''(4) EDUCATIONAL INSTITUTION.—The term 'educational institution' means an institution or place accredited or licensed for purposes of providing 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.

''(5) 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 two or more employees.

''(6) HEALTH CARE.—The term 'health care' means—

''(A) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, including appropriate assistance with disease or symptom management and maintenance, counseling, service, or procedure—

''(i) with respect to the physical or mental condition of an individual; or

''(ii) affecting the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs, or any other tissue; or

''(B) any sale or dispensing, pursuant to a prescription or medical order, of a drug, device, equipment, or other health care-related item to an individual, or for the use of an individual.

''(7) HEALTH CARE OPERATIONS.—The term 'health care operations' means services, provided directly by or on behalf of a health plan or health care provider or by its agent, for any of the following purposes:

''(A) Coordinating health care, including health care management of the individual through risk assessment, case management, and disease management.

''(B) Conducting quality assessment and improvement activities, including outcomes evaluation, clinical guideline development and improvement, and health promotion.

''(C) Carrying out utilization review activities, including precertification and preauthorization of services, and health plan rating activities, including underwriting and experience rating.

''(D) Conducting or arranging for auditing services.

''(8) 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 or any other privately-sponsored program that directly provides items or services that constitute health care to beneficiaries; or

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

''(9) HEALTH OR LIFE INSURER.—The term 'health or life insurer' means a health insurance issuer, as defined in section 9832(b)(2) of the Internal Revenue Code of 1986, or a life insurance company, as defined in section 816 of such Code.

''(10) HEALTH PLAN.—The term 'health plan' means any health insurance plan, including any hospital or medical service plan, dental or other health service plan, health maintenance organization plan, plan offered by a provider-sponsored organization (as defined in section 1855(d)), or other program providing or arranging for the provision of health benefits.

''(11) HEALTH RESEARCHER.—The term 'health researcher' means a person (or an officer, employee, or agent of a person) who is engaged in systematic investigation, including research development, testing, data analysis, and evaluation, designed to develop or contribute to generalizable knowledge relating to basic biomedical processes, health, health care, health care delivery, or health care cost.

''(12) NONIDENTIFIABLE HEALTH INFORMATION.—The term 'nonidentifiable health information' means protected health information from which personal identifiers that reveal the identity of the individual who is the subject of such information or provide a direct means of identifying the individual (such as name, address, and social security number) have been removed, encrypted, or replaced with a code, such that the identity of the individual is not evident without (in the case of encrypted or coded information) use of a key.

''(13) ORIGINATING PROVIDER.—The term 'originating provider', when used with respect to protected health information, means the health care provider who takes an action that initiates the treatment episode to which that information relates, such as prescribing a drug, ordering a diagnostic test, or admitting an individual to a health care facility. A hospital or nursing facility is the originating provider with respect to protected health information created or received as part of inpatient or outpatient treatment provided in the hospital or facility.

''(14) PAYMENT ACTIVITIES.—The term 'payment activities' means—

''(A) activities undertaken—

''(i) by, or on behalf of, a health plan to determine its responsibility for coverage under the plan; or

''(ii) by a health care provider to obtain payment for items or services provided to an individual, provided under a health plan, or provided based on a determination by the health plan of responsibility for coverage under the plan; and

''(B) includes the following activities, when performed in a manner consistent with subparagraph (A):

''(i) Billing, claims management, medical data processing, other administrative services, and actual payment.

''(ii) Determinations of coverage or adjudication of health benefit or subrogation claims.

''(iii) Review of health care services with respect to coverage under a health plan or justification of charges.

''(15) PERSON.—The term 'person' means—

''(A) a natural person;

''(B) a government or governmental subdivision, agency, or authority;

''(C) a company, corporation, estate, firm, trust, partnership, association, joint venture, society, or joint stock company; or

''(D) any other legal entity.

''(16) PROTECTED HEALTH INFORMATION.—The term 'protected health information', when used with respect to an individual who is a subject of information means any information (including genetic information) that identifies the individual, whether oral or recorded in any form or medium, and that—

''(A) is created or received by a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, or educational institution;

''(B) relates to the past, present, or future physical or mental health or condition of an individual (including individual cells and their components);

''(C) is derived from—

''(i) the provision of health care to an individual; or

''(ii) payment for the provision of health care to an individual; and

''(D) is not nonidentifiable health information.

''(17) STATE.—The term 'State' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

''(18) TREATMENT.—The term 'treatment' means the provision of health care by a health care provider.

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

(b) ENFORCEMENT OF PROVISIONS THROUGH CONDITIONS ON PARTICIPATION.—

(1) PARTICIPATING PHYSICIANS AND SUPPLIERS.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following:

''(9) The Secretary may refuse to enter into an agreement with a physician or supplier under this subsection, or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been found to have violated a provision of part D of title XI.''.

(2) MEDICARE+CHOICE ORGANIZATIONS.—Section 1852(h) of the Social Security Act (42 U.S.C. 1395w–22(h)) is amended—

(A) in the matter preceding paragraph (1), by striking ''procedures—'' and inserting ''procedures, consistent with sections 1181 through 1185—''; and

(B) in paragraph (1), by striking ''privacy of any individually identifiable enrollee information;'' and inserting ''confidentiality of protected health information concerning enrollees;''.

(3) MEDICARE PROVIDERS.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by inserting a semicolon at the end of subparagraph (R);

(B) by striking the period at the end of subparagraph (S) and inserting ''; and''; and

(C) by inserting immediately after subparagraph (S) the following new subparagraph:

''(T) to comply with sections 1181 through 1184.''.

(4) HEALTH MAINTENANCE ORGANIZATIONS WITH RISK-SHARING CONTRACTS.—Section 1876(k)(4) of the Social Security Act (42 U.S.C. 1395mm(k)(4)) of the Social Security Act is amended by adding at the end the following:

''(E) The confidentiality and accuracy procedure requirements under section 1852(h).''.

(c) CONFORMING AMENDMENTS.—

(1) TITLE HEADING.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by striking the title heading and inserting the following:

''TITLE XI—GENERAL PROVISIONS, PEER REVIEW, ADMINISTRATIVE SIMPLIFICATION, AND CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION''.

(2) NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS.—Section 306(k)(5) of the Public Health Service Act (42 U.S.C. 242(k)(5)) is amended—

(A) in subparagraphs (A)(viii) and (D), by striking ''part C'' and inserting ''parts C and D'';

(B) in subparagraph (C), by striking ''and'' at the end;

(C) in subparagraph (D), by striking the period at the end and inserting ''; and''; and

(D) by adding at the end the following:

''(E) shall study the issues relating to section 1184 of the Social Security Act (as added by the Patient Protection Act of 1998), and, not later than 1 year after the date of the enactment of the Patient Protection Act of

1998, shall report to the Congress on such section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 1 year after the date of the enactment of this Act, except that subsection (c)(2), and section 1183(b) of the Social Security Act (as added by subsection (a)), shall take effect on the date of the enactment of this Act.

SEC. 5002. STUDY AND REPORT ON EFFECT OF STATE LAW ON HEALTH-RELATED RESEARCH.

Not later than one year after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study on the effect of State laws on health-related research subject to review by an institutional review board or institutional review committee with respect to the protection of human subjects.

SEC. 5003. STUDY AND REPORT ON STATE LAW ON PROTECTED HEALTH INFORMATION.

(a) IN GENERAL.—Not later than 9 months after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study—

(1) compiling State laws on the confidentiality of protected health information (as defined in section 1188 of the Social Security Act, as added by section 5001 of this Act); and

(2) analyzing the effect of such laws on the provision of health care and securing payment for such care.

(b) MODIFICATION OF DEADLINE.—Section 264(c)(1) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) is amended by striking ''36 months after the date of the enactment of this Act,'' and inserting ''6 months after the date on which the Comptroller General of the United States submits to the Congress a report under section 5003(a) of the Patient Protection Act of 1998,''.

SEC. 5004. PROTECTION FOR CERTAIN INFORMATION DEVELOPED TO REDUCE MORTALITY OR MORBIDITY OR FOR IMPROVING PATIENT CARE AND SAFETY.

(a) PROTECTION OF CERTAIN INFORMATION.—Notwithstanding any other provision of Federal or State law, health care response information shall be exempt from any disclosure requirement (regardless of whether the requirement relates to subpoenas, discovery, introduction of evidence, testimony, or any other form of disclosure), in connection with a civil or administrative proceeding under Federal or State law, to the same extent as information developed by a health care provider with respect to any of the following:

(1) Peer review.

(2) Utilization review.

(3) Quality management or improvement.

(4) Quality control.

(5) Risk management.

(6) Internal review for purposes of reducing mortality, morbidity, or for improving patient care or safety.

(b) NO WAIVER OF PROTECTION THROUGH INTERACTION WITH ACCREDITING BODY.—Notwithstanding any other provision of Federal or State law, the protection of health care response information from disclosure provided under subsection (a) shall not be deemed to be modified or in any way waived by—

(1) the development of such information in connection with a request or requirement of an accrediting body; or

(2) the transfer of such information to an accrediting body.

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

(1) The term ''accrediting body'' means a national, not-for-profit organization that—

(A) accredits health care providers; and

(B) is recognized as an accrediting body by statute or by a Federal or State agency that regulates health care providers.

(2) The term ''health care provider'' has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

(3) The term ''health care response information'' means information (including any data, report, record, memorandum, analysis, statement, or other communication) developed by, or on behalf of, a health care provider in response to a serious, adverse, patient-related event—

(A) during the course of analyzing or studying the event and its causes; and

(B) for purposes of—

(i) reducing mortality or morbidity; or

(ii) improving patient care or safety (including the provider's notification to an accrediting body and the provider's plans of action in response to such event).

(5) The term ''State'' has the meaning given such term in section 1188 of the Social Security Act (as added by section 5001 of this Act).

SEC. 5005. EFFECTIVE DATE FOR STANDARDS GOVERNING UNIQUE HEALTH IDENTIFIERS FOR INDIVIDUALS.

Section 1174 of the Social Security Act (42 U.S.C. 1320d–3) is amended by adding at the end the following:

''(c) UNIQUE HEALTH IDENTIFIERS.—Notwithstanding subsections (a) and (b), the Secretary may not promulgate or adopt a final standard under section 1173(b) providing for a unique health identifier for an individual (except in an individual's capacity as an employer or a health care provider), until legislation is enacted specifically approving the standard or containing provisions consistent with the standard.''.

The SPEAKER pro tempore. After 1 hour of debate on the bill, as amended, it shall be in order to consider the further amendment printed in the CONGRESSIONAL RECORD numbered 2, which shall be considered read and debatable for 1 hour, equally divided and controlled by the proponent and an opponent.

The gentleman from Illinois (Mr. HASTERT) and the gentleman from Michigan (Mr. DINGELL) each will control 30 minutes of debate on the bill.

The Chair recognizes the gentleman from Illinois (Mr. HASTERT).

□ 1045

Mr. HASTERT. Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. GOODLING), the distinguished chairman of the Committee on Education and the Workforce.

(Mr. GOODLING asked and was given permission to revise and extend his remarks.)

Mr. GOODLING. Mr. Speaker, I rise today in support of H.R. 4250, the Patient Protection Act. This is truly a historic occasion which rivals the passage of ERISA in 1974. Thanks to ERISA, 150 million Americans are covered by employer-sponsored health care plans. Thanks to the gentleman from Illinois (Mr. FAWELL), most of the 4 million uninsured will have quality affordable health coverage available to them when we pass this legislation.

Increasingly, the American people tell us that they need common sense elements in health insurance reform, and that is what is in the Patient Protection Act, including basic protections such as guaranteed access to emergency medical care, doctors being able to speak freely with patients about their health care options without being gagged and ensuring that a patient can quickly obtain the benefits promised by their health care.

The Patient Protection Act will also provide health care accessibility to patients by requiring that patients have full access to plan information such as what benefits are covered, the participant's financial responsibility, and a complete description of the claims procedure and appeals process. Women and families with small children will be ensured direct access to key specialists such as OB/GYNs and pediatricians.

As I see it, however, our plan differs from other proposals in two key ways. First, we make sure that patients get the care they deserve in a timely manner before harm can occur. We get them into hospital rooms, not into courtrooms.

We take serious, comprehensive steps to expand availability and affordability of health insurance to American working families who have no health insurance. No other plan does this.

I have held a lot of town meetings in my district over the years, and not once has a constituent said to me, ''I would really like to be able to sue my health plan.'' What they have said to me over and over again is ''When are you going to do something about the high costs of health insurance?'' Today, I am happy to say we are doing something about it.

Simply put, the Patient Protection Act will increase access to affordable health insurance for millions of Americans. It is amazing to me that all the other proposals ignore the 42 million uninsured Americans.

The gentleman from Illinois (Mr. FAWELL) has pushed this through our committee on two occasions to make sure that we do something about the uninsured. The problem of the uninsured, both children and adults, is the problem of small business lacking access to affordable health coverage.

Over 80 percent of the 82 million uninsured Americans live in families where someone is working, someone is employed usually by a small employer, or they are self-employed.

To address the affordability problem of the uninsured, the Association Health Plan proposals in the Patient Protection Act would give franchise networks, bona fide trades, business and professional associations, and organizations such as the Chamber of Commerce, and the National Federation of Independent Business the ability to form large group health plans within and across State lines.

Again, the best patient protection is access to affordable health care.

I would like to take a minute to go into a little more detail about some of the claims procedure provisions in the Patient Protection Act as they pertain to ERISA.

The provisions relating to internal review and external review claims procedures and remedies are contained in Subtitle C of Title I and will hold plans accountable and insure patients get the care they deserve in a timely manner.

The current claims procedures that apply to employee benefit plans under federal law are contained in ERISA Title I section 503. The exclusive remedies that apply to such plans are contained in Part 5 of that Act. With minor exception as provided in regulations, the procedures under 503 do not distinguish between group health plans (i.e. employee benefit plans providing medical care) and other plans, including pension plans and other employee welfare benefit plans. In general, plans may take up to 90 days to inform claimants of initial decisions and up to 60 days to inform them of decisions upon internal appeal. Generally, upon satisfaction of administrative remedies, claimants may proceed, pursuant to Part 5, to enforce their rights under the plan and the ERISA law in court. In general, remedies relating to adverse coverage decisions are limited to the payment of benefits as found to be provided under the terms of the plan and to such reasonable attorney's fees as may be provided in the discretion of the court. Certain other civil remedies may also apply.

Under Subtitle C of Title I the ERISA claims procedures are modernized to take into account the rules as they apply to the many diverse kinds of group health plans in today's evolving health care delivery system. Section 503 of ERISA is amended to require group health plans to provide written—and understandable—notice to a participant of any negative coverage decision on requested benefits under the plan within 30 days of the request. If the request is for urgent medical care, the plan must provide the notice within 10 days; for emergencies, the requirement is 72 hours. If the request is for a referral to a physician specialist, the coverage decision must be within 72 hours. This notice also must be sent to the participant's medical provider if the provider initiated the claim or seeks reimbursement from the plan. The participant must be informed in the notice that he or she may file a written request for review (i.e. internal appeal to an appropriate named fiduciary under the plan) of the coverage decision within 180 days after the notice is received. Internal reviews of coverage request denials involving medical necessity and experimental treatment or technology must be conducted by a physician who did not make the initial decision. The same time frames apply to internal review as to the initial coverage decision.

If the internal appeal results in a coverage denial, the participant may make a request within 30 days for an external review, which must be conducted by one or more independent medical experts (in general, a physician with expertise in the matters involved) selected in accordance with procedures that must be specified under the plan. The procedures of selection required under the plan allow for independent intermediaries to select the reviewing medical experts so as to ensure they meet the strict independence rules preventing conflict of interest. The external review must be completed within 25 days of the request. If the final decision under the plan by a physician, who did not make the earlier decision, is an adverse coverage decision, then the participant has recourse to the courts. Alternative dispute resolution procedures would be permitted, however they would have to conform to the requirements for physician review of medical necessity and with the external review procedures.

The remedies under section 502 of ERISA are improved to include civil penalties for fiduciaries who do not provide benefits in accordance with the recommendation of the external review medical expert. If after external review, a participant is denied coverage, a civil court may impose a penalty of up to $500 a day ($1,000 in the case of bad faith violations) starting on the date on which the recommendation was made. The total penalty may be up to $250,000. Also, fiduciaries in an expedited court action or who took or failed to take action that resulted in a denial of coverage after an external review would be liable in such court actions to pay attorney fees and other reasonable costs to the plaintiff—i.e., the patient. In the case of a pattern or practice of violation, the Secretary of Labor may, in a court proceeding, impose a penalty of up to $100,000. In cases in which a physician certifies to a court that the time needed to carry out administrative remedies and procedures for review of coverage denials would run the risk of causing irreparable harm to the health of the participant, the provisions under section 502 allows such participants to take civil action to obtain an injunction or other equitable relief.

This claims process will ensure patients get the care they deserve in a timely manner. It is one of many reasons the Patient Protection Act should be passed by Congress and signed into law.

Mr. DINGELL. Mr. Speaker, I yield myself 2 minutes.

Mr. Speaker, we face a clear choice today between two different approaches. The first, the Patients' Bill of Rights was written last year and revised in March. The other piece of legislation, the Republican leadership bill, was still being written after midnight last night.

The Patients' Bill of Rights has been scored by the CBO at a cost of $2 per month per patient, and we provided revenue offsets to ensure fiscal responsibility.

The leadership's bill was never even seen by the CBO and has not been read by the Members. Only minutes ago did we get a final score from CBO. Since it does nothing, it costs nothing. I think my colleagues should note, a bill that does nothing costs nothing.

The Patients' Bill of Rights guarantees real patient rights. It puts health back into the Health Maintenance Organization. The Republican leadership bill has the word HMO. In that bill, HMO stands for hide my opposition.

If our primary concern is health care for the American people, the choice is clear. The Patients' Bill of Rights puts medical decisions, especially the question of medical necessity into the hands of doctors and takes them away from insurance company bureaucrats who now are hurting the American public.

The Patients' Bill of Rights guarantees that we can see a medical specialist when we need one. The Patients' Bill of Rights says that, if you are a pregnant woman or cancer patient, you will continue to be able to see your doctor when you need continuity of care.

The Patients' Bill of Rights guarantees that we will be able to get the prescriptions that we need. The Patients' Bill of Rights holds health plans accountable when they have denied health care and when their decision kills or injures somebody.

The Patients' Bill of Rights protects the confidentiality of our medical records, and the Republican bill does not. The Republican bill even has one interesting thing. It goes so far as to repeal existing consumer protection laws that help patients. I want my colleagues to hear that.

Last of all, I want my colleagues to look at the roster of supporters of the Patients' Bill of Rights: AMA, all the health care specialists, the nurses, and all of the consumers and aging organizations. The American people want the Patients' Bill of Rights. If we want to serve them, we will vote for the Patients' Bill of Rights today.

I want to particularly single out my good friend and colleague, Dr. GANSKE for his leadership and courage on this issue. He is a man of integrity and stands up for what he believes in. He deserves great credit.

I also want to commend the work of the staff in the development of the Patients Bill of Rights.

Among our staff Bridgett Taylor, Amy Droskoski, and Bernadette Fernandez have worked tirelessly on the bill for many months.

Mr. HASTERT. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Virginia (Mr. BLILEY), chairman of the Committee on Commerce.

(Mr. BLILEY asked and was given permission to revise and extend his remarks.)

Mr. BLILEY. Mr. Speaker, when it comes to health care, patients and their doctors should be in the driver's seat. Right now, they are mere passengers. Fortunately, the Patient Protection Act of 1998 puts patients back at the wheel where they belong.

Our bill gives Americans the care they need when they need it. It protects patients without expanding big government, and it promises patients greater choice and the ability to stick with a favorite doctor.

The Patient Protection Act addresses a major flaw in our health care system, the lack of a real marketplace where patients can shop for the lowest cost and highest quality care.

Even Ron Pollack of Families U.S.A., a staunch supporter of President Clinton's efforts to nationalize health care agrees this is needed. He recently said, and I quote, ''There is no true marketplace today to drive health care quality.'' He is right. Think about it.

When we buy a new car, we do not go to a bank, credit union, or GMAC first. We choose the car we want; then we arrange the financing. In other words,

we, not the lender, choose what car to buy. We, not our employer, choose the financing.

Why can health care not work the same way? Why do health care choices have to be dictated by the terms of health insurance than by consumers' needs and preferences. Why must employers choose the health coverage that finances so many Americans' care?

HealthMarts answer these important questions in a way that puts patients first. HealthMarts are private, voluntary, and competitive health insurance supermarkets. They transfer choice within the employer-based health insurance market from small employers to employees.

HealthMarts give consumers the freedom to choose health coverage from a broad menu of options. Here is how they work: A small business joins a HealthMart because it offers lower cost coverage, makes more options available to employees, and does the administrative work.

Employees choose from among the HealthMart's coverage options. Each can choose a different plan and still benefit from group rates. Sound familiar? It should. It is the type of choice today that is available only to Members of Congress, our staffs, and other Federal employees.

This type of consumer choice is essential to the quality of health care coverage and services. After all, if all Americans had the freedom to choose their coverage, they would be able to get the highest quality care that best meets their needs. HealthMarts will achieve that critical objective.

The bottom line is this: By making quality as important in the selection of health coverage as cost, HealthMarts will move the Nation toward a true health care marketplace.

This new idea gives patients more choice and better quality health care. It puts them back in the driver's seat. It is yet another reason why the Patient Protection Act deserves our strong support.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Iowa (Mr. GANSKE) and note that he has been instrumental in bringing us to where we are today. I salute him for it and thank him on behalf of my colleagues.

Mr. GANSKE. Mr. Speaker, I rise in opposition to H.R. 4250 and in support of the Ganske-Dingell substitute. There is going to be a lot of debate today about the legal situation. I have been for legal reform. I have stood in this well arguing for medical malpractice reform. I voted for securities litigation reform, product liability reform.

I, as a physician, would never want Congress to pass a law that says physicians should be immune from their malpractice. Yet, that is a situation that we have with ERISA.

The problem with H.R. 4250 is it does not remove ERISA preemption for State causes of action. The Ganske-Dingell bill says that Federal law may not preempt State law, but we have a provision in there that protects the employer.

If the employer is not making the decision, if the HMO is making the decision, the employer is not subject to liability. That is a very important distinction. It is fair.

But let me just ask my colleagues something, it is very clear that HMOs have committed malpractice that has resulted in loss of life and limb. ERISA, through the interpretation of the courts, has extended that legal exemption to health plans. However, we have never had our personal fingerprints on that legal immunity and the problems with it.

If we vote for the GOP bill, we are going to be codifying, giving HMOs legal immunity. Would we do that for tobacco companies? I think not. Would we do that for companies that are making life and death decisions? I hope not.

Mr. HASTERT. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. CUNNINGHAM).

Mr. CUNNINGHAM. Mr. Speaker, I have no doubt that Members on both sides of the aisle want to focus on health care, but I personally feel that, in an election year, political pandering on both sides is not a benefit for the American public.

I look at the Democratic ''Bill of Fights'' that is going to drive up health care cost by letting trial lawyers take over. California is a leader in HMOs, but I also see good, bad, and ugly in the HMOs in California. We are losing good doctors in California because of HMOs and managed health care.

□ 1100

But yet there are still some good ones, and we need to attend to that.

Whether the lawyers drive up costs or CEO's from HMOs rip off the system and drive up health care, both are bad, and that is why I say that neither one of these bills are good for the American consumer, and we need to help.

The gentleman from California (Mr. FAZIO) brought over a list of things that are preempted in state law. I do not want that. But, at the same time, I looked into it, and the unions right now are under ERISA. Your supporters are exempt under state law, the unions and large companies. We wanted the small businesses to be able to band together and have the same benefits for low health care costs.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from California (Mr. STARK).

(Mr. STARK asked and was given permission to revise and extend his remarks.)

Mr. STARK. Mr. Speaker, I ask unanimous consent that my infirmity not be taken as support for the Republican bill, which is a cynical sham and should be defeated. I wish to announce my support for the Dingell bill.

Mr. Speaker, today's vote on managed care reform is a complete sham.

It wasn't long ago when the Republican leadership called on their friends in the health insurance industry ''get off your butts and get off your wallets'' to defeat real reform.

Today, they are here to put another nail in the coffin of real reform.

Their answer to managed care reform is the same as their answer to campaign finance reform and tobacco legislation: Make it look like they are doing something, but then work to kill it with the addition of divisive provisions.

H.R. 4250 flunks the fundamental test of real reform—it doesn't hold health plans accountable for their medical decision making. This bill precludes an injured patient or their family from suing a managed care plan that maims or kills them.

Under the Republican bill, health plans could continue to get away with cases like that of Mrs. Florence Corcoran, who lost her baby because of her health plan's refusal to follow her doctors' advice.

Today, if a doctor commits malpractice on a patient, the patient has the right to sue that doctor. If a hospital maims a patient, they are liable for their action. If a defective car causes a person's death, the care manufacturer is liable.

Why should we let managed care plans off the hook? What makes them worthy of legal immunity that we don't grant doctors and hospitals—or any other profession or industry?

In addition, the Gingrich managed care bill before us today includes a number of ''poison pills'' that Congress has rejected numerous times in the past.

Among the poison pills are:

Expansions of medical savings accounts to help the healthy and wealthy at a cost of billions to American taxpayers;

MEWA and HealthMart provisions that would destroy small group market reforms in the states, increase adverse selection and weaken state enforcement authority.

But the cherry on top of this sundae for the managed care industry is the permission this bill gives health plans to withhold even more access to care than they can under current law. This bill gives HMOs the right to define—each plan for itself—what the medically necessary care is that it will provide to its enrollees. Today, medically necessary care is defined by doctors and other medical experts as the best that science and human ability can deliver. But this bill says plans can decide what their version of medically necessary care is, and how much of it they will give you. It lets bureaucrats, not doctors, determine your health care.

Even those managed care reforms where there has been widespread agreement—such as access to emergency care—are botched in the Gingrich bill.

This bill does not provide the protections to the private sector that are enjoyed by Medicare and Medicaid beneficiaries today.

An emergency physician who testified earlier this week, Dr. Charlotte Yeh, got it right when she said that she thought the Republicans had performed some ''unnecessary surgery on the prudent lay person standard to the point where it is hardly recognizable as the consumer protection we envisioned.''

The Gingrich bill destroys medical record confidentiality. It would trample on Fourth Amendment rights by giving health plans and

health providers the right to disclose your medical record to any entity—without your permission. Your medical record, with your name and full history, could wind up in the hands of a drug company's marketing department . . . a credit card company . . . a consultant working on a political campaign . . . a divorce lawyer . . . a newspaper.

The public deserves better from Congress than this shoddy piece of work.

This bill also allows plans to charge people up to $100 to get external appeals—and doesn't allow patients or doctors to present any evidence at that external appeal review. Talk about a sham!

This Republican bill is worse than doing nothing. If Members of Congress took the Hippocratic oath to do no harm, they would not be able to vote for this bill. Vote to defeat H.R. 4250.

I support the Ganske-Dingell substitute. It is a real bill, with real protections.

The Republican bill is a sham. It provides none of the major consumer protections that patients need.

The Republican bill actually does harm. It overrides hundreds and hundreds of State consumer protection laws, leaving people with less protection than they now have. It will drive up the cost of health insurance for most people. It makes your most private medical records available to every Tom, Dick, and Harry salesman. It spends billions on a new tax break for the wealthiest and healthiest in our society. It takes away your right for compensation for pain and suffering because of medical malpractice.

These harmful features are poison pills, designed to cause controversy and confusion in the Senate and to prevent a bill from passing. The Republican bill is another testament to the need for campaign finance reform: it is a bill designed to make their PAC contributors happy.

The Democratic substitute bill, on the other hand, is a real patient protection bill endorsed by the doctors, by the nurses, and all the consumer groups.

It will require that health plans provide you care that is based on the consensus of the latest, best quality of care. The Republican bill, on the other hand, lets each profit-making HMO define what they believe is adequate medical care: they will provide care based on what their accountants tell them—not their doctors.

The choice could not be clearer. We can pass the Republican sham bill today—or we can pass a real bill—the Democratic substitute.

Mr. DINGELL. Mr. Speaker, I yield two minutes to the gentleman from Missouri (Mr. CLAY) the ranking member on the Committee on Education and the Workforce.

Mr. CLAY. Mr. Speaker, I rise to oppose H.R. 4250. This bill is nothing more than a cynical propaganda effort promoted by the Republican leadership to convince the public that they are doing something about the abuse of HMOs. This bill is loaded with special interest provisions that do far more harm than good to consumers of health care.

The Republican bill includes a provision to establish Association Health Plans that would enable small businesses and self-employed individuals to band together and purchase health insurance coverage. The chairman of our Committee on Education and the Workforce has stated that the committee has approved this provision and so no one should be concerned about it. The fact is, the bill was reported over Democrat's vehement objections, because it is clear that the arrangements will do more harm than good.

The National Governors Association and the National Conference of State Legislators join with the National Association of Insurance Commissioners in stating that Association Health Plans would undermine positive state regulatory reforms already in place, would destroy important consumer protections, and would contribute to the collapse of small group health insurance in many states.

According to CBO, Association Health Plans would increase the risk of health plan failure and would disrupt the insurance market, because Federal regulatory standards would probably be less strict than the state standards that apply under current law. Association Health Plans would present state regulations covering such vital matters as sovereignty, mandated care and the policing of fraud and abuse.

Mr. Speaker, I urge my colleagues to reject H.R. 4250 and instead support H.R. 3605, the bipartisan Patients' Bill of Rights act.

Mr. HASTERT. Mr. Speaker, I yield three minutes to the distinguished gentleman from Texas (Mr. ARCHER), the Chairman of the Committee on Ways and Means.

Mr. ARCHER. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, two principles have forever guided our Nation, individual freedom and liberty. As a democratic Nation whose strength derives from its people, we have achieved high degrees of each, unsurpassed by any nation in all history. It is no wonder that people around the globe want to come here and be called Americans. We are the envy of the world. Now, as we consider a plan to protect and strengthen a free people who worry about the health care needs of themselves and their families, we must do so with our guiding principles in mind.

Our Nation's health care system is the best in the world. Americans do not travel abroad to get health care, but visitors come here from all over the world, to the Mayo Clinic, to Mount Sinai, and, yes, to my own City of Houston to the Texas Medical Center Memorial, because we are the best.

The reason our health care system is the best is because it is based on capitalism, on choice and on individualism. That is why the one aspect of the bill before us today that gives me great pride is the expansion and the unfettered opportunity for Americans to choose medical savings accounts, free and unencumbered.

The source of America's frustrations with HMOs is the lack of control which both patients and doctors feel. There is always a third party making a decision. Patients want to be able to pick up the phone and get a quick appointment to see their doctor. Patients want to see the doctor of their choice for all their health needs.

Doctors want to take more time to be with their patients. Doctors want to treat their patients as they see fit, without interference from a third-party payer or an insurance company, and that is why we need medical savings accounts. With MSAs, patients, not insurance companies, control their choices. There are no gatekeepers, there are no middlemen, and there are no third-party payers, except in the case of a catastrophic event.

MSAs let patients and employers deposit money tax-free into accounts that patients control. Like an IRA for retirement needs, MSAs are IRAs for health care needs. When people control their own money, the general use of capitalism will come into play. It has in all things American; it will in health care too.

Our Nation's greatness is based on freedom and liberty. So, too, is our future. While I originally introduced this bill with a Democrat Congressman, Andy Jacobs, six years ago, I realize even more today that MSAs are and should be the future of health care.

I urge support of the bill.

Mr. DINGELL. Mr. Speaker, I yield two minutes to the distinguished gentleman from Texas (Mr. HALL).

Mr. HALL of Texas. Mr. Speaker, I would start by saying that my speech will probably fall on some closed minds, because many already have your minds made up. Many of you have decided or pledged to take a particular vote, or taken an oath to do it, or been whipped by either the Democrat or Republican Whip.

I speak though to those who do not have their feet set in concrete today, I think those that really and truly want the facts about this situation.

I did not speak on the rule. As a matter of fact, I voted for the rule. I think it is about as fair a rule as a majority will give a minority, so I had no problem with the rule. The rule was not good, but I think the worst is yet to come, and let me talk about a little of it.

It does not please me, by the way, to oppose the likes of the U.S. Chamber and the NFIB. I have had 100 percent with them for years and years, but I differ with them on this because I think they are wrong.

I think that ERISA is what this is all about. ERISA is what all these meetings have been about. ERISA is what the insurance companies can hide behind to escape liability, and it is not right, it is not fair, it is not just, and it should have been changed.

All the conferences that have been had over on this side, all the committee meetings, way into the night, last night, late, late, late, war gaming amendments, it is how can we compromise ERISA? That is what the

whole thrust has been, how can we keep ERISA on the table for insurance companies to hide behind when they err, when they guess wrong?

I tell you, H.R. 4250 preempts states patient protections too. I think we need to know that. This bill will remove stronger patient protection bills in over 40 states. I think the facts are out on the sheet that show how your various states are affected.

Tonight we are going to finish this. We are going to go home, we are going to issue press releases carefully worded, but the hard cold fact is you are offending people when you leave ERISA in place as a hiding place for those that ought to be liable.

Mr. Speaker, as I close, I urge Members to vote against 4250.

Mr. DINGELL. Mr. Speaker, I yield two minutes to the distinguished gentlewoman from New Jersey (Mrs. ROUKEMA).

(Mrs. ROUKEMA asked and was given permission to revise and extend her remarks.)

Mrs. ROUKEMA. Mr. Speaker, I must tell my colleagues that I rise in reluctant opposition to this bill, and I am constrained to ask, not facetiously, is this as good as it gets? I am sorry, that is a facetious reference to the movie that we all say identified the backlash out there, and that backlash has promoted our party, both parties, to seek a solution. But I do not believe that this bill is as good as it should get.

I wanted to say that I recognize that there are a lot of benefits to the Republican task force bill, but we have to go beyond that.

Let me point out the issues that are of continuing concern to me. I do not believe we have the patients' access to clinical trials that they need. I do not believe there is expanded access to specialists in a meaningful way, and that is very important to me. I think that the external appeals process, as I read it, and, of course, we only got it really this morning, but as I read it, the appeals process is not even binding. This concerns me, because a right without enforcement is no right at all, as far as I can tell.

I do also want to get to the point of the ERISA question, the health plans. I want to particularly reference the fact that I believe that the gentleman from Iowa (Mr. GANSKE) in his analysis was absolutely correct, and I agree with him. I am concerned that this ERISA preemption as it is supplied to the Association Health Plans and the HealthMarts would be an expanded loophole to legitimate care, particularly for the small business community employees, and I am deeply concerned about that.

These potential loopholes would greatly diminish the quality of care and the medical protections in states such as New Jersey. This is a prime problem. We can have these association pools, we can do these small business pools, without expanding the ERISA preemption.

So I must reluctantly again say, bottom line, the question is whether or not patients will have better access to health care, and health care through the doctors and the professional health care providers, not bureaucrats.

INTRODUCTION

I rise in reluctant opposition to the bill placed before the House today. And I am constrained to ask: Is this ''As good as it get?'' This is my own reference and its not facetious to the motion picture that made graphically clear to policymakers the backlash I long ago predicted against HMOs. This building backlash was the reason I introduced my own bill H.R. 1222, ''The Quality Health Care and Consumer Protection Act'' in 1996 to focus the debate.

Today I say that this bill is clear movement in the right direction. But it is not ''as good as it should get.''

We need to put health care decisions back in the hands of doctors and other health care professionals, and take them away from the managed care companies who are practicing ''bottom line'' medicine and ''rationing'' healthcare.

It is for this reason that I introduced legislation to ensure that managed-care networks provide high-quality, efficient care, not just low-case care that boosts profits. But at the same time my bill guards against unjustified health care costs.

CONCERNS WITH TODAY'S HURRIED PROCESS

But today I must decide between one of two proposals. Before I discuss the proposals I do want to raise a concern wit the process.

The state of our nation's health care is an issue that should be debated through Committee discussions, through hearings, and through floor debate, instead of a limited up or down vote.

BENEFITS OF THE REPUBLICAN TASK FORCE BILL

The bill we have before us today is not altogether bad. There certainly are areas that could use significant improvement; however, the base bill does include information disclosure, internal and external appeals and grievances, a ban on gag clauses, and access to OB/GYNs and pediatricians. These are all moving in the right direction.

However, we are not yet there! Again, this is not ''As Good As It Should Get!''

PROBLEMS WITH THE REPUBLICAN TASK FORCE BILL

This bill does not include a provision to provide patients access to clinical trials, expanded access to specialists, and physician involvement in the development of drug formularies.

This bill also has an external appeals process that is not even binding. This concerns me, because it is a right without enforcement. And a right with no enforcement is no right at all!

In addition I am concerned this legislation does not have a provision relating to provider incentive language to ensure that physicians and pharmacists are consulted in the development of drug formularies when medically necessary.

ASSOCIATION HEALTH PLANS AND HEALTHMARTS

I am also deeply concerned about expanding the ERISA pre-emption to even more businesses than those already able to escape State laws.

We must carefully weigh the benefits of allowing associations the protections of being covered by national laws with the benefits of allowing state laws to determine consumer protection. Association Health Plans and Healthmarts would both allow more people to escape the coverage of state laws. These are potential loopholes that would diminish necessary medical protections in states such as New Jersey.

Businesses have long argued that ERISA is necessary for companies that operate in more than one state because it avoids the onerous burden of complying with 50 different sets of regulations and offering 50 different sets of rules and coverage for their employees. This is a valid argument.

However, in today's market, this has led to loopholes where employers are able to avoid the protections fought for, and placed at the state level. I agree with Dr. Ganske's analysis of how inadequate this provision is.

RIGHT TO SUE

I must also address the right to sue. While I understand the merits to this important right, I am also very concerned that this right would add tremendous costs and affect the quality of health care—doctors and HMOs and hospitals would be practicing defensive medicine—namely executing procedures and conducting tests merely to protect themselves against lawsuits. This concerns me, because this could lead to a reduction in the number of people able to afford health care.

CONCLUSION

The bottom line is whether patients will have better access to health care and whether doctors and health care professionals will be put back in charge instead of insurance company bureaucrats. We need to return the power over medical decisions to those with the medical training and expertise—the doctors and the nurses. This will restore the quality of care that has been our American tradition and leave the field of ''bottom line medicine'' practiced by bureaucrats and so-called ''gatekeepers.''

Mr. HASTERT. Mr. Speaker, I yield myself 15 seconds.

Mr. Speaker, I would like to just remind the gentlewoman from New Jersey that the people that we are bringing under the umbrella of new health care do not have health care today, part of the 40 million people who work for a living, who are out there that do not have health care. We are trying to expand and bring those people under the umbrella of health care.

Mr. Speaker, I yield two minutes to my colleague, the gentleman from Illinois (Mr. FAWELL), the distinguished chairman of the Subcommittee on Employer-Employee Relations, and certainly someone who has worked on this issue of bringing people under the umbrella of health care for a long time.

(Mr. FAWELL asked and was given permission to revise and extend his remarks.)

Mr. FAWELL. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, right now there can be no patient's bill of rights for 43 million people, because they have no access to affordable health care, and we can change that in this legislation with Association Health Plans.

What do Association Health Plans do? By allowing small businesses to

band together under multiple employer health plans, Association Health Plans simply allow the little guys, the small businesses, the self-employed, to have precisely what large employers have had for many years. Thus, small businesses can gain the economies of size, so they can do what, self-insure, and thereby they have the clout to bargain and to discount the price of health care in dealing with health care providers and in dealing with insurance companies.

□ 1115

Who are these association health plans? They are long-standing and respected, not-for-profit, professional business and trade and church associations which, like the large employers, they are not in the business of insurance, but that they will, like large employers, assume the responsibility of sponsoring self-insured and fully-insured plans for the members of their associations.

Examples of these associations, yes, include the National Chamber of Commerce and the NFIB, the National Restaurant Association, but also include the Agricultural Field Workers Association, who cannot get health insurance in the market. National Church Associations, National Farm Bureau, the Boys and Girls Clubs of America with 700 units, and they cannot get regular indemnity policies.

Why are the association health plans important? Because most of the 43 million people who do not have health insurance in America, including most of the uninsured children, are people who live in families with the breadwinners employed by small business or are self-employed. They have to simply go into the individual and small business market, and my colleagues know what happens when one goes into that individual and small business market. The insurance companies and the HMOs do not want to give up and have new competition.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the gentleman from Minnesota (Mr. OBERSTAR).

(Mr. OBERSTAR asked and was given permission to revise and extend his remarks.)

Mr. OBERSTAR. Mr. Speaker, I rise in opposition to the bill before us and in support of the Dingell substitute.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. FORBES), my distinguished friend.

(Mr. FORBES asked and was given permission to revise and extend his remarks.)

Mr. FORBES. Mr. Speaker, I thank the gentleman for yielding me this time.

For an increasing number of years now Americans across this country have made it clear that they are dissatisfied with the manner in which some health maintenance organizations oversee the delivery of their health care services. In fact, just a few years ago the ''hue and cry'' got so loud that on this floor, this very floor, a bipartisan majority of Democrats and Republicans saw fit to pass legislation that corrected the practice of some insurance providers that forced women out of the hospital barely 24 hours after they gave birth.

Yes, the House and Senate together, along with the President, decided that it was wrong and we must mandate, yes, mandate a minimum hospital stay for women who give birth.

Well, unfortunately, that is not the sole example of some of the problems with the HMOs and that is why we are here today. Unfortunately, the Republican initiative, which I would have loved to have supported, does not adequately meet the needs that most Americans are calling for.

The Patients' Bill of Rights, in fact, is the best alternative to restoring common sense in the HMO equation. Only the Patients' Bill of Rights allows patients access to key clinical trials, those experimental, innovative and emergency processes that are the last resort for the severely ill. The Patients' Bill of Rights gives access to important drug therapies that a doctor may believe are important to restoring one's health and cost thousands of dollars and would otherwise mean literally life or death for the patient.

A gross omission in the Republican bill, I am afraid, is something even worse than the early release after giving birth, and that is the so-called omission of preventing drive-by mastectomies, the practice that too many HMOs use to force a woman who has undergone a mastectomy out of the hospital before she is physically able to resume normal activities.

Absent, too, and I believe it should be her right, that every woman who has undergone a mastectomy have the right to access to reconstructive surgery and not have it deemed cosmetic by an uncaring HMO.

Finally, the Patients' Bill of Rights is the only one that ends the special protections for HMOs under ERISA. HMOs should not be exempt from lawsuits if bad decisions lead to injury or death.

Mr. Speaker, I urge adoption of the Patients' Bill of Rights by the gentleman from Michigan (Mr. DINGELL) and the gentleman from Iowa (Mr. GANSKE).

Mr. HASTERT. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Louisiana (Mr. McCrery).

(Mr. MCCRERY asked and was given permission to revise and extend his remarks.)

Mr. MCCRERY. Mr. Speaker, if one believes in the free market, if one believes in the power of individual choice, if one believes our private health care system is, in most respects, the best in the world and is worth preserving, then listen up.

I am going to tell my colleagues about the best part of the Patient Protection Act. It is the part of this bill that really empowers patients. It gives them the ability to choose their own doctors and hospitals. It gives them the economic power to deal effectively with the costs of their health care. It gives individuals the power to take advantage of preventive health care, if they choose. It even offers people the prospect of a sizable nest egg in their later years which they could use for long-term care expenses or retirement.

Mr. Speaker, this Patient Protection Act will finally make medical savings accounts available to everyone, and it removes the burdensome regulations that have prevented many individuals and small businesses from obtaining MSAs. This bill allows both small and large employers to make deductible contributions to an employee's MSA. It allows both employers and employees to make tax-favored contributions to a medical savings account.

Mr. Speaker, if we really want people to be able to take control of their health care choices, if we really want to make the doctor-patient relationship what it used to be and what it should be, if we really want to create a market with forces that can control health care costs, then we must be for the expansion of this valuable, free market tool: medical savings accounts. That alone should make my colleagues vote for this bill.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Arkansas (Mr. BERRY).

Mr. BERRY. Mr. Speaker, I rise in opposition to H.R. 4250 and in support of the Dingell-Ganske bill. The Republican bill is bad for small business, bad for America, and it is shameful. It is a fiscally-irresponsible sham that does nothing to address the real concerns of employers, employees and real people.

This legislation creates a new Federal Commission of Insurance at the Department of Labor, a Department that my Republican colleagues tried to do away with just 2 years ago. It authorizes the hiring of hundreds, perhaps thousands, of new employees at a new Federal Commission of Insurance.

What will this new Federal Commission do? Absolutely nothing. Because its powers are so limited by the Republican bill that its ability to remedy health plan wrongdoing is almost nil.

How much will this new Republican Federal Insurance Commission cost? No one knows, because we still have not seen a CBO score.

Let us see. A multimillion dollar new Federal bureaucracy, thousands of new employees with nothing to enforce, all at the American taxpayers' expense, release of medical records. Your competitors in business, your opponents in politics will have access to your medical records. Protection of insurance company profits, abuse of patients, no access to emergency care or specialists. My Republican colleagues should be ashamed.

Have my colleagues read this bill? My colleagues will be shocked. I urge

my colleagues to vote down this irresponsible proposal. Vote for the Dingell-Ganske substitute. This Republican proposal is a useless drain on our Treasury and a threat to our balanced budget.

Mr. HASTERT. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. CHABOT).

Mr. CHABOT. Mr. Speaker, I rise in support of the Patient Protection Act. There have been numerous managed care reform proposals offered in Congress this year, and many share similar consumer protections.

The Patient Protection Act guarantees that patients can choose their own doctor, gain access to emergency care, communicate openly with health care providers, and independently appeal decisions made by managed care companies.

This bill also contains a number of pro-consumer provisions that the other proposals do not. This legislation increases patient access to affordable care by expanding health care coverage options for workers and their families, many who have no health care coverage at all now.

American families know that the most important patient protection is access to affordable care. Families should not be forced to choose between expensive health care coverage and putting food on the kitchen table.

This legislation will protect consumers from abuses in the managed care industry, while increasing access and affordability. That is why I support the Patient Protection Act.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from Washington (Mr. MCDERMOTT).

(Mr. MCDERMOTT asked and was given permission to revise and extend his remarks.)

Mr. MCDERMOTT. Mr. Speaker, as the public listens to this debate, I am sure they will wind up confused, so I want to give 10 reasons why my colleagues should vote against the Hastert proposal and for the Ganske-Dingell bill. I borrowed these from the gentleman from Iowa (Mr. GANSKE) who is a Republican and a doctor. I am a Democrat and a doctor, and we agree.

He says, the substitute provides, that means the Democratic substitute, patients with access to clinical trials. The Hastert bill does not.

The substitute allows doctors to override drug formularies when medically necessary. The Hastert does not.

The substitute provides for ongoing access to specialists for chronic conditions. The Hastert bill does not.

The Ganske-Dingell substitute prevents plans from giving doctors financial incentives to deny care. The Hastert bill does not.

The substitute has hospital-stay protection for mastectomy patients. The Hastert bill does not.

The substitute provides choice of doctors within the plan. The Hastert bill does not.

The substitute has a provision guaranteeing continuity of care when providers leave the network. The Hastert bill does not.

The Ganske-Dingell plan requires plans to collect quality data and maintain a quality improvement program. The Hastert bill does not.

In addition, the Hastert bill allows the plan to decide what is medically necessary. If one has chest pain and one feels like one should go to an emergency room, one cannot decide whether that is medically necessary, one's plan will tell you if it was medically necessary. Maybe after you get to the hospital, they will say, well, it is just indigestion, so it is not medically necessary to go to an emergency room.

There are more reasons than I can get in in 10 minutes. This cynical process requires a ''no'' vote on Hastert and a ''yes'' vote on Ganske-Dingell.

Mr. HASTERT. Mr. Speaker, I yield myself 30 seconds.

I appreciate the gentleman from Washington, who is a doctor and certainly sees things from a different perspective, but I have to tell my colleagues he named 10 mandates that our bill does not have, 10 mandates. And he also talked about the Federal Government, the HCFA agency starting to lay out what one's health plan should do and what it should not do.

The gentleman from Washington has certainly been an advocate of big health care, government takeover of health care, and that is exactly what this plan is not, and I want the people in this country to know that. We think the decision on what one owes health care should be between the patient and the doctor, and that is exactly what this bill does.

Mr. Speaker, I yield 3 minutes and 15 seconds to the gentlewoman from Texas (Ms. GRANGER) for the purpose of a colloquy.

Ms. GRANGER. Mr. Speaker, I rise today in support of H.R. 4250, and I thank the gentleman from Illinois (Mr. HASTERT) and all of the members of the working group for their ability to listen and their desire to lead.

It has often been said that there is a time in the life of every problem when it is large enough to see and yet small enough to solve. The issue of health care reform is one we can see and solve, and our bill does that.

The Republican goal is to provide quality health care and peace of mind for every American. The Republican plan gives peace of mind when the nearest emergency room can mean the fastest care in the case of a heart attack. Our plan gives peace of mind for mothers because there is no barrier for care by a pediatrician. Our plan gives peace of mind for women because they can go directly to an OB-GYN for their health care. And our plan gives peace of mind for small businesses because they will have choices for their health plans through health marts and association health plans.

□ 1130

Overall, our bill gives HMOs accountability to their patients, not their profits. Our bill says that doctors, not bureaucrats, will be authorized to make medical decisions.

Our bill is the only bill that would provide affordable health care to millions of uninsured Americans. Even Senator DASCHLE agrees with us on that.

In short, our bill, the Patient Protection Act, will ensure that all Americans have access they deserve to the health care they need at a price they can afford.

Mr. Speaker, at this time I would like to engage the gentleman from Illinois (Chairman FAWELL) in a colloquy. Among the most important protections that this legislation affords to patients is the right to internal and external review of decisions made by HMOs. Those reviews will be made by qualified independent doctors.

My home State of Texas has a law that allows HMOs to be liable in court. There is some uncertainty as to whether or not and the extent to which this Texas law is preempted by the ERISA law. In fact, this is a question that is before the courts.

Mr. Speaker, I would like to engage in a colloquy with the gentleman from Illinois regarding the possible effects of this new legislation's internal and external review procedures on whether the ERISA law preempts the State statute.

As one of the authors of this legislation, the principal author of the internal and external review procedures, and one of the leading experts on ERISA, are these new procedures intended in any way to indicate congressional intent about whether the Texas State law is preempted by ERISA?

Mr. FAWELL. Mr. Speaker, if the gentlewoman from Texas (Ms. GRANGER) would yield, no, they are not. The more explicit internal and external review provisions under this new legislation do not and are not intended to expand or contract existing ERISA law.

Therefore, these new procedures do not and are not intended to affect whether or the extent to which ERISA does or does not preempt any particular State statute. These new procedures do not indicate congressional intent either way about whether Texas law is preempted by ERISA.

Ms. GRANGER. Mr. Chairman, reclaiming my time, are the legislation's more explicit internal and external review procedures intended to in any way affect the outcome of any matters pending in court examining the extent or scope of ERISA preemption of State laws?

Mr. FAWELL. Again, no, they are not. The legislation's more explicit internal and external review procedures under ERISA are not intended to expand or contract existing provisions of law. Therefore, it is not intended to have any impact on pending litigation examining the possible scope of ERISA preemption. Accordingly, this new legislation is not intended to and should not affect the outcome of the Texas legislation either way.

Ms. GRANGER. Mr. Speaker, I thank the gentleman from Illinois for this clarification.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from the Virgin Islands (Ms. CHRISTIAN-GREEN), a physician of family medicine who has good advice for my colleagues.

(Ms. CHRISTIAN-GREEN asked and was given permission to revise and extend her remarks.)

Ms. CHRISTIAN-GREEN. Mr. Speaker, I rise to speak against H.R. 4250 and for the Patients' Bill of Rights. As has been pointed out over and over again by physicians and patients alike, what H.R. 4250, if passed, does is codify or write into law the very practices which time and time again have denied needed and appropriate medical care to us and our families.

On the issue of access to emergency care, the Ganske-Dingell bill assures that if patients reasonably think that they have an emergency illness, they can go to an emergency room and receive care that their plan will pay for. In the Republican bill, severe pain could not be used as a reason to access emergency care. That means if someone thinks they are having a heart attack, where often the only symptom is pain, they have to go to a phone and answer a laundry list of questions from some paper pusher maybe millions of miles away, before they can go to the hospital. And if it is not a typical pain, as often happens, that care would be denied.

If we pass H.R. 4250, severe pain, the most common symptom of a severe or serious medical condition, would not be a standard that a reasonable person could apply in going to an emergency room. Emergency care is just one more instance of where H.R. 4250 does not measure up to the demands of the American people.

The Ganske-Dingell bill is true managed care reform. It puts decisions back in the hands of the patient and their doctors and allows access to needed medical care. I urge its passage. Vote against H.R. 4250.

Mr. HASTERT. Mr. Speaker, what is the remaining time for both?

The SPEAKER pro tempore (Mr. KOLBE). The gentleman from Illinois (Mr. HASTERT) has 11½ minutes remaining, and the gentleman from Michigan (Mr. DINGELL) has 12½ minutes remaining.

Mr. HASTERT. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Ohio (Mr. BROWN).

Mr. BROWN of Ohio. Mr. Speaker, I thank the gentleman from Michigan (Mr. DINGELL) for yielding me this time and for his outstanding leadership on this issue.

Mr. Speaker, a mother of a 6-month-old child who was having trouble breathing called her HMO at 3:30 a.m. An HMO bureaucrat told the mother to go to the plan's network hospital 42 miles from her home. On the way to the hospital, the baby suffered cardiac arrest and later had both arms and legs amputated.

For the past 2 years, Democrats in Congress have been fighting to pass the Patients' Bill of Rights that could have protected this mother and child.

Last week, I met with a number of area residents in a restaurant in North Ridgeville who told story after story about coverage denied for emergency care and bureaucratic refusals of doctor-ordered tests to detect breast cancer.

But rather than protecting patients, the Republican leadership in Washington has introduced a proposal that protects millionaire insurance company executives.

A friend has diabetes or breast cancer. The Patients' Bill of Rights would guarantee access to a specialist. The insurance company Republican bill does not.

A grandfather experiences chest pains that may be a warning sign of a heart attack. The Patients' Bill of Rights would ensure he gets immediate attention at the nearest emergency room by requiring his HMO to cover this care. The insurance company Republican bill does not.

A child has been denied access to a pediatric specialist for asthma. The Patients' Bill of Rights would allow a parent to have access to an independent patient's appeal process. The insurance company Republican bill does not.

Under present law, the only people in America who enjoy complete immunity from lawsuits are HMOs and foreign diplomats. The Patients' Bill of Rights holds HMOs accountable in State court if they make a medical decision that harms the patient. The insurance company Republican bill does not.

Our bill provides real patient protections at a mere $2 per patient per month, according to the Republican-appointed Congressional Budget Office. Our bill is supported by the Cancer Society and the National Breast Cancer Coalition.

Mr. Chairman, I urge my colleagues to defeat the Republican insurance company bill. Pass the Patients' Bill of Rights.

Mr. HASTERT. Mr. Speaker, I yield 45 seconds to the gentleman from California (Mr. MCKEON)

Mr. MCKEON. Mr. Speaker, I rise in support of this historic legislation that addresses the problem of the rising number of Americans who cannot afford health insurance. For the first time, we will be able to extend health care options to the 42 million people in our country who remain uninsured, while the Democratic substitute ignores the problem.

We know that most people without health insurance have one thing in common: They cannot afford health care. They are either self-employed or they work in small businesses that cannot afford to pay for health benefits. This bill solves this problem.

The Patient Protection Act creates association health plans to combat high costs of health care in our country. This new and unique solution allows small businesses and those that are self-employed to join together under the umbrella of trade and professional organizations to buy health insurance for themselves and their employees. Consequently, small businesses will have access to the same kind of health care options that big corporations currently enjoy.

Mr. Speaker, I urge my colleagues to support this bill.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. PALLONE), the chairman of our task force on this matter.

Mr. PALLONE. Mr. Speaker, I just wanted to mention, the Republicans keep talking about the number of uninsured in this country. I would point out that 4 years ago, when President Clinton tried to put forward a health care plan that would insure all Americans, they fought it vigorously. The fact that we have more Americans now without health insurance is their fault, because they would not allow the Clinton plan to come forward. So now the numbers of uninsured continue to grow.

Mr. Speaker, I just want to explain why the Democrats' bill is a vastly superior bill in terms of ensuring and expanding patients' access to physicians.

For example, the Patients' Bill of Rights ensures access to specialists. The Republican bill does not. Under the Democratic bill, if a patient has cancer, they could go directly to an oncologist. If their child has a specific problem, they could bring their child to whatever type of specialist their child might need. But under the Republican plan that child would still have to go to their primary physician for a referral, and there is no guarantee that they would get to see a specialist if they need one.

The differences between the two bills are more pronounced when it comes to seeing specialists outside of one's HMO. The Patients' Bill of Rights ensures that patients will be able to go outside their network, at no cost to them, if they need to see a specialist that their HMO does not have. Under the Republican bill, they are out of luck.

Another difference between the access each bill would provide is standing referrals. If a patient is fortunate enough to have an HMO that has the type of specialist they need when they get sick, under the Republican plan they still have to jump through hoops. The Republican plan does not allow patients who need care over a long period of time by a specialist to have standing referrals.

The Patients' Bill of Rights does not require patients to go back time and again to renew referrals. If a patient needs to see a specialist over a long period of time, they are guaranteed the right to see that doctor.

The Patients' Bill of Rights would also allow patients to designate that specialist as their primary care physician. Women could choose their OB/GYN as their primary physician. The Republican bill does not allow patients to designate their specialist as their primary care physician, nor their OB/GYN.

Another major difference is with the continuity of care issue. The Republican bill does not allow patients to continue to have the same doctor.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. BILIRAKIS), the chairman of the Subcommittee on Health and Environment of the Committee on Commerce.

Mr. BILIRAKIS. Mr. Speaker, I rise in favor of H.R. 4250. I am proud of this bill. Whereas the Democratic bill focuses on patient protections, our bill focuses on basically the same patient protections and additionally places great emphasis on expanding health coverage and access for the insured and the uninsured, but both are accomplished without imposing burdensome government mandates.

Guaranteeing access to quality health care must always be a top priority. What good, in fact, are patient protections if access is not there? We do this through the creation of Health Marts and by broadening the role of the community health centers, so that for those who live in medically underserved areas it will be simpler to receive critical services.

The proposal creates community health organizations, which are basically managed care plans controlled by community health centers. It encourages more competition to lower prices for health consumers. Community health centers will have more money because they will have more private-paying patients using their facilities. As a result, these health centers will be able to provide care to even more uninsured people.

Of course, the bill before us includes important new patient protections. For months, people across the country have told Congress that they want to choose their own doctors. We listened to our constituents, and I am proud to say that through our bill, patients will now be guaranteed their choice of medical providers, contrary to what some others on the other side have said, and be better able to understand their health care policies.

Mr. Speaker, is it a surprise in fact to anyone that the other party is attacking a Republican bill? I think not. But we have been able, I think, to accomplish and to do what they did not even attempt during their many years of control of the United States House of Representatives.

Mr. Speaker, I say to my colleagues: Help us pass a bill which will help people now.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Texas (Mr. TURNER).

Mr. TURNER. Mr. Speaker, Democrats initiated the effort in this Congress to protect patients and their doctors from interference by insurance company bureaucrats. The Dingell-Ganske bill provides these protections and eliminates the complete exemption from accountability that many HMOs enjoy today under the Federal ERISA law.

The Republican bill, on the other hand, in an effort to preserve the insurance companies' shield of protection from accountability for their mistakes, creates a Federal bureaucracy in the Department of Labor and a complex appeals process diagramed here on this chart to my right. Look at this. An endless maze of bureaucratic nightmare created by the Republican bill.

In September of 1991, Phyllis Cannon was diagnosed with leukemia. On August 10 of 1992, her doctor sought approval from her HMO for a bone marrow treatment. Forty-three days later, her doctor pleaded for authorization and it was repeatedly denied.

□ 1145

By the time the HMO finally agreed, it was too late for the treatment and Phyllis Cannon died.

Could she have gone through this maze under the Republican bill and done any better? I think not. And if she had made it through the maze under the Republican bill, after her death she would have been entitled to only $500 a day; under the Republican bill, a total recovery for her family of only $20,000.

Is this what we call protecting patients? I think not. Vote against the Republican bill, vote for the Ganske-Dingell bill and prevent this kind of endless bureaucratic interference with medical decisions from happening to the patients of this country.

Mr. HASTERT. Mr. Speaker, I yield 45 seconds to the gentleman from Oregon (Mr. SMITH).

Mr. SMITH of Oregon. Mr. Speaker, H.R. 4250 moves us in the right direction. One of the ways it does this is by allowing community health centers to establish community health organizations. These would be health plans sponsored by health centers and the doctors themselves to give people the extra choice in their health care.

I used to serve on one of these boards and I recently visited these facilities in Michigan. Patients get first-class treatment and these centers do a great job, and this bill will increase the chance that these small hospitals can survive by allowing them to have the community health organizations. These provisions are going to help create the competition needed to make more regulation from Washington, D.C. unnecessary.

Support this bill.

Mr. HASTERT. Mr. Speaker, what is the remaining time?

The SPEAKER pro tempore (Mr. KOLBE). The gentleman from Illinois (Mr. HASTERT) has 8 minutes remaining and the gentleman from Michigan (Mr. DINGELL) has 6½ minutes remaining.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentlewoman from New York (Mrs. KELLY).

Mrs. KELLY. Mr. Speaker, we have included some special provisions in the Patient Protection Act that recognize the distinctive health care needs of patients, especially women and children. Medically, women are not just small men. Their bodies are different and their needs are different. And children are not little adults. They need specific and sometimes immediate care.

This bill provides women with direct access to their OB-GYN without preauthorization or referral by a primary care physician. It also lets parents get to a pediatrician directly.

As a former florist, I also know how costly it is to provide coverage to employees, and I know how frightening it is to an employee not to be sure that their health care will be there when they need it. And although the cost continues to skyrocket, my colleagues on the other side of the aisle continue to turn their backs on small businesses and the burden that these employers face.

The Patient Protection Act is the only proposal that addresses the growing health insurance crisis among the small business community, and the fact is the fastest growing segment of small business owners are businesswomen. These women-owned businesses are the businesses that we use every day: The woman who does our taxes, who cuts our hair, who runs the local day care center.

We have 8 million women-owned businesses that employ 18.5 million people, one out of every four U.S. workers, yet only 48 percent of the women-owned businesses with less than 25 employees can afford to offer health care insurance. We confront that problem by providing affordable health insurance to small businesses so they can provide peace of mind and security for their workers and their families.

I encourage each and every one of my colleagues to vote for this bill.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Florida (Mr. DEUTSCH).

(Mr. DEUTSCH asked and was given permission to revise and extend his remarks.)

Mr. DEUTSCH. Mr. Speaker, I rise against the proposed bill by the majority, which does not address any of the major needs the people of America are asking for in this proposal.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Pennsylvania (Mr. KLINK).

Mr. KLINK. Mr. Speaker, I thank the gentleman for yielding me this time and for his leadership on this issue.

Mr. Speaker, I am a pro-life Democrat, and that means, quite often, that the Democrats get mad at me because I am pro life, and the pro-life people get mad at me because I am a Democrat. But I can handle that.

I say that because whether someone gets to remain in a hospital when they need to, whether they get the drugs that their doctor wants, whether they

can see that specialist that can save their life, to me, is a life or death matter.

I have a lot of problems today standing on the floor of the House and sitting on the floor of the House listening to this debate after we went through this partial-birth abortion debate yesterday. Because to me, this is life and death. And if National Right to Life does not score this vote today, something is wrong. If the Catholic Church does not score this, something is wrong.

We cannot be pro life at conception and then abandon people once they are born, when their life is on the line, when they are fighting to get medical care that they need to live, and that is exactly what this debate is all about.

Let us compare the two bills. The Democratic Patients' Bill of Rights leaves medical decisions in the hands of doctors and parents. The Republican bill leaves the decision still in the hands of insurance companies.

The Dingell-Ganske bill of rights gives everyone the right to see a specialist. The Republican bill does not.

The Patients' Bill of Rights gives everyone the right to a real external appeals process. The Republican insurance company bill allows the insurance companies to make individuals pay for their appeal. So first an individual pays their premium, then they are denied coverage, then they pay the insurance company for an appeal.

The Patients' Bill of Rights that I am supporting gives everyone the right to hold their insurers accountable. If they are denied something and someone dies, if they lose a limb, then the decision-maker must be responsible for that decision. The Republican bill, the Insurance Company Protection Act, does not hold the decision-makers in the insurance companies accountable.

That is the difference between these bills. It is ridiculous. The American public wants us to change it. The Republicans are here today refusing to do that. I say we must vote today to protect life. We must vote for the Ganske-Dingell bill. We must vote also pro choice. Give patients and their doctors the choice, not the insurance companies.

Support Ganske-Dingell.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentleman from South Carolina (Mr. GRAHAM).

Mr. GRAHAM. Mr. Speaker, I thank the gentleman for yielding me this time, and very quickly let me tell my colleagues my experience and what I bring to the debate, I believe.

Unlike most Republicans, I was a trial lawyer. I made my living trying to enforce the rights of people, and at one time I had the largest medical malpractice verdict in the State of South Carolina. And I can tell my colleagues, my client would rather have had good health care than the money.

I know what I am talking about. I have sued doctors who are medically negligent, and it takes years and it is no fun. The goal that I have today is to get people the treatment they need.

Let us talk about the lady who died of cancer. My mother died of cancer. Under this bill that I am supporting here, this is what would happen. An individual does not have to wait 43 days and get told no. The first thing that is a difference today is when a doctor calls up and says the patient needs cancer treatment, they are talking to a doctor, not a nurse. In their bill it can be a nurse. It does not have to be a doctor. So it is doctor-to-doctor. We require that now. No more clerks. The clerks are taken out of the mix and we replace it with a medical doctor.

I have lived in the real world, and sometimes doctors have an allegiance to the company and not to what is good for medicine. Under our bill, if it is an emergency situation, we take that case and send it to a panel of independent doctors who have no idea who the company is that is involved, has no idea the doctor who is treating the patient. They are just looking at the facts. Under our bill they have to give a decision in 6 days of whether or not the treatment is medically necessary. That lady will get the treatment.

If the patient is awarded at the independent review process, if there is a finding for the patient, our bill has a $500 per-day penalty that kicks in. An individual can go to court right after that, get attorney fees, get the full benefit plus $500 a day. And if the judge finds out the decision was made in bad faith to provide care, it is $1,000 a day, up to $250,000. This happens up front. And give me that any time, rather than a 4-year lawsuit.

If the HMO doctor says no, an individual can go get a lawyer, like myself, and go to court within 24 hours and get a temporary restraining order ordering the treatment be paid, by a judge in State or Federal court, and I can get my attorney fees. The lady does not die.

The penalties in this bill are to force people to make the right decision, not awards 4 years later. I will tell my colleagues about the $500 claim in the next part of this debate and how our bill is better.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Mr. Speaker, I rise in strong opposition to 4250, and let me tell the American people why. Privacy, privacy, privacy. Under the Republican bill our medical records are not safe. Any hospital, HMO or pharmacy that keeps our medical records can disclose them without our consent.

Imagine suffering from depression, paying for prescriptions out of our own pocket to keep our condition private. Under the Republican plan, a pharmacy could disclose the use of these prescriptions to an employer. Imagine a health care bureaucrat reviewing someone's family's medical history without their knowledge. Even more frightening is the very real threat that our medical history could then be used against us to deny us employment or when we apply for a mortgage.

Anyone obtaining our medical records could distribute them to a divorce lawyer, to a newspaper or a political campaign. A business could investigate its employees to find out who has potential health problems. They could review our family's medical records to find out if any of our children were sick and how seriously they were, and the insurance company could then raise our premiums.

Wake up, America. Under the Republican plan the patient does not have to give their consent or be informed about the transfer of their medical records. This is an outrage of the highest order. This plan does not protect patients, it destroys the privacy that exists between doctors and patients. It should be called the Puncture of Privacy Act, and the American people should reject it and the Members of the House of Representatives should, too.

Vote for the Dingell-Ganske bill and reject H.R. 4250 on the grounds of privacy; if nothing else, on the grounds of privacy.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from California (Mr. FAZIO).

Mr. FAZIO of California. Mr. Speaker, I rise in opposition to the last-minute Republican sham before us today. This is not the first time Republicans have buckled to pressure from their insurance industry contributors. It is not the first time under Speaker Gingrich Republicans have tried to pull one over on the American people by crafting something that sounds good in a 30-second campaign ad but does nothing fundamental to fix the problem. This is perhaps, however, the most cruel farce the Republicans have brought to this body since they took control.

For those on the other side of the aisle, who have already written the press releases and started patting themselves on the back and scheduled the air time for those 30-second spots, I ask them to look inside their souls and admit that what they have brought forth today will not end families' tragedies and needless human suffering.

If we pass this bill today, those managed care plans that do not operate as honorably as others will still go on putting profits over patients. Only now the blood will be on our hands. Under this bill, a health plan could still unhook a critically ill patient from the intensive care monitors and transfer the patient to an in-plan hospital. A health insurance bureaucrat could still withhold life-saving cancer treatment until it is too late and face no responsibility for that human life.

□ 1200

In my home State of California, State laws protecting patients who need prenatal care, well-child care, mammography screening, cervical cancer screening, diabetic supplies, and

nine other benefits would be overridden by this law, preempted.

This bill is a sham. Support the Dingell-Ganske bill, which doctors and patients support.

The SPEAKER pro tempore (Mr. KOLBE). The gentleman from Michigan (Mr. DINGELL) has 1 minute remaining.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Massachusetts (Mr. OLVER).

Mr. OLVER. Mr. Speaker, I thank the gentleman for yielding.

What this people's House is doing today is the most cynical action I have seen them take in 7 years in Congress.

H.R. 4250, the so-called Patient Protection Act, is based on deception and a big lie. The only thing protected is the insurance industry. The best protection we could provide Americans would be to return decisions about their care to them and their doctors.

Instead, this bill drives the wedge between them and their doctor. The people of Massachusetts will be hurt by H.R. 4250 because it overrides patient protections already provided by State law. The mammography and cervical cancer screening for women, blood lead screening for children, bone marrow transplants for victims of leukemia, home health care for the aged, and a good many more are endangered under the Republican bill.

My constituents and the people of Massachusetts would be better off with no bill rather that 4250, the insurance industry protection act. But Massachusetts has a large insurance industry, and they will be happy with this Republican bill.

Support the Ganske-Dingell bill.

The SPEAKER pro tempore. The gentleman from Illinois (Mr. HASTERT) has 4 minutes remaining.

Mr. HASTERT. Mr. Speaker, I yield 4 minutes to the gentleman from California (Mr. THOMAS), the distinguished chairman of the Subcommittee on Health of the Committee on Ways and Means.

(Mr. THOMAS asked and was given permission to revise and extend his remarks.)

Mr. THOMAS. Mr. Speaker, some of this debate has literally taken my breath away. If anyone listening to this debate wonders how in the world Republicans could get away with treating Americans the way we do, listening to the Democrats, I ask them to just look at the calendar. This is the pre-election warm-up.

Remember Medicare? Pre-election, Republicans were going to destroy Medicare. Well, the American people did not listen to them. We were returned as the majority. And as chairman of the Subcommittee on Health, we prepared a Medicare reform package that was passed in my subcommittee 11–0, no Democrats dissenting. Prior to the election, it would destroy Medicare. After the election, post-politics, everything is okay.

Today we are debating patient protections. Here we go again. It is pre-election time. Have things changed out there in America? Of course they have. In 1988, health care inflation was 18½ percent. Today it is less than 5 percent. Why? To a very good extent, just 5 years ago, in 1993, about a majority of Americans, about half, got their health care from managed care. Today, if they get it from their employer, it is about 85 percent.

So health care markets have changed. Have there been distortions? Yes, there have been distortions. Do there need to be corrections? Of course there need to be corrections. But when we unite egos and politics, we get some pretty ugly offspring.

There have been Members who have taken the well and virtually every word they spoke about the Republican plan is absolutely, totally false. This headline that says ''the bill would allow sale of patient data'' in today's Washington Post is totally, absolutely false.

If my colleagues will turn to the bill, on page 260, the language is clear. If we read on, it says, ''Limitation on Sale or Barter. Notwithstanding subsection (c) which is a limit which guarantees that State law is not overridden,'' it says, ''no health care provider or health plan may as part of conducting health care operations sell or barter protected health information,'' period.

What was said to be contained in the Republican bill is absolutely, totally false. What we heard from my colleagues was that they want ''medical necessity'' defined in law. Who defines ''medical necessity'' in law? Bureaucrats, Health Care Financing Administration. We get specific items, medical necessity. That is cookbook medicine.

Who do we have define ''medical necessity,'' for example, in an emergency room? Quote, page 144: ''A prudent emergency medical professional.'' It is the medical professional there looking at the patient and their problem that determines what needs to be done, not some book drawn up by bureaucrats that lists what is and what is not medically necessary.

It has been said that it does not say ''pain.'' What this bill says is that ''a prudent lay person who possesses an average knowledge of health and medicine would determine such examinations to be necessary.'' Not itemized; across the board.

I heard my colleague the gentlewoman from North Carolina (Mrs. CLAYTON) say she cannot find the gag rule. I will tell her page 141, section 2706, says, ''patient access to unrestricted medical advice.''

So please understand, it is a pre-election season. But let me tell my colleagues something else. The Congressional Budget Office has laid out the numbers on the plan. Their plan increases premiums. Our plan reduces premiums.

Under the Republican plan, CBO, ''lower medical malpractice costs would reduce Federal direct spending for Medicare and Medicaid by $1.5 billion over 10 years.''

We have heard them say ours is a sham and it drives prices up. It is simply not true. CBO says their plan will drive premiums up. CBO says our plan will drop premiums. Correct the marketplace and Federal costs. Vote ''yes'' on 4250.

Mr. DREIER. Mr. Speaker, I rise in support of H.R. 4520, the Patient Protection Act, because it upholds a patient's most fundamental right—the right to choose his/her own health care. As much as I believe that health insurance bureaucrats should not be able to decide what is best for patients, the federal government also should not be issuing onerous mandates and regulations that micromanage the care that patients receive. Instead, we should provide consumers with additional choices that may not be available from their employer-provided health care plan.

Many employees are frustrated because they are forced by their employer to join a health plan that does not offer the level of benefits or protections that they want. This occurs because the federal tax code prevents employees from making important decisions about their health care. Under a quirk in the federal tax code, employers receive a tax subsidy for providing health care to their employees, and since employers pay for the health care, there is an incentive to purchase a plan based on costs, not on level of benefits. To give employees the option to choose coverage with a higher level of benefits, the solution then is not to add another layer of mandates, but to alter the system so that employees can choose the health plan that is best for them.

To accomplish this goal, H.R. 4520 creates a system similar to the Federal Employees Health Benefits program known as HealthMarts which are private non-profit organizations that offer a variety of health benefits to small businesses and the self-insured. Employers pay a set fee to the HealthMart, and it provides a variety of health insurance options, including health maintenance organizations, paid provider organizations, and fee-for-service plans, to employees. With a HealthMart, the employee, not the employer, has the flexibility to choose the type of plan based on the level of benefits, protections and costs. HealthMarts eliminate the possibility that employees feel dissatisfied with the health coverage and empowers them to choose the best provider that meets their needs.

Unlike the Democrat substitute, H.R. 4520 actually addresses the 41 million Americans lacking access to affordable health insurance. Regrettably, many of these Americans are in families in which one member works in a job that does not provide health care coverage. Because they lack the purchasing power of large businesses, many small businesses often find the cost of providing coverage too prohibitive. H.R. 4520 gives small businesses and the self-insured the ability to bank together to obtain more affordable health care coverage. These Association Health Plans allow employers to join together through a trade association or their local Chamber of Commerce to broaden their risk pool and give them the same purchasing power as large corporations.

Mr. Speaker, H.R. 4520 provides an effective means to protect patients by offering them more choices. The Patient Protection Act restores accountability to health plans without raising premiums on the most vulnerable. It

will also reduce the number of uninsured through innovative reforms and the creation of health care ''supermarkets'' so that the average American can have more available choices. I would like to commend my colleagues who served on the Working Group on Health Care Quality for their tremendous efforts in bringing forth this responsible legislation, and I urge support of this measure.

Mr. KOLBE. Mr. Speaker, I rise today in support of H.R. 4250, the Patient Protection Act. This bill lays an excellent foundation and contains many important pro-patient provisions. This bill adapts for the changing health care market without the unintended consequences of increased costs, increased bureaucracies and an explosion of lawsuits. This bill expands access to health care for millions of Americans, makes health care more affordable for working families and small businesses, and holds health insurance companies accountable for their decisions about your care.

First, the Patient Protection Act allows individual's access to the best type of health care based on their and their families' needs. Women would have direct access, without having to go through a gatekeeper, to an ob/gyn as their primary care physician. It would also allow families to utilize a pediatrician for the health care of their children without the interference of an insurance gatekeeper.

The Patient Protection Act also makes it easier for individuals to learn more about what their health care plan covers and discuss options with our doctors to determine the best form of treatment. This bill requires health plans to cover emergency room care for conditions which a prudent layperson would view as requiring emergency treatment.

Second, the Patient Protection Act will make health more affordable for individuals. Most people without health insurance can not afford to pay for health benefits. They usually work in small businesses or are self-employed, but cannot afford to purchase health care insurance. This bill will make it affordable for small business owners to provide their employees with health insurance coverage.

Through the creation HealthMarts, and Community Health Centers Organizations, Association Health Plans, and Medical Savings Accounts, small business will have the same access to health insurance as large business, therefore creating a more affordable health insurance market for workers. Workers that currently are caught between being too poor for Medicaid, but not cannot afford health insurance.

And third, the Patient Protection Act makes health plans accountable for the health care services that are provided. Through the creation of an expedited review process—both internally and externally—individuals will be able to receive the care they need first, rather than being thrown into a long, drawn-out legal process controlled by trial lawyers, with no resolution until long after they've been harmed or killed. This is the only bill that truly relies on getting patients treated first in hospital rooms, rather than in the courtroom.

Mr. Speaker, I am pleased to vote in support H.R. 4250, the Patient Protection Act, and urge my colleagues to join us in protecting patients and guaranteeing choices without the heavy-hand of big government and provide patients, especially the 42 million un-insured, with access to affordable health care, when they need it, where they need it, and with whom they need it.

Mr. MICA. Mr. Speaker, the question before us is whether we want to pay more and get less or correct some of the problems we have experienced with managed care.

It is true that the law and regulations have not kept up with changes in health care delivery.

It is also true that increasing costs are depriving millions of Americans affordable health care.

Unfortunately the Democrat plan will do three things we know will drive up costs. Their solution is more regulation, more bureaucracy, and more litigation.

In hearings I conducted on the President's fancy titled ''Patients' Bill of Rights'' for Federal employees, every administration official testified that his similar Executive Order would impose more paperwork at high cost without any benefit in coverage.

The Democrat plan proposes over 300 new mandates, thousands of new federal bureaucrats, and 59 new federal regulations.

The CBO estimates the Democrat plan will increase costs 4 percent. Add to that cost of living and they escalate health care premiums 7 percent per year.

The Democrat plan increases lawsuits which also increase health care costs. So what do you get? More costly regulation. More costly bureaucracy. More costly litigation.

I submit that's not what the patient, consumer or doctor ordered.

Mr. HILL. Mr. Speaker, recent polls show a growing desire on the part of Americans to address some concerns facing our health care system, including the number of uninsured working adults and dependents, the increased costs being passed to employees, and the lack of choice in health plans.

While Americans enjoy the best quality health care in the world, our system for delivering care often frustrates patients, providers and employers. Moreover, people are concerned that their health plan may not deliver the care they need when they are sick.

Today, we are addressing what the people want and deserve—a patients bill of rights. They do not want a trial lawyers right to work. H.R. 4250, the Patient Protection Act, which I am a cosponsor, will move ahead what I call the three A's—Accessibility, Affordability and Accountability.

The Patient Protection Act promotes accessibility by requiring basic protections to ensure high-quality health care coverage, promotes affordability by creating more choices and access to affordable health care coverage for all Americans, particularly the over 100,000 Montanans that are uninsured, and ensures accountability by holding insurance companies accountable so patients are guaranteed to receive high-quality care.

We achieve this by expanding the eligibility for medical savings accounts, allowing for the creation of new 'health marts' and permitting small employers to pool their risks with others, which will make health care become more affordable as well as more available.

The vast majority of the uninsured have one thing in common, they are either self-employed, work, or have a family member who works in a small business that cannot afford to pay for health benefits.

Furthermore, for those small businesses that are able to offer their employees coverage, often they can only afford to offer one coverage option. In Montana, I constantly hear concerns with the affordability of health care. The Congressional Budget Office estimates that premiums would increase and the number of uninsured Americans will actually increase by 1.4 million if H.R. 3605 became law.

The question is who are we trying to help—patients, employees. We should look at who is opposed to H.R. 3605:

NFIB, Small Business Survival Committee, US Chamber, National Association of Wholesalers-Distributors, National Restaurant Association, the Coalition for Patient Choice, Citizens for a Sound Economy, NAM, National Retail Association among others.

Who supports the H.R. 3605—Trial Lawyers.

We address the very real concern patients in managed care plans have that their health plan won't provide the benefits they are entitled to if they get sick. We should do this by empowering patients, not trial lawyers. I want patients to get the care they are entitled to when they need it, not allow their heirs to sue for some large settlement after they die. The other proposal that I touched on earlier seen to concentrate on courtrooms over hospital rooms and would only increase health care costs by taking money away from care and putting it into the pockets of attorneys.

The Patient Protection Act will build upon what's good about our private health care system—without big government or more bureaucracy. It will make health insurance more accessible, affordable and accountable, while giving patients more choices.

Mr. HOBSON. Mr. Speaker, I rise today in strong support of the House Republican Health Care Proposal, the Patient Protection Act. I believe this bill strikes a good balance between protecting patient rights without the heavy hand of big government. I am excited about many of the large protections in this bill, like giving patients a better and quicker appeal process when the HMO denies their claim, lifting any gag orders on physicians to ensure that patients are better informed, and providing greater access to specialists for women and children. I believe this bill addresses the frustrating problems that upset so many people about their HMOs.

As many of you know, Representative TOM SAWYER and I wrote the Administrative Simplification language in the Health Insurance Portability and Accountability Act—Kassebaum-Kennedy. Administrative Simplification will reduce paper work, speed the processing and payment of medical transactions, and let physicians spend less time on paper work so they can do what they do best: treat patients. In putting together this legislation some estimated that Medicare could save $60–90 billion per year if individual patients' financial records were kept from getting confused. Because of the confusion over individual Medicare financial records, the U.S. Department of Health and Human Services (HHS) which runs the Medicare program, often pays claims for beneficiaries that have outside supplemental insurance. After paying the claim, Medicare's only recourse to get its money back is to sue the insurance company, which it seldom does. The most obvious solution to this problem is a unique identifier for health care beneficiaries.

In these days of increased government scrutiny and tight federal budgets there are tremendous pressures on HHS to recover

these funds. Quite frankly, with these pressures on HHS I was afraid that they would rush to get in place a one-size fits all solution that might compromise patient privacy. To ensure that the system was not run by the bureaucrats at HHS and to guarantee public input, Congress instructed the National Committee on Vital and Health Statistics, an independent research organization, to hold hearings to gather information from private and public sector organizations to develop recommendations on establishing a way to keep individual patients' financial records from getting confused with one another.

After the hearings, the Committee will write a report that will be published in the Federal Register. Moreover, an amendment I introduced to the Patient Protection Act will guarantee that Congress reviews and approves any suggestions made by the Secretary of HHS on individual health care identifiers before they are implemented. This provides a built-in guarantee that Congress and the public will have a chance to comment on, participate in the development of, and ultimately approve any unique health care identifier before it goes into effect. Once again, this process insures public input and oversight to prevent another ''Big-Brother'' bureaucratic solution.

However, Administrative Simplification is not complete without the Confidentiality Standards proposed in the Patient Protection Act. Section 264 of Kassebaum-Kennedy states that if Congress does not pass legislation concerning the confidentiality of patient records within 3 years after the act goes into effect, then the Secretary of HHS will adopt her own final regulations. As a result, Congress is on a very tight time frame to propose and pass confidentiality legislation.

The Medical Record Confidentiality provisions in the Patient Protection Act provide the necessary safeguards required in Kassebaum-Kennedy. It allows patients access to their medical records in order to view, copy, and amend by addition; requires providers, plans and employers to develop safeguards to protect confidentiality of medical information; requires providers, plans and employers to disclose their confidentiality policies to patients, enrollees and employers; encourages health researchers to use non-identifiable information by preempting state laws in this defined area; allows providers and plans to use information within their network for certain defined purposes, including outcomes evaluation, health promotion, and utilization review.

The Medical Record Confidentiality provisions in the Patient Protection Act guarantee accurate records and prevent unlawful use of one's medical records.

Mr. FAZIO of California. Mr. Speaker, I rise in opposition to this last minute Republican sham before us today. Mr. Speaker, this is not the first time the Republicans have buckled to pressure from their insurance industry contributors.

It is not the first time under Speaker GINGRICH, Republicans have tried to pull one over on the American people by crafting something that sounds good in a 30-second campaign ad, but does nothing—fundamental—to fix the problem.

But this is perhaps the most cruel farce the Republicans have brought to this body since they took control.

For those on the other side of the aisle who have already written the press releases patting yourselves on the back—and scheduled the air time for those 30-second spots—I say look inside your souls and admit that what you have brought forth today will not end families' tragedies and needless human suffering.

My colleagues, if you pass this bill today, those managed care plans that do not operate as honorably as others will still go on putting profits over patients. Only now, the blood will be on your hands.

Under this bill, a health plan could still unhook a critically ill patient from the intensive care monitors and transfer the patient to an ''in-plan'' hospital.

A health insurance bureaucrat could still withhold life-saving cancer treatment until it is too late—and face no responsibility for that human life.

In my home state of California, state laws protecting patients who need prenatal care, well child care, mammography screening, cervical cancer screening, and diabetic supplies and 9 other benefits—overriden—prempted by Fed law would be moot.

Put this bill to the test before you vote: Does it provide adequate access to medical specialists? No; Emergency services for severe chest pain? No; Proper care for women who have mastectomies? No; Patient recourse when needed care is denied? No.

Right down the line, the Republican bill is a failure and a cruel hoax.

If you pass this bill today, you will go on hearing the stories from your constituents who were denied care they paid for in their health plans.

If you fail to join Dr. GANSKE and Congressman DINGELL—you will guarantee that life or death decisions are made by health insurance bureaucrats, not doctors. Instead, you will be complicit in people's pain.

You are playing with people's lives here today. Don't choose a placebo over a real cure.

Vote NO on this last minute farce we have before us today. Support Dingell-Ganske which is supported by doctors and patients.

Mr. OXLEY. Mr. Speaker, I rise today in strong support of the Patient Protection Act. Since Republicans took control of Congress in 1995 we have worked diligently to pass health care reform legislation that gives Americans greater choices, makes health care more affordable, and improves the quality of the health care they receive. I believe this legislation adds to the long list of legislative accomplishments that Republicans have achieved in this arena.

Allow me to expand on some of these accomplishments. First, through passage of comprehensive Food and Drug Administration reform, the Republican Congress helped expedite the development and delivery of new healthcare technology. As a result of these reforms, which streamlined the FDA bureaucracy and cut government red tape, we will help save the lives of millions of Americans over the coming years.

Second, while many initially criticized our efforts at passing much needed Medicare reform, we succeeded in passing a bipartisan reform package designed to save this critical program until 2007 while establishing a bipartisan panel to consider options that will ensure Medicare's long-term financial health. This responsible package of reforms also included provisions to give Medicare beneficiaries greater choice, crack down on fraud and abuse, and grant beneficiaries new preventative health benefits. For the 34 million seniors that rely on Medicare for their health care needs I was pleased to support this valuable legislation.

Finally, any discussion of major health care accomplishments would not be complete without highlighting the 1996 Health Care Portability and Accountability Act. This legislation was a common-sense, market based solution to one of America's most difficult health care problems—namely the portability of health insurance. By guaranteeing that people can go from one employer to another without facing pre-existing condition restrictions or being denied coverage by a new employer's insurance plan this legislation ended the problem of job-lock by allowing workers to switch jobs without the fear of losing their insurance coverage.

Today, in our continuing efforts to strengthen the health care American's receive, we will consider legislation that address many of the concerns patients all over our country have with the health care marketplace. This legislation focuses on making health care more affordable for working families and small businesses, while holding insurance companies accountable for their decisions, and expanding access to health care for millions of Americans. I commend Congressman HASTERT for his fine work with the House Republican Working Group on Health Care Quality in bringing this legislation to the House floor. I am pleased with the outcome of the working group that I feel builds on and strengthens our previous accomplishments.

While many have advocated reforms that would significantly increase both costs and expand government bureaucracies, I support the Republican Task Force legislation because it protects patients and expands access to health care without damaging the free market health care system we enjoy today. Mr. Speaker I urge my fellow colleagues to support this much needed legislation that ensures that the health insurance Americans receive is accessible, affordable, and accountable without crippling the free market's ability to hold down health care prices.

Mr. GILMAN. Mr. Speaker, I rise today in support of H.R. 4250, the Patient Protection Act. As managed care has continued to grow as the major system of health care delivery in this country, we are increasingly aware of incidents where patients have suffered serious injury or even death because an HMO or other managed care plans denied a treatment that was necessary to protect the patient. An emphasis on cost control over the quality of care has prevented health care professionals from acting in the best interest of the patient. While looking for ways to control the cost of health care, we must also ensure that people have access to quality health care services when the need it.

The legislation before us today attempts to make significant changes in the managed care industry. H.R. 4250 guarantees access to emergency room care by applying a ''prudent layperson'' standard of what constitutes an emergency, additionally, this bill will allow women direct access to their ob/gyn and children to their pediatrician. This access will prevent patients from having to be referred to these type of specialists by their primary provider.

This bill would also provide for an independent appeal process. If a patient is unhappy

with the initial decision, he or she can ask for an independent internal review within 30 days of the decision. If that decision is unsatisfactory, they can appeal for an independent external review by an independent contracted physician. If after these two appeals, they are still unhappy, the patient can take the HMO to court and sue for damages up to $250,000.

The Patient Protection Act would require all insurance providers to provide detailed information to their customers including patients' responsibilities, the number of appeals made and granted as well as other plan information. This provision is intended to arm the consumer with all of the necessary information up front so that future appeals and litigation become unnecessary.

Although this bill provides a great number of HMO reform provisions, there are still a few items which need to be addressed and amended during the House-Senate conference. I urge the conferees to consider changes to this legislation which will provide greater patient protection and strengthen HMO liability.

Accordingly, I am pleased to support H.R. 4250, the Patient Protection Act.

Mr. UPTON. Mr. Speaker, I rise to express my strong support for the Patient Protection Act. Before I review the reasons that I support this legislation and will work hard for its enactment, I want to take this opportunity to single out two of my colleagues without whom this bill which will do so much to ensure quality of care would not be before us today. First, I want to thank CHARLIE NORWOOD, who saw early-on the need for strong patient protections. He introduced the Patient Access to Responsible Care Act and used this legislation as a vehicle to educate all of us to the need for reforms. Second, I want to express my deep regard for the leadership, patience, and effort that DENNY HASTERT has shown in the development of the Patient Protection Act, the legislation we are considering today. He had a Herculean task, and he did it with skill and grace.

I am proud to be counted as a cosponsor of the Patient Protection Act. This legislation will ensure that our nation's health care system is patient-centered, no profit-centered and that no one, no insurance clerk or green eyeshade worrying about a fat profit, stands between the patient and the physician when potentially life and death health care decisions are being made.

There are some who continue to argue that patient protection legislation is not needed—that the market will work over time to ensure patients have access to care when they need it and receive high quality care. That has not been my experience at all. Rarely a day goes by that I don't hear or read in my constituent mail of serious problems that individuals or their families are having with their managed care plans. Just yesterday, for example, I received a report of a Michigan woman who was experiencing severe pain from an ovarian cyst. She went to the nearest hospital, but her managed care plan would not cover her care at that facility. Instead, a plan clerk directed her to another, more distant facility. Unfortunately, that facility was affected by a massive power outage in the Detroit area and could not see her promptly. She requested permission to return to the first hospital, but was denied. By the time she was finally treated, she had a massive internal infection from the ruptured cyst. Her doctor said she was lucky to be alive.

We need to stop this rising drum-beat of stories of patients being denied appropriate care by their health plans, and the Patient Protection Act will do this. Had the Patient Protection Act been in place, for example, this woman could have sought and received care at the nearest emergency room rather than having to seek prior authorization and go to another, more distant facility.

Perhaps the single most important patient protection in this legislation is the right it will give patients to a timely review of plan determinations with which they disagree. Patients may seek an internal and then an independent external review, both of which must be conducted by physicians who are trained in the provision of the treatment under review. The patient may then go to court to enforce the ruling of the external review organization that a service should be provided or covered. If the court upholds the finding of the independent expert external reviewer, which is highly likely, the plan is subject to fines of $500 per day up to a total of $250,000.

I think the internal/external review appeal process in this legislation is actually more likely to hold plans' feet to the fire for their decisions and ensure appropriate access to care than would be the case if patients could simply go to court and sue their plans or employers. While the penalties leveled in state torts might be greater in some cases, such cases can drag on for years and the outcome is never certain for individuals. And the uncertain, uncapped liability exposure to which employers could be subject under the state court suit option could lead to employers terminating plans and add significantly to the number of individuals and families with no health care coverage.

In closing, I strongly urge my colleagues to join me in voting today for the Patient Protection Act. It ensures that our Nation's health care system is patient-centered, not profit-centered. It ensures that medical decisions are made by patients and their physicians with the well-being of the patient being the first consideration.

Mr. GEJDENSON. Mr. Speaker, for the past few months, my democratic colleagues and I have demanded that Republicans bring HMO reform to the floor. And now, what do we get. Barely 2 hours to debate a bill that was introduced just last week and has had no hearings, no mark-up, no public discussion of any kind.

The Republican bill will do little to fix the problems with the HMO system. The Republican bill does not allow direct access to specialty care. If you have heart disease, you must still go through a primary care doctor before seeing a cardiologist. If you have cancer, you must go through your primary care physician before you can see an oncologist. The Patient's Bill of Rights, which I support, guarantees patients access to specialists without going through a gatekeeper.

The Republican bill will not require HMOs to pay for emergency room visits if a patient has severe pain, but does not have a serious medical problem. Parents who take a child to the emergency room when they complain about pains will not know if their insurance company will cover the visit. This bill expects parents to be doctors and penalizes them for taking prudent steps. The Republican bill will not prohibit gag orders on doctors in group practice. It will not prevent plans from arbitrarily limiting medically-necessary services. It will not allow patients to sue HMOs for decisions that adversely affect them.

The Patient's Bill of Rights will fully address all of these problems. Access to medically needed care, including access to emergency rooms and specialists, is a fundamental element of the Patient's Bill of Rights. This bill will ban all gag rules on physicians. This bill will end the current practice of HMO's offering financial incentives to withhold necessary care. This bill will guarantee timely internal appeals, as well as an independent external appeals when plans deny care. Finally, the Patient's Bill of Rights holds plans legally accountable for decisions that lead to serious injury or death. People need real ways to hold HMOs responsible. In too many instances, courts are the only advocate that patients have in their battles with multi-billion dollar companies.

It is time for true HMO reform. We all know people who have been injured by HMOs. Just this week, a woman from my district got in touch with me and relayed what is probably an all too common occurance:

This Monday, she had a hysterectomy. On Tuesday, 24 hours later, her HMO wanted her out of the hospital even though she was feverish and had medical staples holding her abdomen together. Her doctor demanded that her HMO allow her to stay in the hospital at least one more day. Her HMO relented because of her fever but after the fever broke on Wednesday, she was forced out. She was sent home, still weak and groggy and not even close to recovery. How is she supposed to get well? This is not what she paid for when she paid her premium.

Republicans claim that their bill will stop this type of abuse, but it won't. Their bill has no guarantee that doctors, not HMOs will determine what amount of time is needed to recover from major surgery. The Patient's Bill of Rights will make sure that doctors and patients, not HMO plan administrators, decide when it's time to go home.

Under the Republican bill, what can patients and their families do when they are denied care? Other than jump through some hoops—not much! First, patients will have to prove during the internal appeal that their care is medically necessary. In the Republican bill, the definition of medically necessary is determined by the health plan—not by decades of medical experience, not by doctors there in the examination room with the patient. Then, if the internal appeals process doesn't work, the Republican bill will force patients to pay to have an independent review of their claim.

This is outrageous for two reasons. First, charging a fee is designed to discourage people from using this recourse. Second, HMOs will only be held accountable for failing to follow the provisions of their plan. As a result, as long as the HMO follows its own rules, patients receiving nothing from the external appeals provision even if their health is compromised.

In the Patient's Bill of Rights, the definition of medically necessary is uniform for all—a definition drafted by doctors, not HMOs. The Patient's Bill of Rights not only has internal and external appeals—both free of charge—but also sets up an Ombudsman program to assist consumers in understanding their health insurance options and filing appeals and grievances with their HMOs.

The Republicans also seem to think that it's a good thing that their bill will deny patients access to the court system when their care is denied. Somehow, Republicans believe that the health insurance industry, which makes $952 billion a year, needs protection from lawsuits. When one of your family members dies because an HMO denies access to care, the Republican bill gives you nowhere to turn. No other industry enjoys such a powerful, congressionally-mandated shield from liability for their actions. It's time to remove that protection for health plans and focus on granting more protections for patients.

If the bill in and of itself isn't bad enough, the proponents of this sham have added totally unrelated provisions which further threaten the quality of health care for all Americans. Once again, Republicans are threatening Medicare by expanding so-called Medical Savings Accounts. Remember these? They will allow healthy senior citizens to pull out of Medicare leaving it with only the poorest, sickest older Americans. This is bad medical policy and even worse fiscal policy. Other provisions preempt state laws and jeopardize patient privacy.

We must create a better system for everyone who gives or receives health care in this country. The Republican plan will do nothing to help our Nation's patients. For real reform, we must pass the Patient's Bill of Rights.

Mr. NUSSLE. Mr. Speaker, I rise today in support of the Patient Protection Act. I support this bill because it establishes Association Health Plans and Health Marts as new ways to provide health insurance to workers, many of whom work for small businesses which cannot currently afford to provide health insurance to their employees. Individuals who work for small businesses are the people most likely to be without health insurance. I also applaud the increased care options this bill provides for individuals dissatisfied with the choice of doctors provided by their health plan.

The national debate on health care has been focused almost exclusively on the care provided by HMOs. Providing appeals processes and other recourses for patients in HMOs are important and appropriate steps for Congress to take in order to ensure quality care. However, in all the talk over giving recourse and options to individuals with HMO coverage, both bills have overlooked the fact that the Patient Protection Act and the Kennedy-Dingell bill primarily address the fears and complaints of Americans who are fortunate enough to have real access to health care and a menu of health care options.

For many Iowans, access to health care doesn't mean the ability to see a specialist on demand. There are few specialists in Grundy Center, Iowa. People in Iowa's Second District have to load a family member into the car and drive miles and miles to the nearest doctor, clinic or emergency room. A patient bill of rights means little or nothing to people whose only choice of a hospital or clinic is 40 or 50 miles away. And miles mean minutes, which are crucial in the event of an emergency. Improving access to health care in Iowa means recruiting more doctors so that people will have shorter drives, and maybe a choice of where to go.

I am disappointed that neither proposal the House is considering today contains any initiatives to address the shortage of doctors in rural America. Twenty-five percent of the American population lives in rural areas. By the federal government's own count, almost 2,500 counties in our nation lack adequate medical care. Last year, Congress acted to make this shortage worse by creating a program to pay hospitals to train fewer doctors. What we need in Iowa are more doctors. The resources being spent to reduce the number of physicians would be better spent providing incentives to encourage doctors to locate in areas with inadequate access to health care.

The Patient Protection Act provides valuable protections and new health care options to many individuals, and I support those goals. However, I hope that today's vote on the Patient Protection Act is the beginning of the debate on improving access to health care and not the end. This debate is essential for people in Iowa's Second District and one in which I intend to participate vigorously.

Thank you, Mr. Speaker.

Mr. CRANE. Mr. Speaker, today, this House has an opportunity to improve the health care system for millions of Americans. Like everyone, I want a health care system that is more accessible, more affordable and more accountable. With that goal in mind, I will cast my vote for H.R. 4250, the Patient Protection Act.

It is not a perfect piece of legislation and while there are provisions I think could be improved, there are also other provisions I have long supported. I am particularly pleased with the expansion of medical savings accounts, the creation of association health plans, medical malpractice reform and improving the patient appeals process without increasing the involvement of trial lawyers. In response to the concerns we have heard from our constituents, the bill prohibits gag rules, allows women direct access to gynecological and obstetrical care and allow parents to choose a pediatrician as their child's primary care provider without having to get a referral from a health plan.

This legislation will not only improve health care for the currently insured, we expect it to also make insurance more affordable to the 41 million uninsured Americans, including the 1.3 million uninsured in my state of Illinois.

As a member of the Ways and Means Health Subcommittee, I have taken an active interest in the many innovative ideas in health care. The Patient Protection Act represents the only choice for those of us who do not want a heavy-handed, big-government takover of our health care system. The American people overwhelmingly rejected that proposal and made it clear they want quick access to the best medical care in the world at an affordable price. The Patient Protection Act moves us in that direction and I would urge my colleagues to vote in support of it.

Ms. BROWN of Florida. Mr. Speaker, I represent the 3rd District of Florida. And, senior citizens in my district which ranges from Jacksonville to Orlando have suffered at the hands of HMO providers day-after-day. They are urged to sign up for health coverage plans, and these HMOs only give them cheap gifts and inadequate health coverage.

Because I have hosted numerous town hall meetings on health care for senior citizens, I have been able to hear their stories and provide assistance when their insurance providers have failed to deliver. An 81-year-old man, who after his HMO was sold had to replace his regular hypertension drug with a lower-cost one. Within days his blood pressure skyrocketed. He switched to an HMO that covered his drug, but then the new plan changed its coverage too. Unable to pay for the drug, he went on TV as a cry for help and a local physician with compassion gave him the medication for free. Health care is such a crucial part of our lives, I believe every effort should be made to protect senior citizens and the working poor. It is our responsibility to protect and pass legislation that will protect the rights of our constituents. More importantly, we are charged with ensuring that our nation has access to quality health care at an affordable cost. There is nothing more heart wrenching, than talking with someone who desperately needs medical care and their insurance company will not cover the life-saving medical treatment or reimburse patients for much needed medicine. In another case, a baby girl was diagnosed with a hole in her heart. Chances were good that she would need surgery to fix the defect if it did not close on its own. Her mother switched HMOs for better coverage; however, the new insurance company would not cover the procedure because her daughter's heart defect was a pre-existing condition. The HMO had a 2 year limit on pre-existing conditions and would not pay for the little girl's operation. Thanks to a special state program in Florida the little girl was able to receive care. We need to hold HMOs accountable for their actions and how they treat people. That is why, I urge my colleagues to oppose the Patient Protection Act (H.R. 4250) and support the Patient Bill of Rights (H.R. 3605). H.R. 3605 is the right choice, it puts patients before profits and medical decisions are given back to doctors and nurses. This bill also holds HMOs responsible for decisions when they withhold or limit care to patients.

The challenges of quality health care will require our nation to overcome the barriers of ever-increasing medical cost and recognize the needs of our nation. In a society where technology is progressing at the speed of light, why is it so difficult for us to make the right decision for the American people?

We need to treat quality health care as a right versus a luxury for a privileged few.

Mrs. MINK of Hawaii. Mr. Speaker, I rise in opposition to H.R. 4250, the Patient Protection Act of 1998, because it falls short of addressing America's true health care issues. The essence of the health care debate is threefold: access to health care; patient protections; and patient rights. The Democratic substitute, the Patients' Bill of Rights, would address all three of these issues. This bill, the so called Patient Protection Act, does not.

First, Americans, despite being insured, are tired of having to fight every step of the way for care they are entitled to. Americans want access to care. The Patient Protection Act would not alleviate many of the existing barriers to care identified as priorities. For example:

The Patient Protection Act would not provide direct access to specialists. It does not guarantee women direct access to their OBGYN nor would it provide parents direct access to pediatricians for their children.

The Patient Protection Act would not insure a patient can continue to see the same doctor through a course of a treatment or a pregnancy if that doctor leaves the network.

The Patient Protection Act would not insure that a patient can get the prescription drug chosen by the physician, not the HMO.

The Patient Protection Act would not allow patients with ongoing conditions to have standing referrals to specialists.

The Patient Protection Act would not ensure that patients are allowed to see an outside specialist at no additional cost when specialists in their plan are unable to meet their needs.

The Patients Bill of Rights will provide all of these.

Second, patients should have the right to hold managed care administrators accountable for their decisions when it influences the care that is provided.

The Patient Protection Act does not hold managed care plans accountable when decisions to deny or delay care results in injury or death. It does not provide patients the right to sue HMOs when they are denied needed health care nor does it provide a true external independent appeals process. In fact, the Patient Protection Act reduces accountability by placing an arbitrary cap on medical malpractice awards.

In addition, the Patient Protection Act does not ensure that doctors and nurses can report quality problems without retaliation from HMO's, Insurance companies and hospitals. The Patient Protection Act would not prevent health care professionals from being financially rewarded for limiting a patient's care. Patients deserve care from health care professionals who are not rewarded for providing less care.

The Patients' Bill of Rights would provide these protections and true accountability.

Finally, patients deserve basic health care protections. After preaching a mantra of returning power to the states since taking control of Congress four years ago, Republicans take a hypocritical u-turn and pre-empt carefully constructed state health care protections. The Patients' Protection Act will allow ''Healthmarts'' to pick and choose the services covered under the plan, ignoring state mandated minimum benefit requirements. It would also eliminate state regulations enacted to insure solvency and protect against fraud and abuse.

The Patients' Bill of Rights would not preempt state mandated care nor would it eliminate solvency and fraud and abuse protections.

In closing, Americans deserve health care from qualified physicians who are not influenced by health care plan administrators. Americans deserve the right to take their health plans to court if they are denied care. America wants real managed care reform. The Patient Protection Act is not real managed care reform. This is a facade and a sham designed to provide political cover for Republican leadership who have argued that managed care reform is not necessary.

Do not judge a bill by its title. The Republican Patient Protection Act is a facade. It's meager ''protections'' do not address the real issues we are faced with. The Patients' Bill of Rights on the other hand is a comprehensive and revolutionary bill providing substantive reform.

America understands the difficulties involved with obtaining health care. The Patients' Bill of Rights provides solutions. The Patient Protection Act creates more problems.

Mr. TURNER. Mr. Speaker, it has been suggested that the Republican bill provides better protection for patients. I submit to my colleagues that the Republican bill provides fewer protections for patients than exist in current law in most of our States.

I come from Texas. The Texas Legislature passed patient protection legislation in 1997, fully intending that all HMOs be covered by the protections of State law.

The Republicans submit a bill today that would control patient protections at the Federal level. It would set forth a series of rules that are far inferior to those in the Democratic alternative.

Under the Republic proposal, if the HMO denied coverage, the only remedy, if an individual was enrolled in a self-insured plan, would be to go to Federal Court. And once the individual gets there, he or she would have no genuine recourse.

In 1991, Phyllis Cannon was diagnosed with leukemia. She appealed to her HMO for a bone narrow transplant. The HMO refused. For over 40 days the HMO refused coverage. Due to a denial of medical treatment, about a month after that Ms. Cannon died.

The court ruled that under ERISA, she had no recovery. Under the Republican bill today, her estate would be entitled to $20,000—a small price for a life. Under the Republican bill, the penalty would be $500 per day. This represents a much cheaper alternative for an HMO than providing the treatment that should have been provided to Phyllis Cannon.

I submit to my colleagues that all Members of this House needs to look at what their State has done to protect patients because a vote for the Republican bill amounts to rolling back the protections that most of our State have already provided for patients under the law. In every place in this country, protecting patients enrolled in HMOs has been a bipartisan effort. Only in Washington is patient protection partisan.

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. DINGELL

Mr. DINGELL. Mr. Speaker, I offer an amendment in the nature of a substitute.

The SPEAKER pro tempore. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment No. 2 in the Nature of a Substitute Offered by Mr. DINGELL:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patients' Bill of Rights Act of 1998''.

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

Sec. 1. Short title; table of contents.

TITLE I—HEALTH INSURANCE BILL OF RIGHTS

Subtitle A—Access to Care

Sec. 101. Access to emergency care.
Sec. 102. Offering of choice of coverage options under group health plans.
Sec. 103. Choice of providers.
Sec. 104. Access to specialty care.
Sec. 105. Continuity of care.
Sec. 106. Coverage for individuals participating in approved clinical trials.
Sec. 107. Access to needed prescription drugs.
Sec. 108. Adequacy of provider network.
Sec. 109. Nondiscrimination in delivery of services.

Subtitle B—Quality Assurance

Sec. 111. Internal quality assurance program.
Sec. 112. Collection of standardized data.
Sec. 113. Process for selection of providers.
Sec. 114. Drug utilization program.
Sec. 115. Standards for utilization review activities.
Sec. 116. Health Care Quality Advisory Board.

Subtitle C—Patient Information

Sec. 121. Patient information.
Sec. 122. Protection of patient confidentiality.
Sec. 123. Health insurance ombudsmen.

Subtitle D—Grievance and Appeals Procedures

Sec. 131. Establishment of grievance process.
Sec. 132. Internal appeals of adverse determinations.
Sec. 133. External appeals of adverse determinations.

Subtitle E—Protecting the Doctor-Patient Relationship

Sec. 141. Prohibition of interference with certain medical communications.
Sec. 142. Prohibition against transfer of indemnification or improper incentive arrangements.
Sec. 143. Additional rules regarding participation of health care professionals.
Sec. 144. Protection for patient advocacy.

Subtitle F—Promoting Good Medical Practice

Sec. 151. Promoting good medical practice.
Sec. 152. Standards relating to benefits for certain breast cancer treatment.
Sec. 153. Standards relating to benefits for reconstructive breast surgery.

Subtitle G—Definitions

Sec. 191. Definitions.
Sec. 192. Preemption; State flexibility; construction.
Sec. 193. Regulations.

TITLE II—APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER PUBLIC HEALTH SERVICE ACT

Sec. 201. Application to group health plans and group health insurance coverage.
Sec. 202. Application to individual health insurance coverage.

TITLE III—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Sec. 301. Application of patient protection standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act of 1974.
Sec. 302. ERISA preemption not to apply to certain actions involving health insurance policyholders.

TITLE IV—APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986

Sec. 401. Amendments to the Internal Revenue Code of 1986.

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

Sec. 501. Effective dates.
Sec. 502. Coordination in implementation.

TITLE VI—REVENUE PROVISIONS

Sec. 601. Estate tax technical correction.
Sec. 602. Treatment of certain deductible liquidating distributions of regulated investment companies and real estate investment trusts.

TITLE I—HEALTH INSURANCE BILL OF RIGHTS

Subtitle A—Access to Care

SEC. 101. ACCESS TO EMERGENCY CARE.

(a) COVERAGE OF EMERGENCY SERVICES.—

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

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

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

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating health care provider—

(i) the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider, and

(ii) the plan or issuer pays an amount that is not less than the amount paid to a participating health care provider for the same services; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON STANDARD.—The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term ''emergency services'' means—

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition (as defined in subparagraph (A)), and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—In the case of services (other than emergency services) for which benefits are available under a group health plan, or under health insurance coverage offered by a health insurance issuer, the plan or issuer shall provide for reimbursement with respect to such services provided to a participant, beneficiary, or enrollee other than through a participating health care provider in a manner consistent with subsection (a)(1)(C) if the services are maintenance care or post-stabilization care covered under the guidelines established under section 1852(d)(2) of the Social Security Act (relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after an enrollee has been determined to be stable), or, in the absence of guidelines under such section, such guidelines as the Secretary shall establish to carry out this subsection.

SEC. 102. OFFERING OF CHOICE OF COVERAGE OPTIONS UNDER GROUP HEALTH PLANS.

(a) REQUIREMENT.—

(1) OFFERING OF POINT-OF-SERVICE COVERAGE OPTION.—Except as provided in paragraph (2), if a group health plan (or health insurance coverage offered by a health insurance issuer in connection with a group health plan) provides benefits only through participating health care providers, the plan or issuer 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 or coverage and at such other times as the plan or issuer offers the participant a choice of coverage options.

(2) EXCEPTION.—Paragraph (1) shall not apply with respect to a participant in a group health plan if the plan offers the participant—

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

(B) two or more coverage options that differ significantly with respect to the use of participating health care providers or the networks of such providers 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 or health insurance issuer, coverage of such benefits when provided by a nonparticipating health care provider. Such coverage need not include coverage of providers that the plan or issuer excludes because of fraud, quality, or similar reasons.

(c) CONSTRUCTION.—Nothing in this section shall be construed—

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

(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; or

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

(d) NO REQUIREMENT FOR GUARANTEED AVAILABILITY.—If a health insurance issuer offers health insurance coverage that includes point-of-service coverage with respect to an employer solely in order to meet the requirement of subsection (a), nothing in section 2711(a)(1)(A) of the Public Health Service Act shall be construed as requiring the offering of such coverage with respect to another employer.

SEC. 103. CHOICE OF PROVIDERS.

(a) PRIMARY CARE.—A group health plan, and a health insurance issuer that offers health insurance coverage, shall permit each participant, beneficiary, and enrollee to receive primary care from any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary or appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care provider who is available to accept such individual for such care.

(2) LIMITATION.—Paragraph (1) shall not apply to specialty care if the plan or issuer clearly informs participants, beneficiaries, and enrollees of the limitations on choice of participating providers with respect to such care.

SEC. 104. ACCESS TO SPECIALTY CARE.

(a) OBSTETRICAL AND GYNECOLOGICAL CARE.—

(1) IN GENERAL.—If a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, requires or provides for a participant, beneficiary, or enrollee to designate a participating primary care provider—

(A) the plan or issuer shall permit such an individual who is a female to designate a participating physician who specializes in obstetrics and gynecology as the individual's primary care provider; and

(B) if such an individual has not designated such a provider as a primary care provider, the plan or issuer—

(i) may not require authorization or a referral by the individual's primary care provider or otherwise for coverage of routine gynecological care (such as preventive women's health examinations) and pregnancy-related services provided by a participating health care professional who specializes in obstetrics and gynecology to the extent such care is otherwise covered, and

(ii) may treat the ordering of other gynecological care by such a participating physician as the authorization of the primary care provider with respect to such care under the plan or coverage.

(2) CONSTRUCTION.—Nothing in paragraph (1)(B)(ii) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological care so ordered.

(b) SPECIALTY CARE.—

(1) SPECIALTY CARE FOR COVERED SERVICES.—

(A) IN GENERAL.—If—

(i) an individual is a participant or beneficiary under a group health plan or an enrollee who is covered under health insurance coverage offered by a health insurance issuer,

(ii) the individual has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist, and

(iii) benefits for such treatment are provided under the plan or coverage,

the plan or issuer shall make or provide for a referral to a specialist who is available and accessible to provide the treatment for such condition or disease.

(B) SPECIALIST DEFINED.—For purposes of this subsection, the term ''specialist'' means, with respect to a condition, a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

(C) CARE UNDER REFERRAL.—A group health plan or health insurance issuer may require that the care provided to an individual pursuant to such referral under subparagraph (A) be—

(i) pursuant to a treatment plan, only if the treatment plan is developed by the specialist and approved by the plan or issuer, in consultation with the designated primary care provider or specialist and the individual (or the individual's designee), and

(ii) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

Nothing in this subsection shall be construed as preventing such a treatment plan for an individual from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

(D) REFERRALS TO PARTICIPATING PROVIDERS.—A group health plan or health insurance issuer is not required under subparagraph (A) to provide for a referral to a specialist that is not a participating provider, unless the plan or issuer does not have an appropriate specialist that is available and accessible to treat the individual's condition and that is a participating provider with respect to such treatment.

(E) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a plan or issuer refers an individual to a nonparticipating specialist pursuant to subparagraph (A), services provided pursuant to the approved treatment plan (if any) shall be provided at no additional cost to the individual beyond what the individual would otherwise pay for services received by such a specialist that is a participating provider.

(2) SPECIALISTS AS PRIMARY CARE PROVIDERS.—

(A) IN GENERAL.—A group health plan, or a health insurance issuer, in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has an ongoing special condition (as defined in subparagraph (C)) may receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care. If such an individual's care would most appropriately be coordinated by such a specialist, such plan or issuer shall refer the individual to such specialist.

(B) TREATMENT AS PRIMARY CARE PROVIDER.—Such specialist shall be permitted to treat the individual without a referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the individual's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan (referred to in paragraph (1)(C)(i)).

(C) ONGOING SPECIAL CONDITION DEFINED.—In this paragraph, the term ''special condition'' means a condition or disease that—

(i) is life-threatening, degenerative, or disabling, and

(ii) requires specialized medical care over a prolonged period of time.

(D) TERMS OF REFERRAL.—The provisions of subparagraphs (C) through (E) of paragraph (1) apply with respect to referrals under subparagraph (A) of this paragraph in the same manner as they apply to referrals under paragraph (1)(A).

(3) STANDING REFERRALS.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall have a procedure by which an individual who is a participant, beneficiary, or enrollee and who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the plan or issuer, or if the primary care provider in consultation with the medical director of the plan or issuer and the specialist (if any), determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to such a specialist.

(B) TERMS OF REFERRAL.—The provisions of subparagraphs (C) through (E) of paragraph (1) apply with respect to referrals under subparagraph (A) of this paragraph in the same manner as they apply to referrals under paragraph (1)(A).

SEC. 105. CONTINUITY OF CARE.

(a) IN GENERAL.—

(1) TERMINATION OF PROVIDER.—If a contract between a group health plan, or a health insurance issuer in connection with the provision of health insurance coverage, and a health care provider is terminated (as defined in paragraph (3)), or benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in a group health plan, and an individual who is a participant, beneficiary, or enrollee in the plan or coverage is undergoing a course of treatment from the provider at the time of such termination, the plan or issuer shall—

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

(B) subject to subsection (c), permit the individual to continue or be covered with respect to the course of treatment with the provider during a transitional period (provided under subsection (b)).

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

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

(b) TRANSITIONAL PERIOD.—

(1) IN GENERAL.—Except as provided in paragraphs (2) through (4), the transitional period under this subsection shall extend for at least 90 days from the date of the notice described in subsection (a)(1)(A) of the provider's termination.

(2) INSTITUTIONAL CARE.—The transitional period under this subsection for institutional or inpatient care from a provider shall extend until the discharge or termination of the period of institutionalization and also shall include institutional care provided within a reasonable time of the date of termination of the provider status 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.—If—

(A) a participant, beneficiary, or enrollee 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 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.—If—

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

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

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

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer 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 or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or issuer after the date of the termination of the contract with the health insurance issuer) and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

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

(3) The provider agrees otherwise to adhere to such plan's or issuer'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 or issuer.

(d) 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.

SEC. 106. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS.

(a) COVERAGE.—

(1) IN GENERAL.—If a group health plan, or health insurance issuer that is providing health insurance coverage, provides coverage to a qualified individual (as defined in subsection (b)), the plan or issuer—

(A) may not deny the individual participation in the clinical trial referred to in subsection (b)(2);

(B) subject to subsection (c), may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and

(C) may not discriminate against the individual on the basis of the enrollee's participation in such trial.

(2) EXCLUSION OF CERTAIN COSTS.—For purposes of paragraph (1)(B), routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in a clinical trial, nothing in paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a participating provider if the provider will accept the individual as a participant in the trial.

(b) QUALIFIED INDIVIDUAL DEFINED.—For purposes of subsection (a), the term ''qualified individual'' means an individual who is a participant or beneficiary in a group health plan, or who is an enrollee under health insurance coverage, and who meets the following conditions:

(1)(A) The individual has a life-threatening or serious illness for which no standard treatment is effective.

(B) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of such illness.

(C) The individual's participation in the trial offers meaningful potential for significant clinical benefit for the individual.

(2) Either—

(A) the referring physician is a participating health care professional and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

(B) the participant, beneficiary, or enrollee provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

(c) PAYMENT.—

(1) IN GENERAL.—Under this section a group health plan or health insurance issuer shall provide for payment for routine patient costs described in subsection (a)(2) but is not required to pay for costs of items and services that are reasonably expected (as determined by the Secretary) to be paid for by the sponsors of an approved clinical trial.

(2) PAYMENT RATE.—In the case of covered items and services provided by—

(A) a participating provider, the payment rate shall be at the agreed upon rate, or

(B) a nonparticipating provider, the payment rate shall be at the rate the plan or issuer would normally pay for comparable services under subparagraph (A).

(d) APPROVED CLINICAL TRIAL DEFINED.—

(1) IN GENERAL.—In this section, the term ''approved clinical trial'' means a clinical research study or clinical investigation approved and funded (which may include funding through in-kind contributions) by one or more of the following:

(A) The National Institutes of Health.

(B) A cooperative group or center of the National Institutes of Health.

(C) Either of the following if the conditions described in paragraph (2) are met:

(i) The Department of Veterans Affairs.

(ii) The Department of Defense.

(2) CONDITIONS FOR DEPARTMENTS.—The conditions described in this paragraph, for a study or investigation conducted by a Department, are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines—

(A) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

(B) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(e) CONSTRUCTION.—Nothing in this section shall be construed to limit a plan's or issuer's coverage with respect to clinical trials.

SEC. 107. ACCESS TO NEEDED PRESCRIPTION DRUGS.

(a) IN GENERAL.—If a group health plan, or health insurance issuer that offers health insurance coverage, provides benefits with respect to prescription drugs but the coverage limits such benefits to drugs included in a formulary, the plan or issuer shall—

(1) ensure participation of participating physicians and pharmacists in the development of the formulary;

(2) disclose to providers and, disclose upon request under section 121(c)(6) to participants, beneficiaries, and enrollees, the nature of the formulary restrictions; and

(3) consistent with the standards for a utilization review program under section 115, provide for exceptions from the formulary limitation when a non-formulary alternative is medically indicated.

(b) COVERAGE OF APPROVED DRUGS AND MEDICAL DEVICES.—

(1) IN GENERAL.—A group health plan (or health insurance coverage offered in connection with such a plan) that provides any coverage of prescription drugs or medical devices shall not deny coverage of such a drug or device on the basis that the use is investigational, if the use—

(A) in the case of a prescription drug—

(i) is included in the labeling authorized by the application in effect for the drug pursuant to subsection (b) or (j) of section 505 of the Federal Food, Drug, and Cosmetic Act, without regard to any postmarketing requirements that may apply under such Act; or

(ii) is included in the labeling authorized by the application in effect for the drug under section 351 of the Public Health Service Act, without regard to any postmarketing requirements that may apply pursuant to such section; or

(B) in the case of a medical device, is included in the labeling authorized by a regulation under subsection (d) or (3) of section 513 of the Federal Food, Drug, and Cosmetic Act, an order under subsection (f) of such section, or an application approved under section 515 of such Act, without regard to any postmarketing requirements that may apply under such Act.

(2) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any coverage of prescription drugs or medical devices.

SEC. 108. ADEQUACY OF PROVIDER NETWORK.

(a) IN GENERAL.—Each group health plan, and each health insurance issuer offering health insurance coverage, that provides benefits, in whole or in part, through participating health care providers shall have (in relation to the coverage) a sufficient number, distribution, and variety of qualified participating health care providers to ensure that all covered health care services, including specialty services, will be available and accessible in a timely manner to all participants, beneficiaries, and enrollees under the plan or coverage.

(b) TREATMENT OF CERTAIN PROVIDERS.—The qualified health care providers under subsection (a) may include Federally qualified health centers, rural health clinics, migrant health centers, and other essential community providers located in the service area of the plan or issuer and shall include such providers if necessary to meet the standards established to carry out such subsection.

SEC. 109. NONDISCRIMINATION IN DELIVERY OF SERVICES.

(a) APPLICATION TO DELIVERY OF SERVICES.—Subject to subsection (b), a group health plan, and health insurance issuer in relation to health insurance coverage, may not discriminate against a participant, beneficiary, or enrollee in the delivery of health care services consistent with the benefits covered under the plan or coverage or as required by law based on race, color, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed as relating to the eligibility to be covered, or the offering (or guaranteeing the offer) of coverage, under a plan or health insurance coverage, the application of any pre-existing condition exclusion consistent with applicable law, or premiums charged under such plan or coverage.

Subtitle B—Quality Assurance

SEC. 111. INTERNAL QUALITY ASSURANCE PROGRAM.

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

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

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

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

(A) The activities to be conducted.

(B) The organizational structure.

(C) The duties of the medical director.

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

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

(4) QUALITY CRITERIA.—The program—

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

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

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

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

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

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

(7) DRUG UTILIZATION REVIEW.—The program provides for a drug utilization review program in accordance with section 114.

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

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

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

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

SEC. 112. COLLECTION OF STANDARDIZED DATA.

(a) IN GENERAL.—A group health plan and a health insurance issuer that offers health insurance coverage shall collect uniform quality data that include a minimum uniform data set described in subsection (b).

(b) MINIMUM UNIFORM DATA SET.—The Secretary shall specify (and may from time to time update) the data required to be included

in the minimum uniform data set under subsection (a) and the standard format for such data. Such data shall include at least—

(1) aggregate utilization data;

(2) data on the demographic characteristics of participants, beneficiaries, and enrollees;

(3) data on disease-specific and age-specific mortality rates and (to the extent feasible) morbidity rates of such individuals;

(4) data on satisfaction of such individuals, including data on voluntary disenrollment and grievances; and

(5) data on quality indicators and health outcomes, including, to the extent feasible and appropriate, data on pediatric cases and on a gender-specific basis.

(c) AVAILABILITY.—A summary of the data collected under subsection (a) shall be disclosed under section 121(b)(9). The Secretary shall be provided access to all the data so collected.

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

SEC. 113. PROCESS FOR SELECTION OF PROVIDERS.

(a) IN GENERAL.—A group health plan and a health insurance issuer that offers health insurance coverage shall, if it provides benefits through participating health care professionals, have a written process for the selection of participating health care professionals, including minimum professional requirements.

(b) VERIFICATION OF BACKGROUND.—Such process shall include verification of a health care provider's license and a history of suspension or revocation.

(c) RESTRICTION.—Such process shall not use a high-risk patient base or location of a provider in an area with residents with poorer health status as a basis for excluding providers from participation.

(d) NONDISCRIMINATION BASED ON LICENSURE.—

(1) IN GENERAL.—Such process shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification.

(2) CONSTRUCTION.—Paragraph (1) shall not be construed—

(A) as requiring the coverage under a plan or coverage of particular benefits or services or to prohibit a plan or issuer from including providers only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan or issuer; or

(B) to override any State licensure or scope-of-practice law.

(e) GENERAL NONDISCRIMINATION.—

(1) IN GENERAL.—Subject to paragraph (2), such process shall not discriminate with respect to selection of a health care professional to be a participating health care provider, or with respect to the terms and conditions of such participation, based on the professional's race, color, religion, sex, national origin, age, sexual orientation, or disability (consistent with the Americans with Disabilities Act of 1990).

(2) RULES.—The appropriate Secretary may establish such definitions, rules, and exceptions as may be appropriate to carry out paragraph (1), taking into account comparable definitions, rules, and exceptions in effect under employment-based nondiscrimination laws and regulations that relate to each of the particular bases for discrimination described in such paragraph.

SEC. 114. DRUG UTILIZATION PROGRAM.

A group health plan, and a health insurance issuer that provides health insurance coverage, that includes benefits for prescription drugs shall establish and maintain, as part of its internal quality assurance and continuous quality improvement program under section 111, a drug utilization program which—

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

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

SEC. 115. STANDARDS FOR UTILIZATION REVIEW ACTIVITIES.

(a) COMPLIANCE WITH REQUIREMENTS.—

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

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

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

(b) WRITTEN POLICIES AND CRITERIA.—

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

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed pursuant to the program with the input of appropriate physicians. Such criteria shall include written clinical review criteria described in section 111(b)(4)(B).

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

(c) CONDUCT OF PROGRAM ACTIVITIES.—

(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions. In this subsection, the term ''health care professional'' means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with State law.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

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

(B) PEER REVIEW OF SAMPLE OF ADVERSE CLINICAL DETERMINATIONS.—Such a program shall provide that clinical peers (as defined in section 191(c)(2)) shall evaluate the clinical appropriateness of at least a sample of adverse clinical determinations.

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

(i) provides incentives, direct or indirect, for such persons to make inappropriate review decisions, or

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

(D) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who provides health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

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

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

(5) LIMITATION ON INFORMATION REQUESTS.—Under such a program, information shall be required to be provided by health care providers only to the extent it is necessary to perform the utilization review activity involved.

(6) REVIEW OF PRELIMINARY UTILIZATION REVIEW DECISION.—Under such program a participant, beneficiary, or enrollee or any provider acting on behalf of such an individual with the individual's consent, who is dissatisfied with a preliminary utilization review decision has the opportunity to discuss the decision with, and have such decision reviewed by, the medical director of the plan or issuer involved (or the director's designee) who has the authority to reverse the decision.

(d) DEADLINE FOR DETERMINATIONS.—

(1) PRIOR AUTHORIZATION SERVICES.—Except as provided in paragraph (2), in the case of a utilization review activity involving the prior authorization of health care items and services for an individual, the utilization review program shall make a determination concerning such authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the cases, and in no event later than 3 business days after the date of receipt of information that is reasonably necessary to make such determination.

(2) CONTINUED CARE.—In the case of a utilization review activity involving authorization for continued or extended health care services for an individual, or additional services for an individual undergoing a course of continued treatment prescribed by a health care provider, the utilization review program shall make a determination concerning such

authorization, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, as soon as possible in accordance with the medical exigencies of the cases, and in no event later than 1 business day after the date of receipt of information that is reasonably necessary to make such determination. Such notice shall include, with respect to continued or extended health care services, the number of extended services approved, the new total of approved services, the date of onset of services, and the next review date, if any.

(3) PREVIOUSLY PROVIDED SERVICES.—In the case of a utilization review activity involving retrospective review of health care services previously provided for an individual, the utilization review program shall make a determination concerning such services, and provide notice of the determination to the individual or the individual's designee and the individual's health care provider by telephone and in printed form, within 30 days of the date of receipt of information that is reasonably necessary to make such determination.

(4) REFERENCE TO SPECIAL RULES FOR EMERGENCY SERVICES, MAINTENANCE CARE, AND POST-STABILIZATION CARE.—For waiver of prior authorization requirements in certain cases involving emergency services and maintenance care and post-stabilization care, see subsections (a)(1) and (b) of section 101, respectively.

(e) NOTICE OF ADVERSE DETERMINATIONS.—

(1) IN GENERAL.—Notice of an adverse determination under a utilization review program shall be provided in printed form and shall include—

(A) the reasons for the determination (including the clinical rationale);

(B) instructions on how to initiate an appeal under section 132; and

(C) notice of the availability, upon request of the individual (or the individual's designee) of the clinical review criteria relied upon to make such determination.

(2) SPECIFICATION OF ANY ADDITIONAL INFORMATION.—Such a notice shall also specify what (if any) additional necessary information must be provided to, or obtained by, the person making the determination in order to make a decision on such an appeal.

SEC. 116. HEALTH CARE QUALITY ADVISORY BOARD.

(a) ESTABLISHMENT.—The President shall establish an advisory board to provide information to Congress and the administration on issues relating to quality monitoring and improvement in the health care provided under group health plans and health insurance coverage.

(b) NUMBER AND APPOINTMENT.—The advisory board shall be composed of the Secretary of Health and Human Services (or the Secretary's designee), the Secretary of Labor (or the Secretary's designee), and 20 additional members appointed by the President, in consultation with the Majority and Minority Leaders of the Senate and House of Representatives. The members so appointed shall include individuals with expertise in—

(1) consumer needs;

(2) education and training of health professionals;

(3) health care services;

(4) health plan management;

(5) health care accreditation, quality assurance, improvement, measurement, and oversight;

(6) medical practice, including practicing physicians;

(7) prevention and public health; and

(8) public and private group purchasing for small and large employers or groups.

(c) DUTIES.—The advisory board shall—

(1) identify, update, and disseminate measures of health care quality for group health plans and health insurance issuers, including network and non-network plans;

(2) advise the Secretary on the development and maintenance of the minimum data set in section 112(b); and

(3) advise the Secretary on standardized formats for information on group health plans and health insurance coverage.

The measures identified under paragraph (1) may be used on a voluntary basis by such plans and issuers. In carrying out paragraph (1), the advisory board shall consult and cooperate with national health care standard setting bodies which define quality indicators, the Agency for Health Care Policy and Research, the Institute of Medicine, and other public and private entities that have expertise in health care quality.

(d) REPORT.—The advisory board shall provide an annual report to Congress and the President on the quality of the health care in the United States and national and regional trends in health care quality. Such report shall include a description of determinants of health care quality and measurements of practice and quality variability within the United States.

(e) SECRETARIAL CONSULTATION.—In serving on the advisory board, the Secretaries of Health and Human Services and Labor (or their designees) shall consult with the Secretaries responsible for other Federal health insurance and health care programs.

(f) VACANCIES.—Any vacancy on the board shall be filled in such manner as the original appointment. Members of the board shall serve without compensation but shall be reimbursed for travel, subsistence, and other necessary expenses incurred by them in the performance of their duties. Administrative support, scientific support, and technical assistance for the advisory board shall be provided by the Secretary of Health and Human Services.

(g) CONTINUATION.—Section 14(a)(2)(B) of the Federal Advisory Committee Act (5 U.S.C. App.; relating to the termination of advisory committees) shall not apply to the advisory board.

Subtitle C—Patient Information

SEC. 121. PATIENT INFORMATION.

(a) DISCLOSURE REQUIREMENT.—

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

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

(B) provide to participants and beneficiaries, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in subsection (b), information in printed form on such significant changes; and

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

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

(A) provide to individuals enrolled under such coverage at the time of enrollment, and at least annually thereafter, the information described in subsection (b) in printed form;

(B) provide to enrollees, within a reasonable period (as specified by the appropriate Secretary) before or after the date of significant changes in the information described in subsection (b), information in printed form on such significant changes; and

(C) upon request, make available to the applicable authority, to individuals who are prospective enrollees, and to the public the information described in subsection (b) or (c) in printed form.

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

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

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

(A) covered benefits, including benefit limits and coverage exclusions;

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

(C) the extent to which benefits may be obtained from nonparticipating providers;

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

(E) process for determining experimental coverage; and

(F) use of a prescription drug formulary.

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

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

(B) Out-of-network coverage (if any) provided by the plan or coverage.

(C) Any point-of-service option (including any supplemental premium or cost-sharing for such option).

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

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

(F) The name, address, and telephone number of participating health care providers and an indication of whether each such provider is available to accept new patients.

(G) Any limitations imposed on the selection of qualifying participating health care providers, including any limitations imposed under section 103(b)(2).

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

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

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

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

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

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

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

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

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

(9) QUALITY ASSURANCE.—A summary description of the data on quality collected under section 112(a), including a summary description of the data on satisfaction of participants, beneficiaries, and enrollees (including data on individual voluntary disenrollment and grievances and appeals) described in section 112(b)(4).

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

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

(12) AVAILABILITY OF INFORMATION ON REQUEST.—Notice that the information described in subsection (c) is available upon request.

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

(1) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requirements (including circumstances, time frames, and appeal rights) under any utilization review program under section 115, including under any drug formulary program under section 107.

(2) GRIEVANCE AND APPEALS INFORMATION.—Information on the number of grievances and appeals and on the disposition in the aggregate of such matters.

(3) METHOD OF PHYSICIAN COMPENSATION.—An overall summary description as to the method of compensation of participating physicians, including information on the types of financial payment incentives (described in section 1852(j)(4) of the Social Security Act) provided by the plan or issuer under the coverage.

(4) SPECIFIC INFORMATION ON CREDENTIALS OF PARTICIPATING PROVIDERS.—In the case of each participating provider, a description of the credentials of the provider.

(5) CONFIDENTIALITY POLICIES AND PROCEDURES.—A description of the policies and procedures established to carry out section 122.

(6) FORMULARY RESTRICTIONS.—A description of the nature of any drug formula restrictions.

(7) PARTICIPATING PROVIDER LIST.—A list of current participating health care providers.

(d) FORM OF DISCLOSURE.—

(1) UNIFORMITY.—Information required to be disclosed under this section shall be provided in accordance with uniform, national reporting standards specified by the Secretary, after consultation with applicable State authorities, so that prospective enrollees may compare the attributes of different issuers and coverage offered within an area.

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

(3) UPDATING PARTICIPATING PROVIDER INFORMATION.—The information on participating health care providers described in subsection (b)(3)(C) shall be updated within such reasonable period as determined appropriate by the Secretary. Nothing in this section shall prevent an issuer from changing or updating other information made available under this section.

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

SEC. 122. PROTECTION OF PATIENT CONFIDENTIALITY.

Insofar as a group health plan, or a health insurance issuer that offers health insurance coverage, maintains medical records or other health information regarding participants, beneficiaries, and enrollees, the plan or issuer shall establish procedures—

(1) to safeguard the privacy of any individually identifiable enrollee information;

(2) to maintain such records and information in a manner that is accurate and timely, and

(3) to assure timely access of such individuals to such records and information.

SEC. 123. HEALTH INSURANCE OMBUDSMEN.

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

(1) To assist consumers in the State in choosing among health insurance coverage or among coverage options offered within group health plans.

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

(b) FEDERAL ROLE.—In the case of any State that does not provide for such an Ombudsman under subsection (a), the Secretary shall provide for the creation and operation of a Health Insurance Ombudsman through a contract with a not-for-profit organization that operates independent of group health plans and health insurance issuers and that is responsible for carrying out with respect to that State the functions otherwise provided under subsection (a) by a Health Insurance Ombudsman.

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

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

Subtitle D—Grievance and Appeals Procedures

SEC. 131. ESTABLISHMENT OF GRIEVANCE PROCESS.

(a) ESTABLISHMENT OF GRIEVANCE SYSTEM.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances brought by individuals who are participants, beneficiaries, or enrollees, or health care providers or other individuals acting on behalf of an individual and with the individual's consent, regarding any aspect of the plan's or issuer's services.

(2) SCOPE.—The system shall include grievances regarding access to and availability of services, quality of care, choice and accessibility of providers, network adequacy, and compliance with the requirements of this title.

(b) GRIEVANCE SYSTEM.—Such system shall include the following components with respect to individuals who are participants, beneficiaries, or enrollees:

(1) Written notification to all such individuals and providers of the telephone numbers and business addresses of the plan or issuer personnel responsible for resolution of grievances and appeals.

(2) A system to record and document, over a period of at least 3 previous years, all grievances and appeals made and their status.

(3) A process providing for timely processing and resolution of grievances.

(4) Procedures for follow-up action, including the methods to inform the person making the grievance of the resolution of the grievance.

(5) Notification to the continuous quality improvement program under section 111(a) of all grievances and appeals relating to quality of care.

SEC. 132. INTERNAL APPEALS OF ADVERSE DETERMINATIONS.

(a) RIGHT OF APPEAL.—

(1) IN GENERAL.—A participant or beneficiary in a group health plan, and an enrollee in health insurance coverage offered by a health insurance issuer, and any provider or other person acting on behalf of such an individual with the individual's consent, may appeal any appealable decision (as defined in paragraph (2)) under the procedures described in this section and (to the extent applicable) section 133. Such individuals and providers shall be provided with a written explanation of the appeal process and the determination upon the conclusion of the appeals process and as provided in section 121(b)(8).

(2) APPEALABLE DECISION DEFINED.—In this section, the term ''appealable decision'' means any of the following:

(A) Denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(B) Failure to provide coverage of emergency services or reimbursement of maintenance care or post-stabilization care under section 101.

(C) Failure to provide a choice of provider under section 103.

(D) Failure to provide qualified health care providers under section 103.

(E) Failure to provide access to specialty and other care under section 104.

(F) Failure to provide continuation of care under section 105.

(G) Failure to provide coverage of routine patient costs in connection with an approval clinical trial under section 106.

(H) Failure to provide access to needed drugs under section 107(a)(3) or 107(b).

(I) Discrimination in delivery of services in violation of section 109.

(J) An adverse determination under a utilization review program under section 115.

(K) The imposition of a limitation that is prohibited under section 151.

(b) INTERNAL APPEAL PROCESS.—

(1) IN GENERAL.—Each group health plan and health insurance issuer shall establish and maintain an internal appeal process under which any participant, beneficiary, enrollee, or provider acting on behalf of such an individual with the individual's consent, who is dissatisfied with any appealable decision has the opportunity to appeal the decision through an internal appeal process. The appeal may be communicated orally.

(2) CONDUCT OF REVIEW.—

(A) IN GENERAL.—The process shall include a review of the decision by a physician or other health care professional (or professionals) who has been selected by the plan or issuer and who has not been involved in the appealable decision at issue in the appeal.

(B) AVAILABILITY AND PARTICIPATION OF CLINICAL PEERS.—The individuals conducting such review shall include one or more clinical peers (as defined in section 191(c)(2)) who have not been involved in the appealable decision at issue in the appeal.

(3) DEADLINE.—

(A) IN GENERAL.—Subject to subsection (c), the plan or issuer shall conclude each appeal as soon as possible after the time of the receipt of the appeal in accordance with medical exigencies of the case involved, but in no event later than—

(i) 72 hours after the time of receipt of an expedited appeal, and

(ii) except as provided in subparagraph (B), 30 business days after such time (or, if the participant, beneficiary, or enrollee supplies additional information that was not available to the plan or issuer at the time of the receipt of the appeal, after the date of supplying such additional information) in the case of all other appeals.

(B) EXTENSION.—In the case of an appeal that does not relate to a decision regarding an expedited appeal and that does not involve medical exigencies, if a group health plan or health insurance issuer is unable to conclude the appeal within the time period provided under subparagraph (A)(ii) due to circumstances beyond the control of the plan or issuer, the deadline shall be extended for up to an additional 10 business days if the plan or issuer provides, on or before 10 days before the deadline otherwise applicable, written notice to the participant, beneficiary, or enrollee and the provider involved of the extension and the reasons for the extension.

(4) NOTICE.—If a plan or issuer denies an appeal, the plan or issuer shall provide the participant, beneficiary, or enrollee and provider involved with notice in printed form of the denial and the reasons therefore, together with a notice in printed form of rights to any further appeal.

(c) EXPEDITED REVIEW PROCESS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer, shall establish procedures in writing for the expedited consideration of appeals under subsection (b) in situations in which the application of the normal timeframe for making a determination could seriously jeopardize the life or health of the participant, beneficiary, or enrollee or such an individual's ability to regain maximum function.

(2) PROCESS.—Under such procedures—

(A) the request for expedited appeal may be submitted orally or in writing by an individual or provider who is otherwise entitled to request the appeal;

(B) all necessary information, including the plan's or issuer's decision, shall be transmitted between the plan or issuer and the requester by telephone, facsimile, or other similarly expeditious available method; and

(C) the plan or issuer shall expedite the appeal if the request for an expedited appeal is submitted under subparagraph (A) by a physician and the request indicates that the situation described in paragraph (1) exists.

(d) DIRECT USE OF FURTHER APPEALS.—In the event that the plan or issuer fails to comply with any of the deadlines for completion of appeals under this section or in the event that the plan or issuer for any reason expressly waives its rights to an internal review of an appeal under subsection (b), the participant, beneficiary, or enrollee involved and the provider involved shall be relieved of any obligation to complete the appeal involved and may, at such an individual's or provider's option, proceed directly to seek further appeal through any applicable external appeals process.

SEC. 133. EXTERNAL APPEALS OF ADVERSE DETERMINATIONS.

(a) RIGHT TO EXTERNAL APPEAL.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide for an external appeals process that meets the requirements of this section in the case of an externally appealable decision described in paragraph (2). The appropriate Secretary shall establish standards to carry out such requirements.

(2) EXTERNALLY APPEALABLE DECISION DEFINED.—For purposes of this section, the term ''externally appealable decision'' means an appealable decision (as defined in section 132(a)(2)) if—

(A) the amount involved exceeds a significant threshold; or

(B) the patient's life or health is jeopardized as a consequence of the decision.

Such term does not include a denial of coverage for services that are specifically listed in plan or coverage documents as excluded from coverage.

(3) EXHAUSTION OF INTERNAL APPEALS PROCESS.—A plan or issuer may condition the use of an external appeal process in the case of an externally appealable decision upon completion of the internal review process provided under section 132, but only if the decision is made in a timely basis consistent with the deadlines provided under this subtitle.

(b) GENERAL ELEMENTS OF EXTERNAL APPEALS PROCESS.—

(1) CONTRACT WITH QUALIFIED EXTERNAL APPEAL ENTITY.—

(A) CONTRACT REQUIREMENT.—Subject to subparagraph (B), the external appeal process under this section of a plan or issuer shall be conducted under a contract between the plan or issuer and one or more qualified external appeal entities (as defined in subsection (c)).

(B) RESTRICTIONS ON QUALIFIED EXTERNAL APPEAL ENTITY.—

(i) BY STATE FOR HEALTH INSURANCE ISSUERS.—With respect to health insurance issuers in a State, the State may provide for external review activities to be conducted by a qualified external appeal entity that is designated by the State or that is selected by the State in such a manner as to assure an unbiased determination.

(ii) BY FEDERAL GOVERNMENT FOR GROUP HEALTH PLANS.—With respect to group health plans, the appropriate Secretary may exercise the same authority as a State may exercise with respect to health insurance issuers under clause (i). Such authority may include requiring the use of the qualified external appeal entity designated or selected under such clause.

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

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

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

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

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

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

(B) DETERMINATION CONCERNING EXTERNALLY APPEALABLE DECISIONS.—A qualified external appeal entity shall determine whether a decision is an externally appealable decision and related decisions, including—

(i) whether such a decision involves an expedited appeal;

(ii) the appropriate deadlines for internal review process required due to medical exigencies in a case; and

(iii) whether such a process has been completed.

(C) OPPORTUNITY TO SUBMIT EVIDENCE, HAVE REPRESENTATION, AND MAKE ORAL PRESENTATION.—Each party to an externally appealable decision—

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

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

(iii) may make an oral presentation.

(D) PROVISION OF INFORMATION.—The plan or issuer involved shall provide timely access to all its records relating to the matter of the externally appealable decision and to all provisions of the plan or health insurance coverage (including any coverage manual) relating to the matter.

(E) TIMELY DECISIONS.—A determination by the external appeal entity on the decision shall—

(i) be made orally or in writing and, if it is made orally, shall be supplied to the parties in writing as soon as possible;

(ii) be binding on the plan or issuer;

(iii) be made in accordance with the medical exigencies of the case involved, but in no event later than 60 days (or 72 hours in the case of an expedited appeal) from the date of completion of the filing of notice of external appeal of the decision;

(iv) state, in layperson's language, the basis for the determination, including, if relevant, any basis in the terms or conditions of the plan or coverage; and

(v) inform the participant, beneficiary, or enrollee of the individual's rights to seek further review by the courts (or other process) of the external appeal determination.

(c) QUALIFICATIONS OF EXTERNAL APPEAL ENTITIES.—

(1) IN GENERAL.—For purposes of this section, the term ''qualified external appeal entity'' means, in relation to a plan or issuer, an entity (which may be a governmental entity) that is certified under paragraph (2) as meeting the following requirements:

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

(B) The entity conducts external appeal activities through clinical peers.

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

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

(2) CERTIFICATION OF EXTERNAL APPEAL ENTITIES.—

(A) IN GENERAL.—In order to be treated as a qualified external appeal entity with respect to—

(i) a group health plan, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting the requirements of paragraph (1) by the Secretary of Labor (or under a process recognized or approved by the Secretary of Labor); or

(ii) a health insurance issuer operating in a State, the entity must be certified (and, in accordance with subparagraph (B), periodically recertified) as meeting such requirements by the applicable State authority (or, if the States has not established an adequate certification and recertification process, by the Secretary of Health and Human Services, or under a process recognized or approved by such Secretary).

(B) RECERTIFICATION PROCESS.—The appropriate Secretary shall develop standards for the recertification of external appeal entities. Such standards shall include a specification of—

(i) the information required to be submitted as a condition of recertification on the entity's performance of external appeal activities, which information shall include the number of cases reviewed, a summary of the disposition of those cases, the length of time in making determinations on those cases, and such information as may be necessary to assure the independence of the entity from the plans or issuers for which external appeal activities are being conducted; and

(ii) the periodicity which recertification will be required.

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

Subtitle E—Protecting the Doctor-Patient Relationship

SEC. 141. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.

(a) PROHIBITION.—

(1) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or restrict the provider from engaging in medical communications with the provider's patient.

(2) NULLIFICATION.—Any contract provision or agreement described in paragraph (1) shall be null and void.

(b) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

(1) to prohibit the enforcement, as part of a contract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by a group health plan or health insurance issuer to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider) but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers and their patients; or

(2) to permit a health care provider to misrepresent the scope of benefits covered under the group health plan or health insurance coverage or to otherwise require a group health plan health insurance issuer to reimburse providers for benefits not covered under the plan or coverage.

(c) MEDICAL COMMUNICATION DEFINED.—In this section:

(1) IN GENERAL.—The term ''medical communication'' means any communication made by a health care provider with a patient of the health care provider (or the guardian or legal representative of such patient) with respect to—

(A) the patient's health status, medical care, or treatment options;

(B) any utilization review requirements that may affect treatment options for the patient; or

(C) any financial incentives that may affect the treatment of the patient.

(2) MISREPRESENTATION.—The term ''medical communication'' does not include a communication by a health care provider with a patient of the health care provider (or the guardian or legal representative of such patient) if the communication involves a knowing or willful misrepresentation by such provider.

SEC. 142. PROHIBITION AGAINST TRANSFER OF INDEMNIFICATION OR IMPROPER INCENTIVE ARRANGEMENTS.

(a) PROHIBITION OF TRANSFER OF INDEMNIFICATION.—

(1) IN GENERAL.—No contract or agreement between a group health plan or health insurance issuer (or any agent acting on behalf of such a plan or issuer) and a health care provider shall contain any provision purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions, or omissions of the plan, issuer, or agent (as opposed to the provider).

(2) NULLIFICATION.—Any contract or agreement provision described in paragraph (1) shall be null and void.

(b) PROHIBITION OF IMPROPER PHYSICIAN INCENTIVE PLANS.—

(1) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage may not operate any physician incentive plan (as defined in subparagraph (B) of section 1876(i)(8) of the Social Security Act) unless the requirements described in subparagraph (A) of such section are met with respect to such a plan.

(2) APPLICATION.—For purposes of carrying out paragraph (1), any reference in section 1876(i)(8) of the Social Security Act to the Secretary, an eligible organization, or an individual enrolled with the organization shall be treated as a reference to the applicable authority, a group health plan or health insurance issuer, respectively, and a participant, beneficiary, or enrollee with the plan or organization, respectively.

SEC. 143. ADDITIONAL RULES REGARDING PARTICIPATION OF HEALTH CARE PROFESSIONALS.

(a) PROCEDURES.—Insofar as a group health plan, or health insurance issuer that offers health insurance coverage, provides benefits through participating health care professionals, the plan or issuer shall establish reasonable procedures relating to the participation (under an agreement between a professional and the plan or issuer) of such professionals under the plan or coverage. Such procedures shall include—

(1) providing notice of the rules regarding participation;

(2) providing written notice of participation decisions that are adverse to professionals; and

(3) providing a process within the plan or issuer for appealing such adverse decisions, including the presentation of information and views of the professional regarding such decision.

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

SEC. 144. PROTECTION FOR PATIENT ADVOCACY.

(a) PROTECTION FOR USE OF UTILIZATION REVIEW AND GRIEVANCE PROCESS.—A group health plan, and a health insurance issuer with respect to the provision of health insurance coverage, may not retaliate against a participant, beneficiary, enrollee, or health care provider based on the participant's, beneficiary's, enrollee's or provider's use of, or participation in, a utilization review process or a grievance process of the plan or issuer (including an internal or external review or appeal process) under this title.

(b) PROTECTION FOR QUALITY ADVOCACY BY HEALTH CARE PROFESSIONALS.—

(1) IN GENERAL.—A group health plan or health insurance issuer may not retaliate or discriminate against a protected health care professional because the professional in good faith—

(A) discloses information relating to the care, services, or conditions affecting one or more participants, beneficiaries, or enrollees of the plan or issuer to an appropriate public regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the plan or issuer; or

(B) initiates, cooperates, or otherwise participates in an investigation or proceeding by such an agency with respect to such care, services, or conditions.

If an institutional health care provider is a participating provider with such a plan or issuer or otherwise receives payments for benefits provided by such a plan or issuer, the provisions of the previous sentence shall apply to the provider in relation to care, services, or conditions affecting one or more patients within an institutional health care provider in the same manner as they apply to the plan or issuer in relation to care, services, or conditions provided to one or more participants, beneficiaries, or enrollees; and for purposes of applying this sentence, any reference to a plan or issuer is deemed a reference to the institutional health care provider.

(2) GOOD FAITH ACTION.—For purposes of paragraph (1), a protected health care professional is considered to be acting in good faith with respect to disclosure of information or participation if, with respect to the information disclosed as part of the action—

(A) the disclosure is made on the basis of personal knowledge and is consistent with that degree of learning and skill ordinarily possessed by health care professionals with

the same licensure or certification and the same experience;

(B) the professional reasonably believes the information to be true;

(C) the information evidences either a violation of a law, rule, or regulation, of an applicable accreditation standard, or of a generally recognized professional or clinical standard or that a patient is in imminent hazard of loss of life or serious injury; and

(D) subject to subparagraphs (B) and (C) of paragraph (3), the professional has followed reasonable internal procedures of the plan, issuer, or institutional health care provider established or the purpose of addressing quality concerns before making the disclosure.

(3) EXCEPTION AND SPECIAL RULE.—

(A) GENERAL EXCEPTION.—Paragraph (1) does not protect disclosures that would violate Federal or State law or diminish or impair the rights of any person to the continued protection of confidentiality of communications provided by such law.

(B) NOTICE OF INTERNAL PROCEDURES.—Subparagraph (D) of paragraph (2) shall not apply unless the internal procedures involved are reasonably expected to be known to the health care professional involved. For purposes of this subparagraph, a health care professional is reasonably expected to know of internal procedures if those procedures have been made available to the professional through distribution or posting.

(C) INTERNAL PROCEDURE EXCEPTION.—Subparagraph (D) of paragraph (2) also shall not apply if—

(i) the disclosure relates to an imminent hazard of loss of life or serious injury to a patient;

(ii) the disclosure is made to an appropriate private accreditation body pursuant to disclosure procedures established by the body; or

(iii) the disclosure is in response to an inquiry made in an investigation or proceeding of an appropriate public regulatory agency and the information disclosed is limited to the scope of the investigation or proceeding.

(4) ADDITIONAL CONSIDERATIONS.—It shall not be a violation of paragraph (1) to take an adverse action against a protected health care professional if the plan, issuer, or provider taking the adverse action involved demonstrates that it would have taken the same adverse action even in the absence of the activities protected under such paragraph.

(5) NOTICE.—A group health plan, health insurance issuer, and institutional health care provider shall post a notice, to be provided or approved by the Secretary of Labor, setting forth excerpts from, or summaries of, the pertinent provisions of this subsection and information pertaining to enforcement of such provisions.

(6) CONSTRUCTIONS.—

(A) DETERMINATIONS OF COVERAGE.—Nothing in this subsection shall be construed to prohibit a plan or issuer from making a determination not to pay for a particular medical treatment or service or the services of a type of health care professional.

(B) ENFORCEMENT OF PEER REVIEW PROTOCOLS AND INTERNAL PROCEDURES.—Nothing in this subsection shall be construed to prohibit a plan, issuer, or provider from establishing and enforcing reasonable peer review or utilization review protocols or determining whether a protected health care professional has complied with those protocols or from establishing and enforcing internal procedures for the purpose of addressing quality concerns.

(C) RELATION TO OTHER RIGHTS.—Nothing in this subsection shall be construed to abridge rights of participants, beneficiaries, enrollees, and protected health care professionals under other applicable Federal or State laws.

(7) PROTECTED HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this subsection, the term ''protected health care professional'' means an individual who is a licensed or certified health care professional and who—

(A) with respect to a group health plan or health insurance issuer, is an employee of the plan or issuer or has a contract with the plan or issuer for provision of services for which benefits are available under the plan or issuer; or

(B) with respect to an institutional health care provider, is an employee of the provider or has a contract or other arrangement with the provider respecting the provision of health care services.

Subtitle F—Promoting Good Medical Practice

SEC. 151. PROMOTING GOOD MEDICAL PRACTICE.

(a) PROHIBITING ARBITRARY LIMITATIONS OR CONDITIONS FOR THE PROVISION OF SERVICES.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer in connection with the provision of health insurance coverage, may not arbitrarily interfere with or alter the decision of the treating physician regarding the manner or setting in which particular services are delivered if the services are medically necessary or appropriate for treatment or diagnosis to the extent that such treatment or diagnosis is otherwise a covered benefit.

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

(3) MANNER OR SETTING DEFINED.—In paragraph (1), the term ''manner or setting'' means the location of treatment, such as whether treatment is provided on an inpatient or outpatient basis, and the duration of treatment, such as the number of days in a hospital, Such term does not include the coverage of a particular service or treatment.

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

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

SEC. 152. STANDARDS RELATING TO BENEFITS FOR CERTAIN BREAST CANCER TREATMENT.

(a) REQUIREMENTS FOR MINIMUM HOSPITAL STAY FOLLOWING MASTECTOMY OR LYMPH NODE DISSECTION.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, may not—

(A) except as provided in paragraph (2)—

(i) restrict benefits for any hospital length of stay in connection with a mastectomy for the treatment of breast cancer to less than 48 hours, or

(ii) restrict benefits for any hospital length of stay in connection with a lymph node dissection for the treatment of breast cancer to less than 24 hours, or

(B) require that a provider obtain authorization from the plan or the issuer for prescribing any length of stay required under subparagraph (A) (without regard to paragraph (2)).

(2) EXCEPTION.—Paragraph (1)(A) shall not apply in connection with any group health plan or health insurance issuer in any case in which the decision to discharge the woman involved prior to the expiration of the minimum length of stay otherwise required under paragraph (1)(A) is made by the attending provider in consultation with the woman or in a case involving a partial mastectomy without lymph node dissection.

(b) PROHIBITIONS.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not—

(1) deny to a woman eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

(2) provide monetary payments or rebates to women to encourage such women to accept less than the minimum protections available under this section;

(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

(5) subject to subsection (c)(3), restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

(c) RULES OF CONSTRUCTION.—

(1) Nothing in this section shall be construed to require a woman who is a participant or beneficiary—

(A) to undergo a mastectomy or lymph node dissection in a hospital; or

(B) to stay in the hospital for a fixed period of time following a mastectomy or lymph node dissection.

(2) This section shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for hospital lengths of stay in connection with a mastectomy or lymph node dissection for the treatment of breast cancer.

(3) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with a mastectomy or lymph node dissection for the treatment of breast cancer under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsection (a) may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

(d) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(e) EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723(d)(1) of the Public Health Service Act) for a State that regulates such coverage that is described in any of the following subparagraphs:

(A) Such State law requires such coverage to provide for at least a 48-hour hospital

length of stay following a mastectomy performed for treatment of breast cancer and at least a 24-hour hospital length of stay following a lymph node dissection for treatment of breast cancer.

(B) Such State law requires, in connection with such coverage for surgical treatment of breast cancer, that the hospital length of stay for such care is left to the decision of (or required to be made by) the attending provider in consultation with the woman involved.

(2) CONSTRUCTION.—Section 2723(a)(1) of the Public Health Service Act and section 731(a)(1) of the Employee Retirement Income Security Act of 1974 shall not be construed as superseding a State law described in paragraph (1).

SEC. 153. STANDARDS RELATING TO BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY.

(a) REQUIREMENTS FOR RECONSTRUCTIVE BREAST SURGERY.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for breast surgery in connection with a mastectomy shall provide coverage for reconstructive breast surgery resulting from the mastectomy. Such coverage shall include coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased when reconstruction on the diseased breast is performed and coverage of prostheses and complications of mastectomy including lymphedema.

(2) RECONSTRUCTIVE BREAST SURGERY DEFINED.—In this section, the term ''reconstructive breast surgery'' means surgery performed as a result of a mastectomy to reestablish symmetry between two breasts, and includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

(3) MASTECTOMY DEFINED.—In this section, the term ''mastectomy'' means the surgical removal of all or part of a breast.

(b) PROHIBITIONS.—

(1) DENIAL OF COVERAGE BASED ON COSMETIC SURGERY.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not deny coverage described in subsection (a)(1) on the basis that the coverage is for cosmetic surgery.

(2) APPLICATION OF SIMILAR PROHIBITIONS.—Paragraphs (2) through (5) of section 152 shall apply under this section in the same manner as they apply with respect to section 152.

(c) RULES OF CONSTRUCTION.—

(1) Nothing in this section shall be construed to require a woman who is a participant or beneficiary to undergo reconstructive breast surgery.

(2) This section shall not apply with respect to any group health plan, or any group health insurance coverage offered by a health insurance issuer, which does not provide benefits for mastectomies.

(3) Nothing in this section shall be construed as preventing a group health plan or issuer from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for reconstructive breast surgery under the plan (or under health insurance coverage offered in connection with a group health plan), except that such coinsurance or other cost-sharing for any portion may not be greater than such coinsurance or cost-sharing that is otherwise applicable with respect to benefits for mastectomies.

(e) LEVEL AND TYPE OF REIMBURSEMENTS.—Nothing in this section shall be construed to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(f) EXCEPTION FOR HEALTH INSURANCE COVERAGE IN CERTAIN STATES.—

(1) IN GENERAL.—The requirements of this section shall not apply with respect to health insurance coverage if there is a State law (as defined in section 2723(d)(1) of the Public Health Service Act) for a State that regulates such coverage and that requires coverage of at least the coverage of reconstructive breast surgery otherwise required under this section.

(2) CONSTRUCTION.—Section 2723(a)(1) of the Public Health Service Act and section 731(a)(1) of the Employee Retirement Income Security Act of 1974 shall not be construed as superseding a State law described in paragraph (1).

Subtitle G—Definitions

SEC. 191. DEFINITIONS.

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

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

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

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

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

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

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

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

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

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

SEC. 192. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

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

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

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

(b) RULES OF CONSTRUCTION.—Except as provided in sections 152 and 153, nothing in this title shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

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

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

(2) STATE.—The term ''State'' includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

SEC. 193. REGULATIONS.

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

TITLE II—APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER PUBLIC HEALTH SERVICE ACT

SEC. 201. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

''SEC. 2706. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each group health plan shall comply with patient protection requirements under title I of the Patients' Bill of Rights Act of 1998, and each health insurance issuer shall comply with patient protection requirements under such title with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A group health plan shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to

the requirements referred to in subsection (a) and a health insurance issuer shall comply with such notice requirement as if such section applied to such issuer and such issuer were a group health plan.''.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2706)'' after ''requirements of such subparts''.

SEC. 202. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2751 the following new section:

''SEC. 2752. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Each health insurance issuer shall comply with patient protection requirements under title I of the Patients' Bill of Rights Act of 1998 with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 711(d) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of such title as if such section applied to such issuer and such issuer were a group health plan.''.

TITLE III—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 301. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new section:

''SEC. 713. PATIENT PROTECTION STANDARDS.

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of title I of the Patients' Bill of Rights Act of 1998 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

''(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting the following requirements of title I of the Patients' Bill of Rights Act of 1998 with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) Section 101 (relating to access to emergency care).

''(B) Section 102(a)(1) (relating to offering option to purchase point-of-service coverage), but only insofar as the plan is meeting such requirement through an agreement with the issuer to offer the option to purchase point-of-service coverage under such section.

''(C) Section 103 (relating to choice of providers).

''(D) Section 104 (relating to access to specialty care).

''(E) Section 105(a)(1) (relating to continuity in case of termination of provider contract) and section 105(a)(2) (relating to continuity in case of termination of issuer contract), but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(F) Section 106 (relating to coverage for individuals participating in approved clinical trials.)

''(G) Section 107 (relating to access to needed prescription drugs).

''(H) Section 108 (relating to adequacy of provider network).

''(I) Subtitle B (relating to quality assurance).

''(J) Section 143 (relating to additional rules regarding participation of health care professionals).

''(K) Section 152 (relating to standards relating to benefits for certain breast cancer treatment).

''(L) Section 153 (relating to standards relating to benefits for reconstructive breast surgery).

''(2) INFORMATION.—With respect to information required to be provided or made available under section 121, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide or make available the information (and is not liable for the issuer's failure to provide or make available the information), if the issuer is obligated to provide and make available (or provides and makes available) such information.

''(3) GRIEVANCE AND INTERNAL APPEALS.—With respect to the grievance system and internal appeals process required to be established under sections 131 and 132, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such system and process (and is not liable for the issuer's failure to provide for such system and process), if the issuer is obligated to provide for (and provides for) such system and process.

''(4) EXTERNAL APPEALS.—Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external appeal entity for the conduct of external appeal activities in accordance with section 133, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

''(5) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of any of the following sections, the group health plan shall not be liable for such violation unless the plan caused such violation:

''(A) Section 109 (relating to nondiscrimination in delivery of services).

''(B) Section 141 (relating to prohibition of interference with certain medical communications).

''(C) Section 142 (relating to prohibition against transfer of indemnification or improper incentive arrangements).

''(D) Section 144 (relating to prohibition on retaliation).

''(E) Section 151 (relating to promoting good medical practice).

''(6) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(7) APPLICATION TO CERTAIN PROHIBITIONS AGAINST RETALIATION.—With respect to compliance with the requirements of section 144(b)(1) of the Patients' Bill of Rights Act of 1998, for purposes of this subtitle the term 'group health plan' is deemed to include a reference to an institutional health care provider.

''(c) ENFORCEMENT OF CERTAIN REQUIREMENTS.—

''(1) COMPLAINTS.—Any protected health care professional who believes that the professional has been retaliated or discriminated against in violation of section 144(b)(1) of the Patients' Bill of Rights Act of 1998 may file with the Secretary a complaint within 180 days of the date of the alleged retaliation or discrimination.

''(2) INVESTIGATION.—The Secretary shall investigate such complaints and shall determine if a violation of such section has occurred and, if so, shall issue an order to ensure that the protected health care professional does not suffer any loss of position, pay, or benefits in relation to the plan, issuer, or provider involved, as a result of the violation found by the Secretary.

''(d) CONFORMING REGULATIONS.—The Secretary may issue regulations to coordinate the requirements on group health plans under this section with the requirements imposed under the other provisions of this title.''.

(b) SATISFACTION OF ERISA CLAIMS PROCEDURE REQUIREMENT.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting ''(a)'' after ''SEC. 503.'' and by adding at the end the following new subsection:

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subtitle D (and section 115) of title I of the Patients' Bill of Rights Act of 1998 in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 713''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 712 the following new item:

''Sec. 713. Patient protection standards.''.

(3) Section 502(b)(3) of such Act (29 U.S.C. 1132(b)(3)) is amended by inserting ''(other than section 144(b))'' after ''part 7''.

SEC. 302. ERISA PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS INVOLVING HEALTH INSURANCE POLICYHOLDERS.

(a) IN GENERAL.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by adding at the end the following subsection:

''(e) PREEMPTION NOT TO APPLY TO CERTAIN ACTIONS ARISING OUT OF PROVISION OF HEALTH BENEFITS.—

''(1) IN GENERAL.—Except as provided in this subsection, nothing in this title shall be construed to invalidate, impair, or supersede any cause of action brought by a plan participant or beneficiary (or the estate of a plan participant or beneficiary) under State law to recover damages resulting from personal injury or for wrongful death against any person—

''(A) in connection with the provision of insurance, administrative services, or medical services by such person to or for a group health plan (as defined in section 733), or

''(B) that arises out of the arrangement by such person for the provision of such insurance, administrative services, or medical services by other persons.

For purposes of this subsection, the term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

''(2) EXCEPTION FOR EMPLOYERS AND OTHER PLAN SPONSORS.—

''(A) IN GENERAL.—Subject to subparagraph (B), paragraph (1) does not authorize—

''(i) any cause of action against an employer or other plan sponsor maintaining the group health plan (or against an employee of such an employer or sponsor acting within the scope of employment), or

''(ii) a right of recovery or indemnity by a person against an employer or other plan sponsor (or such an employee) for damages assessed against the person pursuant to a cause of action under paragraph (1).

''(B) SPECIAL RULE.—Subparagraph (A) shall not preclude any cause of action described in paragraph (1) against an employer or other plan sponsor (or against an employee of such an employer or sponsor acting within the scope of employment) if—

''(i) such action is based on the employer's or other plan sponsor's (or employee's) exercise of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and

''(ii) the exercise by such employer or other plan sponsor (or employee) of such authority resulted in personal injury or wrongful death.

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed as permitting a cause of action under State law for the failure to provide an item or service which is not covered under the group health plan involved.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to acts and omissions occurring on or after the date of the enactment of this Act from which a cause of action arises.

TITLE IV—APPLICATION TO GROUP HEALTH PLANS UNDER THE INTERNAL REVENUE CODE OF 1986.

SEC. 401. AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.

Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (as amended by section 1531(a) of the Taxpayer Relief Act of 1997) is amended—

(1) in the table of sections, by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Standard relating to patient freedom of choice.''; 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 title I of the Patients' Bill of Rights Act of 1998 (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this section.''.

TITLE V—EFFECTIVE DATES; COORDINATION IN IMPLEMENTATION

SEC. 501. EFFECTIVE DATES.

(a) GROUP HEALTH COVERAGE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after October 1, 1999 (in this section referred to as the ''general effective date'').

(2) TREATMENT OF COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made by sections 201(a), 301, and 401 (and title I insofar as it relates to such sections) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) the general effective date.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this Act shall not be treated as a termination of such collective bargaining agreement.

(b) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The amendments made by section 202 shall apply with respect to individual health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after the general effective date.

SEC. 502. COORDINATION IN IMPLEMENTATION.

Section 104(1) of the Health Insurance Portability and Accountability Act of 1996 is amended by striking ''this subtitle (and the amendments made by this subtitle and section 401)'' and inserting ''the provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, the provisions of parts A and C of title XXVII of the Public Health Service Act, chapter 100 of the Internal Revenue Code of 1986, and title I of the Patients' Bill of Rights Act of 1998''.

TITLE VI—REVENUE PROVISIONS

SEC. 601. ESTATE TAX TECHNICAL CORRECTION.

(a) IN GENERAL.—Paragraph (2) of section 2001(c) of the Internal Revenue Code of 1986 is amended by striking ''$10,000,000'' and all that follows and inserting ''$10,000,000. The amount of the increase under the preceding sentence shall not exceed the sum of the applicable credit amount under section 2010(c) (determined without regard to section 2057(a)(3)) and $359,200.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the amendments made by section 501 of the Taxpayer Relief Act of 1997.

SEC. 602. TREATMENT OF CERTAIN DEDUCTIBLE LIQUIDATING DISTRIBUTIONS OF REGULATED INVESTMENT COMPANIES AND REAL ESTATE INVESTMENT TRUSTS.

(a) IN GENERAL.—Section 332 of the Internal Revenue Code of 1986 (relating to complete liquidations of subsidiaries) is amended by adding at the end the following new subsection:

''(c) DEDUCTIBLE LIQUIDATING DISTRIBUTIONS OF REGULATED INVESTMENT COMPANIES AND REAL ESTATE INVESTMENT TRUSTS.—If a corporation receives a distribution from a regulated investment company or a real estate investment trust which is considered under subsection (b) as being in complete liquidation of such company or trust, then, notwithstanding any other provision of this chapter, such corporation shall recognize and treat as a dividend from such company or trust an amount equal to the deduction for dividends paid allowable to such company or trust by reason of such distribution.''.

(b) CONFORMING AMENDMENTS.—

(1) The material preceding paragraph (1) of section 332(b) of such Code is amended by striking ''subsection (a)'' and inserting ''this section''.

(2) Paragraph (1) of section 334(b) of such Code is amended by striking ''section 332(a)'' and inserting ''section 332''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after May 21, 1998.

The SPEAKER pro tempore. Pursuant to House Resolution 509, the gentleman from Michigan (Mr. DINGELL) and the gentleman from Illinois (Mr. HASTERT) each will control 30 minutes.

The Chair recognizes the gentleman from Michigan (Mr. DINGELL).

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the gentleman from Iowa (Mr. GANSKE), my distinguished friend, for purposes of offering the amendment.

Mr. GANSKE. Mr. Speaker, I rise in support of the Ganske-Dingell substitute. This substitute is supported by Consumers Union, other consumer groups, about 170 health groups, both consumer groups and provider groups. It is supported by the AARP, it is supported by the AMA, the Nurses Association, and by the AFL–CIO. It has broad, widespread support, for a good reason.

Let me specifically address my friend LINDSEY GRAHAM's comments about the underlying Republican bill and how it relates to the substitute on liability. My friend LINDSEY GRAHAM is trying to improve the GOP bill.

Consider the family of Joyce Chiang. Her complaints of severe abdominal pain and requests for a referral to a specialist went unheeded. The delay prevented the timely discovery of a colon cancer that might have been cured. Instead, by the time she got the additional tests she requested, the cancer had perforated her bowel and no amount of surgery could save her.

Under the Hastert bill, Joyce Chiang's family could only collect $500 for every day the care was denied. But I would say that is hardly an effective remedy or deterrent, when it can cost health plans more to provide the needed care than it would potentially cost them in a subsequent legal action.

Mr. Speaker, I am not interested in granting tobacco companies legal protections for their conduct; and I cannot see how it serves our constituents to allow health plans who are making life-and-death decisions to hide from their consequences.

Republicans believe in personal responsibility, and this immunity that is preserved in the Hastert bill flies in the face of that. Health plans should be treated like any other industry and held accountable for their negligent actions.

Furthermore, the GOP bill does not get at a fundamental underlying problem, and that is that the HMOs can define what is medically necessary. Before our Committee on Commerce we had a medical reviewer describe how she had made decisions that resulted in the loss of life because she could manipulate the way the HMO defined ''medically necessary.'' Under the Ganske-Dingell bill, we address that problem. Their bill does not.

I strongly urge my Republican colleagues to vote for the best bill, the one that addresses the smart bomb of HMOs, the issue of what is defined as ''medically necessary.''

Mr. HASTERT. Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. WELDON).

Mr. WELDON of Florida. Mr. Speaker, I thank the gentleman for yielding.

I am a practicing physician. And I do not plan on staying in this body. I plan on returning in a few short years to my practice. And I think it is a wonderful thing that we are having this debate today. We both want to do what we can to restore the doctor-patient relationship. We both want to do what we can to return quality as number one in health care in the United States. They have their plan. We have ours.

Now, I believe that there is an important feature in our bill that makes our bill the better bill over their bill. But I want to address a few points made by my colleague the gentleman from Iowa (Mr. GANSKE).

I served on the task force that produced this bill, and one of the most important things that I was going after was timely access to specialists. And contrary to the claims that were made by him and the claims by others, we have important language in our bill that will require people in managed care entities to have timely access to specialists.

Here is the difference between their bill and our bill, and I will tell my colleagues about it. I was on a radio talk show last week where a lady called in and she was saying some bad things about her HMO and she said, ''The other HMO I was in was just as bad. I had switched.'' I said, ''What do you mean, you switched from one HMO to another HMO? Are you in the FEHBP plan?'' And she said, ''Yes.'' And I said, ''Well, you know, I am in that, too; and there are some better plans that you could select. Why didn't you select one of those better coverage plans?'' And do you know what she said to me? ''Well, we cannot afford it. That is why I am in an HMO.''

Now, we are to be led to believe by our colleagues on the other side of the aisle that their bill which is going to place all these government mandates is not going to drive up costs for that lady?

Let me tell my colleagues something. Every month in my practice a clerk from my billing office brought a stack of charts of working people who were not able to pay their bills and I did what thousands of other physicians all across America do; I wrote off those bills, thousands of dollars every year. Why? Because those people had no health insurance.

Now we are led to believe by these folks that they here in Washington are going to make all these HMOs do all these wonderful things that are mandated in their bill and it is not going to drive up costs, it is not going to increase the number of uninsured?

Let me tell my colleagues something. We have a good bill here that is going to work very hard to restore quality and it is not going to drive up costs. Indeed, we believe the provisions in this bill, which allow small employers to pool, which has malpractice reform, is actually going to drive down costs. It is going to allow more people to get insurance.

We have, in my opinion, the better bill. And I can say that as somebody who is going to go back in a few short years to be working in the system.

PERMISSION TO FILE CONFERENCE REPORT ON H.R. 4059, MILITARY CONSTRUCTION APPROPRIATIONS ACT, 1999

Mr. LIVINGSTON. Mr. Speaker, I ask unanimous consent that the managers on the part of the House may have until midnight tonight, Friday, July 24, 1998, to file a conference report on the bill (H.R. 4059) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 1999, and for other purposes.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

PERMISSION FOR COMMITTEE ON APPROPRIATIONS TO FILE PRIVILEGED REPORT ON DEPARTMENT OF TRANSPORTATION AND RELATED AGENCIES APPROPRIATION BILL, 1999

Mr. LIVINGSTON. Mr. Speaker, I ask unanimous consent that the Committee on Appropriations may have until midnight tonight, July 24, 1998, to file a privileged report on a bill making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 1999, and for other purposes.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

The SPEAKER pro tempore. Pursuant to the provisions of clause 8 of rule XXI, the Chair reserves all points of order on the bill.

□ 1215

PATIENT PROTECTION ACT OF 1998

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. LATOURETTE).

(Mr. LATOURETTE asked and was given permission to revise and extend his remarks.)

Mr. LATOURETTE. Mr. Speaker, I want to thank the dean of the House the gentleman from Michigan (Mr. DINGELL) and my classmate the gentleman from Iowa (Mr. GANSKE) for the opportunity to address my support for the Patient Bill of Rights. I also want to thank the gentleman from Illinois (Mr. HASTERT) for doing what he thinks is the right thing.

Obviously there is a slight concern when you endorse a proposal that is labeled the Democratic bill when you are a Republican and vice versa. While I am saddened that this issue has a partisan spin to it, today I am driven to support the initiative that I believe gives the greatest protection and possibility of care for the people that I represent. That bill is Ganske-Dingell.

I want to direct my remarks to the liability provisions, however, relating to employer-provided health care plans. Being a lawyer, I like that profession as well as any other, but I am sensitive to the concerns of small business owners, many of whom administer their own plans, about the liability problem. Some of the calls our office has received have been driven from K Street, but many others have come from business owners who are operating on small margins and who want to do the right thing by their employees.

Last night, therefore, I read and I reread page 66 of the Ganske bill concerning liability, and it only reinforced my belief that employers have been needlessly frightened, similar, I am sad to say, to the shameful way seniors were frightened during the Medicare debates.

The only time that an employer is exposed to liability is when the employer makes discretionary medical decisions. Not a doctor, not a hospital, not a nurse, not an HMO. I cannot even think of one situation where an employer would want to make a medical decision, good, bad or otherwise.

Nevertheless, I would ask the sponsors of the bill to tighten the language of the employers' exception in conference. The one thing that I do know about my profession is that they have a unique ability to take words that seem to say one thing and then get a judge somewhere, usually an appointed one, to interpret them in another.

I urge passage of the substitute and would ask both parties to work diligently in conference to create a product that represents the best of both bills. I would ask that we not be about the business of creating campaign commercials here on the floor today but we be about the business of helping Americans of all ages receive the care that they need.

Mr. HASTERT. Mr. Speaker, I yield 1 minute to the gentleman from Arkansas (Mr. DICKEY).

Mr. DICKEY. Mr. Speaker, I come here as a former small business owner and as a lawyer. When I first looked at this situation, I looked at it from the doctor's standpoint and I saw a tremendous need, dire circumstances that doctors are facing, even to the extent that we were going to lose doctors presently existing and applicants were not going to apply. And I rushed in with my philosophical approach to this and said, ''We've got to help the doctors at all costs.'' What I found out was that ''at all costs'' meant the cure was going to be worse than the disease, that the small business owners were going to be killed by being put into courtrooms without any type of protection and in greater numbers.

So what I wanted to do was to try to look at the patients and say we need to

get them in the treatment room and not in the courtroom. I have looked carefully at this and I can see that the Hastert bill is a perfect solution for this, or maybe not perfect but it is a perfect start. It is something we need to look at. If we do not do this, we are going to have patients who will not have choices because they won't have doctors, and that is serious.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Mrs. CAPPS).

(Mrs. Capps asked and was given permission to revise and extend her remarks.)

Mrs. CAPPS. Mr. Speaker, on behalf of the patients of the central coast of California and all across America, I rise to say that enough is enough. I have been an elected official for only four months but I have been a nurse for over 30 years. As a nurse I know firsthand the importance of accessible, quality, patient-centered care.

We must pass a bill which is more than a band-aid, which will ensure patients' rights and consumer protection against the abuses of HMOs. For common sense, comprehensive managed care reform, we must guarantee that critical decisions will remain in the hands of doctors and nurses, not insurance companies. We must guarantee access to specialists, so that people can really choose their own doctors. We must guarantee an end to financial incentives to limit medical care. We must guarantee emergency room care so people are not turned away from the hospital door. We must guarantee tough enforcement to hold insurance company bureaucrats responsible for their cost-cutting actions.

The American people deserve a bill with these guarantees, not a Republican bill, not a Democrat bill but a people's bill. The Ganske-Dingell proposal protects patients with the force of law. This bipartisan bill will allow people to choose their own doctor, end oppressive gag rules so patients can have access to all critical treatment options, and perhaps most importantly give patients legal recourse when insurance companies deny important medical coverage.

Basic patients' rights can mean the difference between life and death. If patients can sue their doctors for poor care, they should be able to sue the insurance bureaucrats who pull the strings and are behind these cost-cutting decisions.

As one of three nurses in Congress, it is my duty to speak out. The leadership bill has huge loopholes which do nothing to prohibit HMOs from denying care. Our health care system needs serious medicine, not a political placebo.

Mr. Speaker, we still have time to act. With 32 days left in Congress, if we do nothing else, we must guarantee real patients' rights for the American people. Let us pass comprehensive, bipartisan managed care reform today.

Mr. HASTERT. Mr. Speaker, I yield 3 minutes to the gentleman from Georgia (Mr. NORWOOD) who worked on the task force and certainly was the creator of a lot of the thoughtful positions that are included in our plan.

Mr. NORWOOD. Mr. Speaker, it seems to me that it has been years in my life till we get to this day. I have wanted this to happen a long time. I am saddened deeply by what I hear and see happening in this room today. I had hoped that all of us would recognize the importance of protecting human beings' lives, the importance of correcting the malfunctioned ERISA laws of 1974 and could come together and actually offer good patient protections that the people of this country so deserve. But I hear over and over again demagoguery, politicization, misrepresentation, total untruths, just simply getting it wrong and not telling it right, and I am saddened by that.

The Dingell-Ganske bill has good patient protections in it. I do not question that. I know that it does. It is imperfect, however. The Republican bill has excellent patient protections in it, though it, too, is also imperfect.

I want to speak to my friend from Texas who says, oh, all of a sudden the Democrats have realized we need to protect patients. We bring this up today because we are Democrats.

I would remind my friend from Texas that you are the same group that tried to put everybody in the country in managed care 4 years ago, with no thought to any particular patient protections. I have for at least two terms of Congress as a Republican tried to protect patients, and I am delighted that you have joined with us at this late date.

Mr. Speaker, I have spent the last year and a half calling for support to end the ERISA preemption of State medical malpractice law. I pled with the President to add ERISA liability to his advisory committee report in November 1997. He did not. I requested that the President call for ERISA liability reform in his State of the Union address in January of 1998. He did not. I argued day after day with the Republican Working Group to add ERISA liability reform to this bill. They would not. There is a reason for that. It is a big enough reason that we can end up this year with no law, no patient protections over this subject. As much as I am for it, I am for a law this year that will get as many patient protections as we possibly can meet. The task force met me more than halfway with a new proposal that I frankly like very much. It is about liability and it is about suing an HMO. If I could only have one of the two liability provisions, I believe today that I would take our own. I ask you to stop this politicization of this bill and let us work together and pass patient protections.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Speaker, I rise today in strong support of the Ganske-Dingell Patients' Bill of Rights, and in equally strong opposition to the Hastert bill. Nothing in the Republican bill would have protected the rights of young Brice Randa from Colorado. Here is a picture of the Randa family, Allen and Jodi with their children Taylor on the left and Brice on the right. Brice died just two months after this picture was taken.

Brice was diagnosed with Lissencephaly, a terrible disease that made Brice's short life limited to breathing tubes, stomach wraps and motor seizures, a disease which eventually killed him. Although it was inevitable, Brice's death is heartbreaking for more than one reason. The tragedy lies in the fact that this family spent the few precious months they had with their son negotiating with the HMOs instead of taking care of their precious little boy. The 16 months the Randas had with Brice were consumed with lawyers filing paperwork and appealing decisions made by their HMO.

The Randas' doctor wrote the HMO begging, ''The family is overwhelmed. We petition for 4 hours per day extra assistance,'' and the HMO denied this.

Under the Republican bill, a health plan can define medical necessity any way it wants, giving families like the Randas no protection from insurance company bureaucrats deciding what medical care is appropriate. Moreover, under the GOP's rules, if the Randas did want an external review of the decision denying the 4 hours a day of care for Brice, they would have to pony up $100 from their pocket just to have the case heard by somebody who would have to follow guidelines set by the very HMO that denied the care in the first place. And if Brice had needed emergency care, the HMO would have had 72 hours to consider an appeal of an emergency care decision. Frankly, this GOP scheme is worse than the status quo. It stabs at the heart of what the debate over HMO reform is really about. On the other hand, the Ganske-Dingell bill ensures that the medical profession will define medically necessary care.

Vote for our alternative. Vote ''no'' on the Hastert bill.

Mr. HASTERT. Mr. Speaker, I yield myself 10 seconds. I just want to remind the gentlewoman from Colorado that if it is emergency care, our patients are in the emergency room immediately, not 72 hours. She is wrong and she misrepresented the facts.

Mr. Speaker, I yield 1 minute to the gentleman from Arizona (Mr. HAYWORTH).

Mr. HAYWORTH. I thank my colleague from Illinois and I thank the gentlewoman from Colorado, because she unintentionally demonstrates why we should oppose the Dingell bill and support the reasonable, rational, compassionate Patient Protection Act.

You see, Mr. Speaker, we are faced with a choice today. Do we support a true patient bill of rights, or do we support a lawyer's right to bill? I rise with

colleagues from both sides of the aisle who say they do not want decisions made by bureaucrats, whether they are Washington bureaucrats or insurance company bureaucrats. Health care decisions should be made by physicians and health care professionals consulting with their patients. That is the element that we preserve, uphold and amplify in the Patient Protection Act. Sadly, endless litigation and lawsuit after lawsuit is provided for in the Dingell substitute. That is what we have to remember; true compassion, not courtroom drama.

□ 1230

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Wisconsin (Mr. KLECZKA).

Mr. KLECZKA. Mr. Speaker, I rise today in opposition to H.R. 2450, what the Republicans have called the Patient Protection Act, but is better termed the Republican Patient Election Year Posturing Act.

H.R. 4250 is full of hollow promises and empty protections. Republicans call this a managed care reform bill, but in reality it is far from it.

For starters, the Election Year Posturing Act does little to address the serious problems of our current health delivery system and does a lot to maintain the status quo.

Let me detail what the Republican bill does not provide. It does not put medical decisions back in the hands of doctors and, instead, keeps it in the hands of insurance company accountants and their executives, people who we call the bean counters.

It does not give patients access to specialty care where they need it. We heard from our Republican colleague the gentleman from Florida (Mr. WELDON), a doctor, previously indicating he was on a talk show, and a woman indicated she was in the same Federal health plan as all of us. He asked, ''why did you not choose a different one to get the doctor of your choice?'' She said to him, and hopefully I am quoting this right, she could not afford it.

So the bottom line is we cannot afford it. We get substandard care. I think that is wrong on the part of the Republicans. It does not give patients access to specialty care. It does not provide women undergoing a mastectomy from being pushed out of the hospitals just hours after surgery and does not require insurers to cover reconstruction surgery after mastectomy. It does not allow a woman to choose a gynecologist or other specialist as a primary care doctor.

Let me also indicate that we heard from a trial attorney Republican supporting the Republican bill. He indicated that if one is misdiagnosed and does not get subsequent needed treatment, we are going to give them $500 a day. Oh, well, we will give you $1,000 a day.

But if that is one's mother, and that misdiagnosis or lack of coverage and treatment, like a bone marrow transplant, or needed chemotherapy, is denied, it might be to the insurance company's advantage to give them the $1,000 a day versus having the right to sue the provider and the health care bean counter.

Mr. Speaker, I ask the Members to support the Dingell-Ganske bill.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentleman from South Carolina (Mr. GRAHAM).

Mr. GRAHAM. Mr. Speaker, I thank the gentleman for yielding to me.

For any lawyer out there, listen up close. The $500 a day is to ensure prompt payment. The bill ensures treatment. That is the whole point of this bill. If one has a medically urgent situation, one can go to court within minutes of being said no to and get a temporary restraining order ordering the treatment to be given.

Also, the physician and hospital can provide one the treatment and subrogate to one's interest and have an external review of the HMO decision within 6 days. That is when the $500 per day kicks in, to get them to pay.

During the initial waiting period, one is getting the treatment. That is the point. The $500 a day is to ensure payment. Under our bill, one gets treatment from day one, from minute one, because one has avenues to compel them to treat them.

But what about the $500 claim? As a lawyer, one comes in to my office with a $500 claim, no matter how meritorious it is, I am going to say that is very nice, but I have got to make a living and feed my family. I cannot chase $500.

Under the Democratic bill, if we have a small claim, we are not entitled to external review until the significant threshold is passed. Under the Republican bill, if they nickel and dime us for $100, $200, $500, and that is what happens every day. They nickel and dime us out there. We allow people to go to external appeal no matter how small the claim is if they put up from $25 to $100. The filing fee in South Carolina for tort actions is $35.

So they get an external appeals process and a small claim, then the $500 a day kicks in plus attorneys' fees, plus the benefit. I will take the case then, because I can get paid, and there is a $500 clock running for the small claims.

So HMOs will not nickel and dime people. That is where the abuse is at. And my colleagues do nothing about that. This really makes them honest. We get the treatment up front. The penalties are significant. We get people what they need, which is health care, not a jury award 4 years later when they are dead.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Speaker, I rise in support of the Ganske-Dingell bill and in opposition of the Republican bill.

For the last 2 years, I have been working on legislation to end the practice of drive-through mastectomies. The bill simply ensures that breast cancer patients are allowed 48 hours in the hospital to recover from this physically and emotionally devastating surgery. It does not seem like much to ask, and yet the Republican leadership has refused to schedule hearings on this important legislation.

The Democratic Patients' Bill of Rights ends the practice of drive-through mastectomies. The House Republican leadership bill ignores this problem. What is worse, their legislation will actually strip away existing State protections.

My State of Connecticut has led the fight to end outpatient mastectomies. The Connecticut legislature has already acted to outlaw this outrageous practice. But the Republican bill would repeal those hard-fought patient protections.

The Republican bill will not put medical decisions back in the hands of doctors and patients. It makes current problems worse. It eliminates consumer safeguards. In the case of breast cancer patients, this bill is a slap in the face.

Mr. HASTERT. Mr. Speaker, I yield 1 minute to the gentleman from Nevada (Mr. ENSIGN).

(Mr. ENSIGN asked and was given permission to revise and extend his remarks.)

Mr. ENSIGN. Mr. Speaker, I rise in support of the Republican bill today for several reasons. First of all, we have to listen to the other side. These are the people who are now saying that they want the doctors to choose their health care and the type of choices in those health care plans. But these are the same people who 4 years ago or 5 years ago were saying, ''Do you know what? We want everybody to be in nationalized health care, and we want bureaucrats to make those decisions.'' Look beneath the surface.

The Republican plan contains medical malpractice and medical savings accounts, two things that I strongly support. In the final bill, they probably will not be able to be included because the President has said he would veto the bill over those two provisions, unfortunately, because they would help bring costs down. But we could still have good patient protections in this bill if it is enacted even if we have to drop those provisions.

In the State of Nevada, we got together, Republicans and Democrats alike, and enacted patient protections similar to what are in the Patients' Bill of Rights that we have on the floor today. This was authored, by the way, by a Nevada Democrat State legislator. We ought to do the same thing here. Put common sense together; put party politics aside.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from Connecticut (Mrs. KENNELLY).

Mrs. KENNELLY of Connecticut. Mr. Speaker, the 161 million Americans in

managed care today deserve to know that their health care comes first.

For 18 years, I have represented Hartford, Connecticut, the insurance capital of the world. So I know how managed care came into being. Health insurance premiums were rising at double-digit rates, 17 percent in 1988, 21 percent the following year, 17 percent again in 1990.

The industry responded to rein in the costs, and it worked. But it so often happens in reform, once a balance is reached, some people do not know when to stop. So now profits became the prize.

Yes, we have stable prices, but they have come at a terrible cost. That is what we are addressing today, the cost of our confidence that we will get the health care that we need, that we deserve, and that we pay for.

Specialist treatment, continuity of care, emergency room treatments are not options. They are not frills, as some managed care companies seem to believe. When patients are denied adequate care by arbitrary decision-makers, they must have recourse.

Mr. Speaker, we must put patients first again in this bill. H.R. 3605 offers real relief at modest cost, and I urge my colleagues to do this today.

Mr. HASTERT. Mr. Speaker, I yield 1 minute to the gentlewoman from Kentucky (Mrs. NORTHUP).

Mrs. NORTHUP. Mr. Speaker, we all know that, in this fast-emerging change in health care that there have been abuses by HMOs, and we are proud to be here today to deal with those and to address those and make sure that there is the important level of care that every American deserves. We are going to deal with that today.

But we should not let this be an excuse for huge new Federal controls of the delivery of health care. That is what people that believe in a big bureaucracy dealing with health care support. We should not also make this an excuse to give the trial attorneys a huge new cut of our medical premiums. Medical money needs to go to medical care and not to trial attorneys.

I am proud that I am not on the trial attorneys' side and not on their team. It is no wonder that the team that is on their side is supporting this substitute here today.

The SPEAKER pro tempore (Mr. FOLEY). The gentleman from Michigan (Mr. DINGELL) has 16½ minutes remaining. The gentleman from Illinois (Mr. HASTERT) has 17¾ minutes remaining.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Rhode Island (Mr. KENNEDY).

Mr. KENNEDY of Rhode Island. Mr. Speaker, today I stand on behalf of Kathryn Carberry in my State of Rhode Island. She was released too quickly from the hospital because her insurance company denied her treatment for a breast operation that she had and continued treatment for that.

I also stand on behalf of Deborah Kushner's little boy who was nearly killed because her HMO denied treatment in an emergency room.

The Republican leadership have refused any committee debate with full and free testimony because they are afraid of these stories. Now they come up with a bill that is a product of the HMO industry itself.

We have waited for managed care reform, so why should we settle for the HMO's own plan. This bill leaves out so many crucial provisions, it is almost laughable. Where is the provision against drive-through mastectomies that could have saved Ms. Carberry's life. It is not in there. Where is the prudent layperson for Mrs. Kushner's son? It is not in there. Where is the provision to hold accountable these HMOs? It is not in there.

Every other product in this country can be held liable but managed care organizations. It is time we put a stop to managed care organizations who are practicing medicine without a medical license.

Mr. HASTERT. Mr. Speaker, I yield myself 5 seconds. I would just like to recommend to the gentleman from Rhode Island that he read the right bill.

Mr. Speaker, I yield 1 minute to the gentleman from North Carolina (Mr. BALLENGER).

Mr. BALLENGER. Mr. Speaker, I support the Patient Protection Act. While the bill is not perfect, it is an important step in ensuring access to health care insurance for many people who are currently without it.

As a small business officer of a company which self-insures its 200 employees, the unlimited liability of the Dingell bill is frightening. We insure all of our employees currently, but if big government Dingell bill were to become law, we would be forced to give our employees the money and let them buy their own insurance at, obviously, a higher cost. Many businesses would have to do the same.

The Dingell bill encourages patients to sue after a denial of coverage occurs rather than bringing a quick appeals process that would help the patient get coverage for care in a timely fashion.

Also, the Congressional Budget Office has estimated that the Dingell bill will increase the cost of health care and not make it more affordable. On behalf of the American people who need affordable care, oppose this substitute.

In the United States today, there are more than 42 million Americans without health insurance—many of whom are employed, or have a family member employed, by a small business that cannot afford to offer health care coverage for its employees.

The Patient Protection Act addresses the lack of coverage of these individuals in several ways, including the creation of association health plans which will be governed by uniform standards. These plans would allow small businesses, trade associations, labor unions and professional associations to pool together to obtain the same economies of scale, purchasing clout and administrative efficiencies, that employees of large employers benefit from. Association health plans will have the freedom and flexibility to design more affordable benefit options. This will allow small businesses to offer their workers access to the same benefit choices regardless of where they live. At the same time, these plans must meet strict new solvency standards to protect patients' interests and ensure that their benefits are paid.

I want to mention just very briefly that I appreciate that authors of this bill attempt to deal with the issue of confidentiality of medical information. It's a complicated issue, and one that has to be dealt with carefully. I do have some concerns with what is in the bill, in terms of its potential risk to employers and the lack of clarity, particularly with regard to two areas in my committee's jurisdiction, workers compensation and occupational safety and health. I hope that these are issues that we can address during the conference to ensure that the medical confidentiality provisions work well, and do not inadvertently create problems in these areas.

Accessible, affordable, quality health care is very important to all Americans. I have been contacted by many constituents who are demanding that we act in their interest. So, with their letters and concerns in mind, I support this important piece of legislation and urge my colleagues to do the same.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Texas (Mr. GREEN).

(Mr. GREEN asked and was given permission to revise and extend his remarks.)

Mr. GREEN. Mr. Speaker, for many months, a lot of Members have been working for this debate today. What is frustrating is the debate we have now.

I rise in support of the Dingell-Ganske amendment. But instead of a real debate and a committee process we have, the Republican leadership is forcing this weak fig leaf bill through which will do little to give the American people what they really need for their health insurance.

In fact, it will hurt State laws now in effect. In my home State of Texas, this Republican bill would override State law on mammogram screening, Alzheimer's treatment, and prostate cancer screening, and many more.

On page 187 of their bill, because some of us had a chance to skim their bill that was released last night, line 19 exempts these State protections. So maybe they ought to read their bill before they defend it.

I think it is ironic they talk about this being a trial lawyer bill, Mr. Speaker, and I ask unanimous consent to place in the RECORD a letter from the American Medical Association, who typically does not support the trial lawyers. It was sent to me yesterday, talking about the reasons that the Republican bill is so bad and the Dingell-Ganske amendment is so good.

The letter referred to is as follows:

AMERICAN MEDICAL ASSOCIATION,
Chicago, IL, July 23, 1998.

Hon. GENE GREEN,
House of Representatives, Rayburn House Office Building, Washington, DC.

DEAR CONGRESSMAN GREEN: The American Medical Association (AMA) recognizes that

changes may be offered to H.R. 4250, the House Republican ''Patient Protection Act of 1998,'' when it is brought to the House floor, to begin to address some of the serious concerns with the legislation as introduced. We urge Members of Congress to take the time to fully explore whether any such amendments correct the problems outlined below. As you may know the AMA has carefully reviewed and lent its full support to H.R. 3605, the ''Patients' Bill of Rights Act of 1998.'' We believe that H.R. 3605 provides comprehensive and meaningful patient protections that should be enacted before Congress adjourns this fall.

On behalf of the 300,000 physician members of the AMA and the millions of patients we serve, we strongly urge you to oppose H.R. 4250, as introduced, and to vote in favor of the Ganske-Dingell substitute (text of H.R. 3605). In our view, only H.R. 3605 would provide meaningful patient protections to address existing abuses in managed health care.

There are ten reasons to vote against H.R. 4250 and to vote for H.R. 3605.

Reason #10: ''The Devil is in the Details''—Here are the facts.

H.R. 4250 claims to offer ''similar'' protections to those extended in H.R. 3605, but the legislative language of H.R. 4250, at nearly every turn, clearly favors health plans and insurance companies at the expense of patients. These problems are much more than just ''technical drafting matters.'' In fact, Members of Congress have not had time to fully understand critical differences in the two bills since last Friday's introduction of the House Republican bill. By contrast, H.R. 3605 was drafted and introduced earlier this year, with ample time for public examination; its provisions ensure that patients would receive medically necessary covered services. H.R. 4250 would continue to allow insurance companies and health plans to put their financial bottom-line ahead of patient care.

Reason #9: H.R. 4250 would allow health insurance companies to decide what is medically necessary; H.R. 3605 would restore physician medical decision-making.

By retaining the power to define what is and what is not medically necessary, under H.R. 4250, health plans—not physicians—would continue to decide all patient health care decisions, Linda Peeno, MD, a former HMO medical director, described this retained control ''as a health plan's smart bomb capability'' in testimony before the House Commerce Committee. Consequently, the external appeals process proposed by H.R. 4250 would be of little or no value if the health plan were always allowed to define what is medically necessary or appropriate. By contrast, H.R. 3605, promotes good medical practice by specifically prohibiting health plans from practicing medicine by substituting their decisions for the patient-specific medical judgments of the treating physician.

Reason #8: The internal and external review process in H.R. 4250 does not require health plans to use physicians with the appropriate medical specialty training to review treatment denials. H.R. 3605 is clear that only ''clinical peers''—physicians with similar specialty training will review other physicians' medical decisions.

As an example, only cancer specialists should review cancer treatment. Reviewers must have the right specialty training to decide life and death issues. Only H.R. 3605 would provide this critical patient protection.

Reason #7: H.R. 4250 would require patients to pay for the privilege of an external review of treatment denial; H.R. 3605 imposes no such fees on patients seeking to exercise their rights.

Patients should not have to pay to have a treatment denial reviewed.

Reason #6: H.R. 4250 does not contain several key physician choice provisions that are included in H.R. 3605.

H.R. 4250 does not include a provision found in H.R. 3605 that would allow a patient in the midst of serious illness or pregnancy to continue a relationship with a physician who leaves or is forced to leave a health plan network. The House Republican bill also does not provide patients with critical ongoing access to specialists for chronic conditions (such as asthma, diabetes, etc). H.R. 4250 also does not require plans to disclose to prospective enrollees the adequacy of the physician network to serve a given patient population. H.R. 2605 provides both access to necessary specialty care and disclosure of the plan's physician mix to patients.

Reason #5: H. R. 4250 would provide a huge loophole for plans to circumvent the point of service provisions.

Under the terms of H.R. 4250, employers would not have to offer employees point of service coverage if they could prove that the plan's premiums would increase by 1%. The AMA has always said that patients may choose to bear reasonable additional costs to obtain a point of service option that would ensure greater choice of physicians. This opt-out provision of H.R. 4250 could effectively ''gut'' the concept of a point of service option for many plan participants.

Reason #4: H.R. 4250 would delay the effective date of patient protections for up to two years after the date of enactment. H.R. 3605 would provide for nearly immediate implementation of most patient protections.

The evidence is overwhelming that patients need and are demanding protections now. The delayed effective date in H.R. 4250 is an opportunity for more legislative mischief by health plans seeking passage of ''gutting'' amendments before patient protections are actually offered to patients. H.R. 3605 would generally extend all patient protections soon after enactment.

Reason #3: H.R. 4250 does not adequately protect the broadest possible range of ''medical communications,'' nor would it ensure all necessary emergency care. It even cuts back on the Balanced Budget Act's antigag clause/practices and prudent layperson provisions that cover Medicare patients.

On anti-gag practices, H.R. 4250 does not include the words ''otherwise restrict'' medical communications. The omission of these key words would allow health plans to continue to gag physicians. The ''prudent layperson'' provision for emergency services in H.R. 4250 does not include ''severe pain'' in the definition of what a reasonable person would think requires immediate treatment.

Reason #2: H.R. 4250 creates a new federal preemption of state patient protections laws for association health plans and would override many of the patient protections laws already enacted by some 43 states.

Association health plans would be exempt from state patient protection requirements. H.R. 4250 also lacks express language recognizing the authority of state legislators to regulate the health care delivery practices of such entities for state residents.

Reason #1: H.R. 4250 does not hold health plans properly accountable for making medical treatment decisions that result in patient injury or death.

The managed care liability issue is about basic fairness and holding health plans accountable for their conduct. No other industry in America enjoys the special legal protections currently extended to health plans. Members of Congress have spoken out against special legal protections for tobacco companies. Why should health plans continue to be given special liability protections? The AMA continues to lobby for tort reforms, but we have never advocated that patients should be denied adequate compensation for true medical negligence. The damages and penalties in H.R. 4250 fall far short of providing patients with proper compensation for preventable injuries and death.

Again, we urge you to vote for a House floor procedure rule that will allow a vote on H.R. 3605, and to vote for passage of H.R. 3605.

Respectfully,

E. RATCLIFFE ANDERSON, JR., MD.

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PARLIAMENTARY INQUIRY

Mr. DINGELL. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore (Mr. FOLEY). The gentleman will state it.

Mr. DINGELL. Mr. Speaker, who has the right to close debate on this bill?

The SPEAKER. As stated on page 567 of the House Rules and Manual, the Chair will assume that the manager of a measure is representing the committee of jurisdiction, even where the measure called up is unreported.

House Resolution 509 specifically named Mr. HASTERT as the manager of this bill; Mr. HASTERT called up the measure; and Mr. HASTERT is a member of the committee having primary jurisdiction over the bill. As such, the gentleman from Illinois has the right to close.

Mr. HASTERT. Mr. Speaker, I yield three minutes to the gentleman from California (Mr. THOMAS), Chairman of the Subcommittee on Health Care of the Committee on Ways and Means.

(Mr. THOMAS asked and was given permission to revise and extend his remarks.)

Mr. THOMAS. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, one of the things we have to make sure we do not do is revise history. I think it might be useful just to remember where the prudent layperson language in the Republican provision and in the Democrat provision came from. It came from the changes that were made in the Medicare program.

I think when you examine the gag rule provision, it is in the Democratic bill, it is in the Republican bill, it came from the Medicare revisions. If you recall, I said, prior to the election, the Democrats were accusing the Republicans of trying to destroy Medicare. After the election we sat down and put together a prudent package to preserve and protect Medicare. We included a number of provisions that were applicable only to Medicare because it was a bill dealing with Medicare. That was in 1997.

We then began in the Subcommittee on Health a series of hearings about the problems that were out in the current marketplace because of the distortion of the rapid movement to managed care. We began examining the Medicare changes to find what we could include in the package.

You have heard repeatedly that somehow the Republican plan was

thrown together in a couple of days. That is pre-election rhetoric. It simply is not the truth.

We include significant patient protections; they include some patient protections.

We include the opportunity to get health care, make it more affordable, make it more accessible. Do not believe me, believe the Congressional Budget Office. They looked at their bill. They evaluated it. They priced it out. They said if the Democrat's bill were law, premiums would cost more. Health care costs would go up.

The Congressional Budget Office looked at our bill, they examined it, they priced it. The nonpartisan fiscal analyst said if the Republican bill became law, health care costs, premiums, would go down.

In addition to that, a provision that they had said is a poison pill, it would kill the bill, the medical malpractice provision that is in the Republican bill, it is not in the Democratic bill, that that measure alone, reforming medical malpractice, would save, directly save the Federal Government and the Medicare and Medicaid program, $1.5 billion a year over a 10 year period; $1.5 billion.

Where is that money going to come from? It is going to come from money that does not go to trial lawyers. Why do they call it a poison pill? Frankly, given the way their bill is structured, it is the trial lawyers who are going to be the main beneficiaries of those premiums going up. CBO says their plan increases premiums. CBO says our plan reduces premiums.

Yes, it is important to address the changes in the health care market today about patient protections. It is also important to make sure that health care is affordable for more Americans. Our plan does it; their's does not.

Mr. DINGELL. Mr. Speaker, I yield one minute to the distinguished gentleman from Michigan (Mr. LEVIN).

(Mr. LEVIN asked and was given permission to revise and extend his remarks.)

Mr. LEVIN. Mr. Chairman, let me give you a real live example of the major differences between these two bills. Twenty-five years ago one of my constituents was diagnosed with multiple sclerosis. A battery of medications have been developed in recent years that can often slow the course this disease, but it is expensive. His doctor prescribed the medication, but then the HMO said, ''You need another opinion.''

The day after he went to that second doctor, he received a letter from the HMO stating no way would they pay for the drug. So my constituent called that second neurologist and he said he had not even spoken to the HMO.

Then the HMO said the reason my constituent was denied access to the drug was that he was at stage seven of MS, and there was no published research about the use of this drug on stage seven MS. So even though two doctors believed that he would benefit from the medication, they were overruled by the HMO.

Ganske-Dingell, the Patients' Bill of Rights Act, would help avoid situations like this. Vote for Ganske-Dingell.

Mr. HASTERT. Mr. Speaker, I yield three minutes to the gentlewoman from Connecticut (Mrs. JOHNSON) a member of the Subcommittee on Health of the Committee on Ways and Means, and distinguished for her work on health care for many, many years.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman from Illinois for yielding me time, who has done such an outstanding job in leading this task force and developing this bill.

This is indeed an historic day for the U.S. House of Representatives. We are going to pass legislation that forcefully protects patients' needs, puts physicians back in charge of medical decisions, holds insurance companies accountable for quality care and gives millions of uninsured Americans access to affordable health coverage. We have heard the many concerns of the American people and are acting to address them directly and realistically.

Key to the reforms in this bill is the strong internal and external appeals mechanism that guarantees physicians will control medical decisions. Both the internal and external appeals process, in both of those processes, the physician must review the decision. It is physician-controlled and physician-directed, both within the plan and in the independent external review process. This guarantees that physicians, not HMO bureaucrats, will control medical decisions.

Both the internal and external appeal decisions are governed by strict time frames within which decisions must be made. Patients will no longer be kept in limbo while bureaucrats delay. Rather, physicians will make timely decisions about lifesaving medical treatments. This will inject fairness and objectivity into our medical system.

Accountability is key to this legislation. I have worked with the bill's sponsors to insert an important provision that will force public accountability of the insurance companies on this very issue, because we will now report publicly the results of these appeals processes. In other words, if the plan denies a patient care and that decision is overturned on external appeal, people will know it. They can change plans. They will not buy that plan. The market will deliver a far more devastating verdict to that plan than the courts could over many years.

The external and internal appeals, because they are physician-controlled, they are patient-oriented, will bring timely decisions and access to specialty care, in the right way, to the people without raising costs, but improving quality of care.

Coupled together, the provisions in this bill are what we need to restore fairness and quality to our health care system. This is a good bill that not only provides the consumer protections the American people have been looking for, but it expands access to all those that are too often ignored, the uninsured in America, and prevents an increase in costs that would merely drive people out of the system.

I urge support of this legislation.

Mr. DINGELL. Mr. Speaker, I yield one minute to the distinguished gentleman from Maryland (Mr. CARDIN).

Mr. CARDIN. Mr. Speaker, let me thank my friend from Michigan for yielding me this time and congratulate him on his leadership.

Mr. Speaker, we have a clear choice. If you want to provide protection for your constituents for full access to emergency care with symptoms with severe pain; if you want to provide your constituents with a choice of doctors within their HMOs, access to specialists like cancer specialists, women adequate care for mastectomies and the right for reconstructive surgery, that will provide continuing care if the HMO drops a doctor so you can continue to see that doctor until you get to a new doctor; if you want to provide your constituents with clinical trials and experimental treatment which may be the only way to save their life; if you want them to have the latest drugs that your doctor thinks are needed; if you want to make sure that an HMO has enough doctors and locations so your constituents can get to see the doctor; if you want to provide all these protections to your constituents, then you must vote for the Ganske-Dingell substitute, because the Republican bill does not provide those protections to your constituents and does not provide for adequate enforcement.

The choice is clear. I urge my colleagues to support the amendment.

Mr. HASTERT. Mr. Speaker, I would inquire as to the remaining time.

The SPEAKER pro tempore (Mr. FOLEY). The gentleman from Illinois (Mr. HASTERT) has 10¾ minutes remaining and the gentleman from Michigan (Mr. DINGELL) has 12½ minutes remaining.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from California (Mr. WAXMAN).

Mr. WAXMAN. Mr. Speaker, today this House has a very basic decision to make: Are we going to pass effective and enforceable legislation to ensure a patient bill of rights for people in this country? Are we going to agree to the Ganske-Dingell proposal which is going to give people the rights they need to deal with arbitrary and unfair treatment by big insurance companies and HMOs? Or are we going to rush through a Republican leadership bill that is designed to do just one thing, fool people into thinking that something is being done to help them just long enough to get through the next election? Because that is exactly the issue before us.

Are we going to pass legislation that requires HMOs to have an adequate

number and variety of health care providers so that people can get the services they need and are paying for? The Ganske-Dingell bill does that. The Republican leadership bill does not.

Are we going to be sure that people can get to a specialist if they need one? Ganske-Dingell says yes. The Republican bill does not.

Are we going to let insurance companies make the decisions about what medical patients need? Ganske-Dingell says decisions belong to the patients and their doctors. The Republican bill does not. That is why the doctors support the Ganske-Dingell legislation.

Today this House has a very basic decision to make: are we going to pass effective and enforceable legislation to ensure a patient bill of rights for people in this country?

Are we going to agree to the Ganske-Dingell proposal which is going to give people the rights they need to deal with arbitrary and unfair treatment by big insurance companies and HMO's?

Or are we going to rush through a Republican leadership bill that is designed to do just one thing: fool people into thinking that something is being done to help them just long enough to get through the next election.

Because that is exactly the issue before us.

Are we going to pass legislation that requires HMO's to have an adequate number and variety of health care providers so that people can get the services they need—and are paying for? The Ganske-Dingell bill does that. The Republican leadership bill does not.

Are we going to be sure that people can get to a specialist if they need one? Ganske-Dingell says yes. The Republican bill does not.

Are we going to let insurance companies make the decisions about what medical care patients need? Ganske-Dingell says that decision belongs to the doctor and the patient. The Republican bill does not. It actually increases the power of insurance companies to decide what is medically necessary. Since when did insurance bureaucrats become qualified to be doctors?

Are we going to override the protections the States have enacted to assure people health benefits and give them some consumer protections? Ganske-Dingell builds on and strengthens them. The Republican leadership bill actually takes away the protections that are there.

And are we going to make sure that people have an effective way to enforce the rights we are giving them, or not? Ganske-Dingell says if you can't enforce it, you don't have it. The Republican leadership bill sneaks in language that makes sure the insurance companies decision about what is medically necessary is not going to be challenged.

We owe the American people legislation that works to protect their rights. We need to level the field between big insurance and their desire to profits, and patients who depend on their insurance and HMOs for their health care. We owe people a way to make sure they get the medical services they need from their HMO or any other health plan.

This debate should be about patients, not profits.

The Republican leadership bill is on this floor today only for one reason: after months of opposition and working hand in hand with big insurance to kill any patient bill of rights, they noticed the polls told them the American people were demanding action.

So Mr. GINGRICH and his allies have responded with a cynical bill that is designed to look like it's doing something when it is not.

They've made sure that this bill didn't get looked at by the Committees or the public. They've made sure that we vote on this before anyone has a chance to know what it really does.

They claimed to have privacy protections—but actually they made it OK to sell medical records. When they were caught, they changed it.

They claimed to make sure emergency care would be covered if a prudent person would think it was necessary. But they actually weakened the protections we already have in law for Medicare beneficiaries. They said severe pain wouldn't be a reason to go. They said the HMO could make you foot most of the bill if you didn't go to their facility. In other words, they gutted the protections.

Well they got caught again, so they changed it.

How many things are in this bill that haven't been found yet? It's a cynical way to deal with people's lives and health care.

Does anyone believe that a Republican leadership that has urged insurance companies to spend money to defeat these bills is actually going to write a good one? Does anyone believe that after they've fought it every step of the way, they've suddenly seen the light?

Let's adopt the bill that works. Let's adopt the bill that has been endorsed by the doctors and the nurses and the patients. Let's adopt the Ganske-Dingell bill.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from New Jersey (Mr. PASCRELL).

(Mr. PASCRELL asked and was given permission to revise and extend his remarks.)

Mr. PASCRELL. Mr. Speaker, a question was asked a few seconds about whose side are we on.

The average CEO from an HMO makes $6 million a year. It goes up to $20 million a year. You are asking us whose side we are on?

A woman in my district recently summed up the problems with our current managed care system in a conversation with me. She asked if there was a way she could get into Medicare early because she thought she could receive better care under her Medicare than under her current health insurance program.

All across my State of New Jersey, patients are being denied their basic rights, and I think that is what this argument and debate is all about. New Jerseyans who benefit from some of the strongest patient protections in the country would lose under the original bill.

Benefits and services such as bone marrow transplants, diabetic supplies, mammogram and prostrate screenings and minimum maternity stays would all be in jeopardy for thousands of patients in our State. Let us do the right thing today.

Mr. HASTERT. Mr. Speaker, I yield 4½ minutes to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Speaker, as we close down this debate and come toward the end of what, for me, has been a long time coming, I want you to know I am not only saddened by the debate but I am exhilarated by this debate also because it is with great pleasure I see each side of the aisle trying to outdo the other on patient protections, and Lord knows that has been a long time coming.

It is often asked of me why would a conservative Republican like myself, why would you be involved in something like this? Why would you want to deal with national standards? I think that is a reasonable question, and I think it is a fair question.

The answer is pretty clear. What I want to do is take health care out of the ERISA laws that should never have been put in the ERISA laws, that never was about health care but always about your pension plans, but we cannot do that.

□ 1300

But we cannot do that. The other option is to do nothing, and we all know that is wrong, and the other option then is to set some national standards, and that is where I am, and that is where we are in this debate today.

We have today one of the reasons I might mention that I am involved in this is that we have today the best medical care, best trained physicians, best technology in the world, but it does no good to have any of that if we are denied our care. We all can agree, I believe, on that.

I have been in Congress 3½ years. There is a lot I do not know, but I will tell my colleagues one thing I do know something about. I know something about treating patients. I have been doing that all of my adult life. In fact, I have been doing that longer than any of my colleagues have been in Congress, except maybe the gentleman from Michigan (Mr. DINGELL). Generally speaking, that is all I know, And I have in every sense since I have come to this town tried to say that there are serious problems out there that are occurring that we must address. Thank God we are. It is a contest of who is addressing them best, perhaps.

Mr. Speaker, I remember seeing patients back when there really was a doctor-patient relationship, back when there was a free market, before the 1973 HMO Act, before the 1974 ERISA Act. Things are not better today for patients. Maybe our skills are better, maybe our technology is better, but people have been denied the benefits that are in their plan. I thank my colleagues for joining with us, I thank them for joining with us to try to address that, and we are going in the end to address that, I believe, in a very correct manner.

One of the other reasons I have been so interested in this is that in 1994 I did not like Clinton care. Do my colleagues want to know why? Clinton care was a program to deny patients' choice of

doctor and of hospital. It was a program that would deny them care and rationed care, and it was a program designed to use untrained and less trained people to take care of patients. Guess what? They won. That is exactly what we have today. The big difference is Mr. Clinton would have used Federal bureaucrats; today we use corporate bureaucrats. I promise my colleagues, a patient that has been denied care and their child has died does not care whether it was a corporate bureaucrat or whether it was a Federal bureaucrat.

Mr. Speaker, we have before us today, I say to my colleagues, two bills, and we are debating actively on who has done the best job. These bills are fighting to see who can protect patients most. I think that is wonderful.

Let me just simply close by saying that there are many things that are similar. There are many very good protections in the Republican bill, and I certainly do not oppose the liability part, except I am scared that it will kill the bill for this Congress and we will have no protections.

Vote against the motion to recommit, vote for this bill, and work with us to make it all better.

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from New York (Mr. SCHUMER).

(Mr. SCHUMER asked and was given permission to revise and extend his remarks.)

Mr. SCHUMER. Mr. Speaker, I want to thank the gentleman for yielding me this time. I want to say that the American people are clamoring for real reform of HMOs. If we pretend to give them reform, if we offer a phoney solution, they will not be fooled. The Dingell-Ganske substitute will make a true difference to millions of families. Let us go the real way. Let us really help people and not just make it appear we are.

Let us support Dingell-Ganske and make a difference for the millions who are suffering under the yoke of unfair HMOs.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentlewoman from Washington (Ms. DUNN), a member of our leadership.

Ms. DUNN. Mr. Speaker, I thank the gentleman for yielding me this time.

I rise today to say to American families who are worried about their health care coverage, we understand your fears and your anxieties, and help is on the way.

H.R. 4250, the Republican plan to make health care more accessible and strengthen patient protection, is a sensible approach to the problems facing Americans, especially working women.

Mr. Speaker, 80 percent of all the health care decisions in this country today are made by women. As a result, women view health care as a consumer issue, not a political issue. That is why the Republican plan addresses the need to expand access to health care for those who cannot afford it, or are uninsured by their employers. H.R. 4250 makes some important reforms that will allow small businesses, an area of our economy increasingly dominated by women, to ban together to purchase health care coverage.

One of the biggest obstacles to health coverage for small business women and their employees is cost. By allowing these small businesses to join together and pool their resources, they will be able to purchase health care at the same discounted rates enjoyed now by big business.

In addition, our Patient Protection Act will give our Nation's women direct access to their OB–GYN. These physicians are extremely important to the lives of every woman and they should not be considered specialists. We should demand that the essential care that they give be accessible without having to jump through bureaucratic hoops.

The Republican plan will also help our Nation's mothers get easier access to pediatricians for the care of their children. Once again, the care given to our Nation's youth is critical to fostering a healthy childhood and it must be available without delay.

Whether it be expanding access to health care for America's small business women or ensuring that mothers and children have the care that they deserve when they need it, the Republican health care plan is right for our Nation's families.

Mr. Speaker, I urge my colleagues to support H.R. 4250 and help give families the peace of mind they so richly deserve.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Oregon (Ms. HOOLEY).

Ms. HOOLEY of Oregon. Mr. Speaker, I thank the gentleman for the leadership he has shown on this issue.

Let me tell my colleagues a little bit about this issue. I look at these two bills and I see mirror images. The Hastert bill takes us a step backwards, at least in Oregon, in protecting patients, and the Ganske-Dingell bill moves that agenda forward.

I want to tell my colleagues how backwards this takes us. In Oregon, our State has already adopted model patient protections. Make no mistake: I would like to see us move forward on patient protection. This, in fact, moves Oregonians backwards. It repeals protections Oregonians already have been guaranteed by the State. Cervical cancer, mammogram screenings, minimum maternity care, mastectomy stays, breast reconstruction, alcoholism and drug abuse treatment, well child care.

In the last session of the Oregon legislature they worked in a bipartisan fashion, held extensive hearings, took the data and opinions of everyone concerned, and what they got was a model piece of legislation. They had hearings on it. What a contrast to this.

Please support the Ganske-Dingell bill.

The SPEAKER pro tempore (Mr. FOLEY). The gentleman from Illinois (Mr. HASTERT) has 9 minutes remaining; the gentleman from Michigan (Mr. DINGELL) has 4 and a quarter minutes remaining.

Mr. HASTERT. Mr. Speaker, I yield 15 seconds to the gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Speaker, let us try to get this straight. The Federal law known as ERISA is what preempts State laws. It is not this bill; it is the ERISA law that preempts State laws.

Mr. DINGELL. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. PELOSI).

(Ms. PELOSI asked and was given permission to revise and extend her remarks.)

Ms. PELOSI. Mr. Speaker, I thank the gentleman for yielding and for his tremendous leadership in providing access to quality health care for all Americans.

I rise in strong opposition to the Republican bill and in strong support of the Ganske-Dingell bill.

Mr. Speaker, I rise in strong support of the Patients' Bill of Rights, the substitute to the fatally flawed Republican HMO protection bill. The manner in which this legislation is being rushed through by the leadership should tell us clearly that they want to avoid real scrutiny, and given their bill, that is understandable.

With the health care system transforming around us, the most important decision we have to make in writing health care reform legislation is: What interests are we going to protect? Do we stand with patients trying to access quality care and needed specialty services? Or do we craft legislation which gives cover to the industry and considers patients second?

The Democratic Patients' Bill of Rights is true patient protection that will make a difference in the lives of every American.

The contrasts between the Republican and Democratic plan are many and stark. I want to focus on three issues which are very important to constituents in my district.

First, OB/GYN services are among the most personal, and important, health care services. This area of health care goes to the heart of the treasured doctor-patient relationship. When that relationship is full of trust and honesty, it can lead to better diagnosis, treatment, and comfort in the medical care setting.

The Democratic plan gives women direct access to OB/GYN services, without limitations that can stand in the way of receiving services, such as limits on the number of visits to the doctor. The Republican plan does not guarantee this coverage for all health insurance consumers.

Second, I am often approached by people in my district who depend on access to clinical trials. People with AIDS, breast cancer, and other health problems know that the cure for their diseases has not been found yet.

Their hope is their ability to participate with others in the search for medical answers. The Democratic plan promotes access to clinical trials that may provide people access to new, life-saving therapies. The Republican plan fails to do this.

Third, the Dingell-Ganske substitute, but not the Republican bill, permits individuals to sue the health plans under State law for personal injury or wrongful death.

We need health care legislation that puts patients, not HMOs, first. And we need enforcement mechanisms that make those protections real. The Republican plan falls far short on both counts. It is cover for the health industry and for Republicans, not tangible protection for consumers.

I urge my colleagues to support real protection for patients by voting for the Democratic substitute.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Rhode Island (Mr. WEYGAND).

(Mr. WEYGAND asked and was given permission to revise and extend his remarks.)

Mr. WEYGAND. Mr. Speaker, I thank the gentleman for yielding me this time.

I was just very interested, being a former small business owner, when the gentleman just came up a little while ago and mentioned that this bill does not preclude many of the State requirements that the gentlewoman from Oregon (Ms. HOOLEY) just mentioned.

Let me tell my colleagues what this bill does. It shifts small businesses who, like myself, belong to an association health care plan. It took all of the care of my employees and puts it now into ERISA.

This is what it is going to do for those people in the State of Rhode Island. It is going to remove the requirement that there be a well child care program, mammography screening, minimum maternity stays, minimum mastectomy stays, breast cancer reconstruction, cervical cancer screening, diabetic supplies, alcoholism treatment, drug abuse treatment, home health care, off-label drug use, newborn sickle cell testing and blood lead screening, removes patient rights from small business owners and employees of small businesses. This bill does that. The Ganske-Dingell bill does not. Please support the Ganske-Dingell bill.

Mr. HASTERT. Mr. Speaker, I yield 2 minutes to the gentleman from Arizona (Mr. SHADEGG).

Mr. SHADEGG. Mr. Speaker, I thank the gentleman for yielding me this time. I would like to engage in a colloquy with the gentleman from California (Mr. THOMAS), the chairman of the Subcommittee on Health from the Committee on Commerce.

It is my understanding that the gentleman, along with most of our Republican colleagues and leaders, would agree with me that the biggest problem with health care today is that the Tax Code encourages employers, and not individuals, to be the purchasers of health care. Indeed, employers have a tax incentive to offer health care benefits for their employees, and individuals do not have that same benefit, so they are discouraged from purchasing their own health care.

Mr. THOMAS. Mr. Speaker, will the gentleman yield?

Mr. SHADEGG. I yield to the gentleman from California.

Mr. THOMAS. Mr. Speaker, I would inform the gentleman that the Subcommittee on Health is a subcommittee of the Committee on Ways and Means.

In looking at the Tax Code, we are very concerned about what has happened. Clearly, there are some advantages to managed care and HMOs in dealing with treating the patient, but I think it is fairly obvious that most employers turned to a controlled cost structure, as well. The employed had no ability to control the rising costs, 18½ percent a year in 1988. What they did was determine, I will take a health care that gives me a fixed dollar amount per employee.

Mr. SHADEGG. Mr. Speaker, I know the gentleman would agree with me that this legislation today, the Republican legislation before us today, takes important steps toward solving these problems, but that there is also agreement on the part of the gentleman and on the part of our Republican leadership that the best long-term solution would be to adopt reforms which make it possible, and indeed, encourage, individuals, whether they are employees of a company or the self-employed, or for that matter unemployed, to purchase their own health insurance without having to go through their employer and get the same tax advantage as their employer currently gets under the law.

Mr. THOMAS. Mr. Speaker, if the gentleman will continue to yield, I could not agree with the gentleman more. The current system is fatally flawed. What we are doing is simply working on the edges. The only way to fundamentally deal with the problems in our health insurance area is to empower consumers, empower them with the wherewithal to purchase the insurance, and just as importantly, empower them with the knowledge to make choices. They have neither of those in today's current system. It needs fundamental reform beginning with the Tax Code, and with the collection of data, to make those changes possible.

Mr. SHADEGG. Mr. Speaker, I understand there is a commitment on the part of the Members to move that as soon as possible.

Mr. THOMAS. Mr. Speaker, I would tell the gentleman that I have no interest in playing on the margin; I want to go to the heart of the problem and change it.

Mr. SHADEGG. Mr. Speaker, I thank the gentleman very much.

The SPEAKER pro tempore. The gentleman from Illinois (Mr. HASTERT) has 2 minutes remaining and has the right to close; the gentleman from Michigan (Mr. DINGELL) has 8 minutes remaining.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from New York (Mr. ENGEL).

(Mr. ENGEL asked and was given permission to revise and extend his remarks.)

Mr. ENGEL. Mr. Speaker, I rise in strong support of the Ganske-Dingell bill and in opposition to the Republican bill.

The Democratic Patients' Bill of Rights takes health care decisions away from insurance company bureaucrats and gives them back to doctors and patients.

The Republican bill is a sham—it will actually turn the clock back on health care consumers and is another empty political promise from this GOP Congress.

The Republican bill covers too few people, provides too few patient protections and contains unnecessary and irrelevant provisions.

The Democratic bill:

First, returns health care decisions to health care professionals and their patients. The Republican bill does not.

Second, the Democratic plan guarantees patients the right to see a specialist when they need to do so. The Republican bill does not.

Third, the Democratic bill guarantees an end to financial incentives to limit medical care. The Republican bill does not.

Fourth, the Democratic bill guarantees tough enforcement that will hold insurance companies responsible for their actions. The Republican bill does not.

Fifth, the Democratic bill guarantees emergency care. The Republic bill does not.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Illinois (Mr. POSHARD).

(Mr. POSHARD asked and was given permission to revise and extend his remarks.)

Mr. POSHARD. Mr. Speaker, I rise in strong support of the Ganske-Dingell bill.

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Mr. DINGELL. Mr. Speaker, I yield such time as she may consume to the distinguished gentlewoman from Texas (Ms. JACKSON-LEE).

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in strong support of the Ganske-Dingell bill that does not hurt Texas.

Mr. Speaker, thank you for the opportunity to speak on this important issue today. Mr. Speaker, I am deeply concerned that after spending the last full year blocking any type of adequate health care reform the legislation that is on the floor today is an unacceptable proposal to Americans' very real health care reform concerns. Once again, Mr. Speaker, the House Republican leadership has allowed the insurance industry and its powerful lobbyists to make the rules!

H.R. 4250 may give the appearance of reform, but there is no substance to this bill. There is no provision for specialty care, no provision for needed drugs and clinical trials, and no effective mechanism to hold plans responsible when plan abuse inevitably kills or injures someone.

Instead of protecting patients who desperately need help, the bill here on the floor protects the insurance industry! H.R. 4250 has serious and apparent flaws and I urge my colleagues to oppose this bill.

This bill does not provide enforceable guarantees to protect consumers from bureaucratic abuses. It does not allow patients to seek recourse for denial of care which may result in

injury or death. In addition, the Republican bill which would be more aptly named as the Patient Propaganda Act, Insurance Industry Protection Act or the Profit Protection Act does not guarantee patients access to needed care outside of their managed care plan, does not guarantee the right of patients to see a specialist and does not guarantee access to all necessary prescription drugs. Unfortunately, this bill does nothing to prohibit or prevent HMOs from offering bonuses to doctors for denying necessary care. By contrast the Patients' Bill of Rights Act allows patients access to specialists, and protects the doctor-patient relationship.

The Democratic Patients' Bill of Rights, in contrast is supported by over 300 health related organizations including the Children's Defense Fund, the National Partnership for Women and Families, the National Association of Children's Hospitals, the American Medical Association, and the National Breast Cancer Association. In addition, the American Public Health Association who represents more than 50,000 public health professionals, believes that H.R. 4250 provides inadequate protection of personal health data and may lead to undesirable uses of private information.

H.R. 4250 will allow health insurance companies, not doctors to decide what is medically necessary. In testimony before the House Commerce Committee, Dr. Linda Peeno, a former HMO medical director described the control that health insurance companies would have over our health as ''a health plan's smart bomb capability.'' External appeals will be of no value if the health plan itself is always allowed to decide and define what is medically necessary or appropriate. By contrast, our democratic bill specifically prohibits health plans from practicing medicine by substituting their decisions for the doctors.

And what about the gag rule? H.R. 4250 does not adequately protect the broadest possible range of ''medical communications'' and it would not ensure necessary emergency care! Because H.R. 4250 does not include the words ''otherwise restrict'' medical communications, because of this important omission, health plans can continue to silence physicians. Imagine, even with severe pain, there is no requirement for an insurance plan to allow treatment! In fact, this bill still does not deal with Americans' concerns with gag clauses, yet the bipartisan Ganske-Dingell bill extends the prohibition on gag clauses to subcontracts—in other words, assuring that health care professionals in all types of managed care will be protected and that patients will be protected.

Because we are about women's health concerns, the Dingell-Ganske bill prohibits drive-through mastectomies and requires coverage for reconstructive surgery after a mastectomy. H.R. 4250 does not even include anything close to this type of protection for women. As an advocate of women's rights, I am concerned that the Republican plan does not allow women to choose their obstetrician or gynecologist as a primary care physician, and it also does not allow a woman undergoing an active cause of treatment in her last trimester of pregnancy to continue with her doctor if her employer changes plans.

As a concerned parent and Chair of the Congressional Children's Caucus, I wonder about the children that would not receive adequate care under the Republican bill, in that it does not guarantee access to pediatric specialists.

I urge my colleagues to oppose the Republican plan. We must provide our country's citizens with adequate health care. Our President strongly endorses this plan, and as an article in the July 3, New York Times states, doctors and advocates for consumer groups prefer the Patients' Bill of Rights over the Republican plan, and the New York Times itself said that the Democratic bill seems to be far more prescriptive.

One of the letters I received recently is from a Texas woman, a senior citizen who has worked a lifetime in the medical profession. She told me that she had worked during an era when a doctor saved a gravely ill child—sutured bleeding patients—sat at the bedside of someone's dying loved one knowing there was nothing further he could do except to be there—and then see those same physicians feeling badly in accepting fresh garden vegetables or a dozen eggs with a pound of butter as a payment for his services.

She spoke of a time when doctors were able to act for the benefits of their patients alone, when insurance companies could not deny sick and dying patients their only hope for treatment and cure, based only on greed and profit. The Democratic Patients' Bill of Rights is the only plan guaranteeing that doctors and patients make medical decisions, not insurance bureaucrats!

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to my good friend, the gentleman from Pennsylvania (Mr. DOYLE).

(Mr. DOYLE asked and was given permission to revise and extend his remarks.)

Mr. DOYLE. Mr. Speaker, I urge my colleagues to vote for Dingell-Ganske.

Mr. Speaker, I rise to urge my colleagues to vote for real patient protection legislation, in the form of the Dingell-Ganske Patients' Bill of Rights.

The Dingell-Ganske bill is a bipartisan effort to put healthcare decisions back into the hands of doctors and nurses, not insurance companies. It would guarantee emergency care and access to specialists, and retain for doctors the right to speak freely with patients about their medical treatment.

Contrary to the claims of the insurance industry, these important patient protections can be guaranteed without radically increasing costs. We need to continue to get the news out about the recent Congressional Budget Office study, showing that the average policyholder will pay only an additional two dollars a month for these protections.

The Republican leadership bill would leave treatment decisions in the hands of the insurance companies and would not guarantee the right to see a specialist. This is not real reform at all.

I'm sorry to say that the Republican leadership bill still bears the faint aroma of something drafted by industry lobbyists behind closed doors. Even after last-minute changes last night, the Republican bill would still work to actually tear down existing patient protections. In my home state of Pennsylvania, and around the country, existing state patient protection laws would be preempted by this Republican leadership bill.

For example, H.R. 4250, the Republican leadership bill, would override Pennsylvania's medical records confidentiality law. There would be nothing to stop your health plan from sharing your medical information with other organizations, such as your employer. Should an employer have unfettered access, or any access at all, to every employee's health information? I don't think so. On this and a number of other issues, H.R. 4250 is more than just a sop to the issue of HMO reform, it's a bad bill, and we must vote to reject it.

Today, we have a choice between real reform, or a watered-down, half-hearted motion designed simply to provide political cover to the Republican party. I urge my colleagues on both sides of the aisle to support the bipartisan Patients' Bill of Rights. Thank you, and I yield the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from New Jersey (Mr. MENENDEZ).

Mr. MENENDEZ. Mr. Speaker, I thank the gentleman from Michigan (Mr. DINGELL) for yielding me this time.

Mr. Speaker, when Republicans seek to avoid reform, they raise the specter of Big Government. Yet it is the Republican majority's lack of governmental intervention that has let the abuses take place over the years of their majority in the HMOs across the country. It is only when Democrats clamored for patient protection that they came forth with the fig leaf they produced today.

One mother in my district came to me because her child had been denied necessary rehabilitative treatment after surgery, and now that child will live with the damaging effects of this denial for the rest of his life. The Republicans' bill gives that family no relief, no enforcement mechanism. That is not family values.

Today HMOs have all of the protection and none of the responsibility. We want to give patients protection. We want to make sure HMOs are responsible for their actions. We want to preserve what is trusted by Americans, their relationship with their doctor. We want to give them those choices. We want to make sure that a doctor is making those decisions.

Mr. Speaker, that is why I join the gentleman from Iowa (Mr. GANSKE), a Republican, in supporting the Ganske-Dingell bill.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Indiana (Mr. VISCLOSKY).

(Mr. VISCLOSKY asked and was given permission to revise and extend his remarks.)

Mr. VISCLOSKY. Mr. Speaker, I rise in support of the Ganske-Dingell substitute.

Mr. Speaker, I rise this morning as a cosponsor of the bipartisan Patients' Bill of Rights and a believer in the notion that doctors should make decisions about their patients' medical treatments, not insurance companies. Today's managed care plans are run by insurance industry bureaucrats whose first

concern is the bottom line for insurance companies, not quality care for patients. These insurance industry bureaucrats seek to maximize profits for insurance companies by restricting treatment to patients and preventing doctors from providing proper care.

In addressing this situation, the bipartisan bill, which is the basis of the Dingell/Ganske substitute, offers its protections to patients, who need to know that their insurance companies are not interfering with their access to quality health care. This bill is dramatically different than the Republican bill which seeks only to protect the insurance industry.

Currently, 125 million Americans are enrolled through their employers in self-insured health plans, in which the insurance companies cannot be held liable for their decisions to restrict medical treatment, even if those decisions directly result in the death or maiming of the patient. The Congress should eliminate this legal protection for insurance companies, so that insurance companies can be held legally accountable for their decisions, just like everyone else. The bipartisan bill would offer Americans the legal protections of their individual states in holding insurance companies accountable for their decisions. The Republican bill on the other hand, would go the other way by restricting patients' legal rights and increasing the number of patients who are not protected by state malpractice laws from insurance companies.

Americans need to know that they have access to adequate internal and external appeals processes if their insurance company denies them coverage for a treatment. While the bipartisan bill provides for an external review that is truly independent and bases the definition of medical necessity on ''generally accepted principles of professional medical practice,'' the Republican bill would allow the insurance company to determine what is considered medically necessary and who performs the external review.

Americans need to know that they have access to emergency care when it is necessary, and we should encourage people to go to the emergency room when they experience severe chest pain—a sign of a possible heart attack. But the Republican bill fails to guarantee payment for care in such cases, leaving the health of Americans at risk. That's why the President of the American College of Emergency Physicians has said that the Republican bill ''will not bring peace of mind to anyone seeking emergency care when they need it.''

Americans need to know that their insurance companies are not restricting the range of treatments that their doctors are allowed to discuss, and are not offering financial incentives to doctors to limit patient care. While the bipartisan bill provides strong protections to patients in both of these circumstances, the Republican anti-gag provision is riddled with loopholes, and their bill doesn't even address the problem of financial incentives designed to limit care.

Americans need to know that they will have access to a specialist when it is needed and not become a victim of managed care bureaucrats. The bipartisan bill provides this protection to patients; the Republican bill does not.

With a set of consumer protections so weak as to be almost meaningless, the Republican bill is a cynical attempt to include erroneous provisions that have absolutely nothing to do with the problems of managed care such as provisions that would allow companies unrestricted access to your personal, confidential medical information and that would allow wealthy Americans to set up tax shelters through medical savings accounts.

Mr. Speaker, the American people deserve strong protections from the insurance bureaucrats who seek to do nothing more than maximize profits by restricting care. Please join me in voting for real protections for patients and against further protections for insurance companies, and vote for the bipartisan substitute and against the Republican bill.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Georgia (Mr. LEWIS).

Mr. LEWIS of Georgia. Mr. Speaker, we need a real Patients' Bill of Rights. I know because I have heard from the people in my district.

A mother told me her daughter had a mastectomy. The mother begged, pleaded to keep her daughter in the hospital for just one night. She needed to be there, but the insurance company sent her home.

I have heard from a doctor, a doctor who had to fight the insurance company to get coverage to treat his cancer.

Mr. Speaker, too many patients are paying more and are getting less. Under the present system, too many patients are getting a raw deal. They need a fair deal. They need a good deal. They need a better deal.

The differences are clear. Democrats are concerned about protecting patients. Republicans are concerned with protecting big business and insurance companies. The system is broken. It needs help. It needs a doctor. The Republicans are only offering a Band-Aid.

We need a bill to let doctors make medical decisions. The Democratic bill makes sense. If we can choose who fixes our car when it is broken, then we should be able to choose who would care for us when we are sick.

If insurance companies want to tell us that we cannot see a doctor, that we cannot get treatment, then they must be held accountable. The doctors and nurses on Main Street should make the decisions about our health care, not the insurance company and wheelers and dealers on Wall Street.

The Democratic bill protects patients. The Republican bill does not. Mr. Speaker, we need a real patient's protection act and we need it now. Not tomorrow, not next week, not next year, but now.

Mr. Speaker, we should vote for a real patient protection bill and we need it now. Vote for the Ganske-Dingell bill.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Michigan (Mr. BONIOR).

Mr. BONIOR. Mr. Speaker, after ignoring the public outcry for months, the Republicans have rushed to the floor with a midnight deal that does nothing to end HMO abuses. We might as well call the Republican bill the Insurance Company Protection Act, because that is all it does. It does not protect patients.

These are the same insurance companies that have spent millions on TV ads to kill HMO reform and the same insurance companies that cut corners with people's lives. When insurance companies play doctor, and that is what they are doing, people get hurt, people die.

Under the Republican bill, many HMOs can still limit what doctors can tell their patients. Under the Republican bill, HMOs can still restrict patients' access to emergency rooms. If patients have a heart attack and the ambulance speeds to a hospital close by but outside their network, they can get stuck with a $4,000, $5,000, $6,000 emergency room bill. It is enough to give them another heart attack.

Under the Republican bill, patients have little access to specialists or freedom to choose their own doctor. Under the Republican bill, HMOs can release private medical records without the patient's permission.

Under the Republican bill, it even gives HMOs the authority to define ''medical necessity.'' And if an HMO denies necessary medical care, the HMO cannot be sued for damages. That is not reform. That is reprehensible. But that is what the Republicans propose. They are telling our constituents: Take two aspirins and call us after the election.

The President has made it very clear, he will veto this sham reform. I urge my colleagues to stand firm today. Support the Dingell-Ganske bill for real HMO reform and patient protections.

Mr. DINGELL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Illinois (Mr. DAVIS).

(Mr. DAVIS of Illinois asked and was given permission to revise and extend his remarks.)

Mr. DAVIS of Illinois. Mr. Speaker, I rise in favor of the Dingell-Ganske bill.

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Missouri (Mr. GEPHARDT) the minority leader, for purposes of concluding debate.

(Mr. GEPHARDT asked and was given permission to revise and extend his remarks.)

Mr. GEPHARDT. Mr. Speaker, the bill that the Republican leadership has brought to the floor is what happens when they bring a bill that they really do not believe in, when they bring a bill that is really designed to be political cover to address an area they really genuinely do not believe needs to be treated with legislation.

It is a fake. It is a fig leaf. It is a sham. It is a subterfuge. It is a charade. It is cosmetic. It is ineffective. And it will not work to solve the real problems and the real concerns that the American people have in this area.

If Republicans really believed in their bill and thought that it had merit, they would have had extensive hearings in the committee and allowed doctors and nurses, senior citizens and

patients, consumers, health care company officials and others to come and testify and tell us in the Congress their feelings, pro and con, about the bill.

If they really believed in their bill and what it did, they would not have been writing it at midnight last night, changing it, trying to shove things into it to try to attract the last few votes on their side to be able to pass the bill. They would have proudly stood for their bill as an effective answer.

Mr. Speaker, I just ask Members today to ask themselves one simple question: Where are the doctors and nurses on this piece of legislation? Which piece of legislation do they support, the people who, on a daily basis, give their lives and their careers to help get people well?

Mr. Speaker, they are for the Patients' Bill of Rights, the patient protection act written by the gentleman from Michigan (Mr. DINGELL) and the gentleman from Iowa (Mr. GANSKE). They are against this sham, this political fig leaf that has been put up on the other side.

Why is that the case? Let me give just three quick, simple reasons. First, the Republican bill does not guarantee that if our doctor says we need to see a specialist, that we will actually be able to see that specialist. Just imagine if a patient has cancer and their doctor says they need to see an oncologist. If the Republican bill passes, there will be no guarantee in the law that patient will be able to see that oncologist.

Secondly, the idea of what is medically necessary will still, under the Republican bill, be up to bureaucrats in insurance companies who have their eyes on the bottom line, the profit line, and not on what is good medical care.

Finally, no enforcement. No enforcement. This is a bill with rhetoric but without a remedy. What we need in this area is to be able to know that if the medical necessity is not observed, if the guarantee of the plan is not observed, that patients have some place to go to get a remedy.

What physicians say to me is, ''I am accountable for my health care decisions every day, every minute of every day. But now we have some bureaucrat at the end of an 800-number who can make medical decisions that are just as important as my decisions, and they are not in any way accountable to anybody for the decisions they make.'' That is the heart of this bill, and that is why the Democratic bill is the only good bill before us today.

Let me end with this. Members are voting today on the rights and the ability of flesh and blood human beings in their district. Make no mistake about this, they care about this bill. This really counts in their lives. When Americans need the Bill of Rights, they need it.

Mr. Speaker, I sat with my son when he was sick in the hospital and talked to other parents of kids who had cancer and they would say, ''My policy did not cover, my policy did not work on the treatment, the experimental treatment that my son or daughter needed.'' Let me tell my colleagues that when one is sitting in that hospital room and they have a loved one in front of them who is dying because they cannot get the treatment that they have paid for, they will want this Patients' Bill of Rights and they will want it now.

Mr. Speaker, I urge my colleagues to vote against this fig leaf. Vote for a good bill.

Mr. HASTERT. Mr. Speaker, I yield such time as he may consume to the gentleman from Florida (Mr. MICA).

(Mr. MICA asked and was given permission to revise and extend his remarks.)

Mr. MICA. Mr. Speaker, I rise in support of the Republican alternative and against the Democrat, more regulatory, bureaucratic, and more litigious approach.

Mr. HASTERT. Mr. Speaker, I yield such time as he may consume to the gentleman from Georgia (Mr. LINDER).

(Mr. LINDER asked and was given permission to revise and extend his remarks.)

Mr. LINDER. Mr. Speaker, I rise in favor of the Republican alternative.

Mr. HASTERT. Mr. Speaker, I yield the balance of my time to the gentleman from Georgia (Mr. GINGRICH), Speaker of the House.

Mr. GINGRICH. Mr. Speaker, let me thank my colleagues and let me thank the gentleman from Illinois (Mr. HASTERT) and everyone who served on the Health Task Force for developing the Patients' Protection Act.

Let me remind everyone that this is not a new process for us. We founded the Health Reform Task Force in 1991. We developed a series of reforms which included Medical Savings Accounts, which included preventive care for diabetes, for prostate cancer, for colorectal cancer, for breast cancer.

We have moved a series of initiatives on child health. We moved a series of initiatives to expand access to health insurance for small business. And now we are back working in the same general direction which is really to do three things: To make sure that every citizen has access to health care; to make sure that it is the most modern and best health care in the world; and to lower its costs.

Let us be clear about the choices here. The Dingell bill is a well-meaning bill, if one is a trial lawyer.

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The Dingell bill is terrific for trial lawyers. The Dingell bill is about trial lawyer enrichment. We are better on every count. We save money. The Dingell bill costs money. So we make it easier to buy health insurance and expand the coverage. We have provisions so that more people can get covered by health insurance.

The Dingell bill will actually take a million and a half people out of health insurance and put them on the taxpayer. So they have less health insurance for fewer people at greater cost.

Our bill says if someone gets sick and they have a reasonable layman's standard, they go to the emergency room and they are automatically covered. It then says if that individual is not in an emergency situation, but that individual does not agree, they can get, within 72 hours, an internal review. And if they do not agree with that, they can get, within 72 hours, an external review. They do not have to go to a trial lawyer.

And the review, by the way, is done by appropriate medical professionals of comparable specialties. So medical people make medical choices in our bill. Trial lawyers make litigation choices in the Dingell bill.

This is not a complicated issue. This is an issue of the trial lawyers seeking to enrich themselves at the expense of everybody else in this country by having more lawsuits over a longer period of time and a more jammed courtroom. We have a proposal which says more patients have more rights by appealing against the HMO, appealing against the insurance company, and appealing directly to an independent council of medical professionals.

Now, let us say the medical professionals decide, yes, the patient deserves the coverage, and the HMO says we are not going to do it. At that point, under our plan, that individual goes to court with a presumption that the HMO is guilty. The judge is now looking at an independent medical panel having said, yes, the patient should get this treatment. So we give the American people better treatment, faster, with medical specialties, at lower cost.

But we do one thing that our good friends cannot stand: We do not make the trial lawyers richer. We also have malpractice reform, which is what every doctor has told us for 20 years they want.

So I would say the vote on Dingell is very simple: If we want better patient protection, vote ''no''. If we want lower cost, vote ''no''. If we want more people covered by health insurance, vote ''no''. If we want medical doctors making medical decisions, vote ''no''. But if Members really think they owe it to the trial lawyers to give them a new chance to get richer, vote ''yes''.

Mr. SERRANO. Mr. Speaker, I rise in strong support of H.R. 3605, the Dingell-Ganske Patients' Bill of Rights, and in equally strong opposition to H.R. 4250, the pale shadow of reform offered by the Republican leadership.

The American people have called on us to rein in the managed care companies that are putting profits ahead of people, denying and delaying care and causing real harm. We have heard from patients with terrible stories of injury and death caused by the decisions of arrogant, unfeeling insurance company bureaucrats intent on their corporate bottom line. We have heard from doctors who have been forced to beg for permission to treat their patients according to their professional judgment. We have heard from nurses who daily see

and deal with the results of denial and delay. We have even heard from former HMO employees about what they had to do—until they couldn't stomach it any more—to keep their jobs.

While it is gratifying that Republican leaders have finally listened to the American people and scheduled floor debate on managed care reform, this is a holly exercise. Their useless bill, which is likely to pass, will be vetoed. We know that already. So this is not serious attempt to accomplish meaningful reform, it is an attempt to give Republican candidates cover on an issue that is critical to millions of Americans, to permit Republicans to claim they have done something about health care.

In stark contrast, the Dingell-Ganske bill would provide meaningful, enforceable patient protections and quality health care. It would let doctors and patients make medical decisions and end financial incentives to limit medical care. It would guarantee access to specialists outside the HMO, to emergency services, to the full range of prescription drugs, and to clinical trials. It would end excessive use of cost-cutting devices such as outpatient mastectomies and drive-by deliveries. Most important, it would be enforceable.

The Interreligious Health Care Working Group supports legislation that includes ''patient access to information; choice of providers and plans; access to emergency services; participation in treatment decisions; respect and nondiscrimination; confidentiality of health information; and complaint and appeal procedures'' as well as credible means of enforcing those rights. H.R. 3605 meets this standard. H.R. 4250 does not.

The Consumer Federation of America supports legislation that includes ''holding managed care companies accountable; requiring an external grievance and appeals system; comprehensive information disclosure; quality assurance programs; and protection of the doctor-patient relationship in a manner that allows advocacy on behalf of patients and prohibits improper physician incentive plans.'' H.R. 3605 meets this standard. H.R. 4205 does not.

Similarly, the American Federation of Teachers, Families USA, the Lutheran Office for Governmental Affairs, Consumers Union, and others that have outlined principles for addressing problems in the managed care industry find H.R. 4250 sadly lacking in both protections and enforcement. They all support H.R. 3605.

The American Medical Association—the AMA, Mr. Speaker—lists 10 reasons to vote against the Republican leadership's bill and for the Patients' Bill of Rights. I won't list them all, but I should mention a couple of key issues. AMA Reason No. 9 is ''H.R. 4250 would allow health insurance companies to decide what is medically necessary * * *'' AMA Reasion No. 7 is ''H.R. 4250 would require patients to pay for the privilege of an external review of treatment denial; H.R. 3605 imposes on such fees * * *'' AMA Reason No. 4 is ''H.R. 4250 would delay the effective date of patient protection for up to 2 years * * * H.R. 3605 would peovide for nearly immediate implementation * * *''. Finally, and perhaps most importantly, AMA Reason No. 1 is ''H.R. 4250 does not hold health plans properly accountable for making medical treatment decisions that result in patient injury or death.''

Of course, Mr. Speaker, the Republican leadership doesn't stop at offending the American people by offering only a hollow promise of reform, it throws in posion pills that have been considered and rejected before. Exempting Association Health Plans (AHAs) and Multiple Employer Welfare Arrangements (MEWAs) from state law would deny millions of Americans coverage under many of the patient protection laws already enacted by 43 states. That includes my own state of New York, which has been a pioneer in establishing patient protections. Expanding the availability of medical savings accounts (MSAs) would give tax breaks to the healthy and wealthy while increasing costs of health insurance for the sicker and poorer.

It is obvious that this is a political exercise. The Republican leadership's bill was introduced only last week and has not been examined in a single hearing or subjected to amendment by any committee. It hasn't been scored by the Congressional Budget Office. As the AMA writes, ''In fact, Members of Congress have not had time to fully understand critical differences in the two bills since last Friday's introduction of the House Republican bill''. Not surprisingly, then, the bill has been a work in progress, subjected to numerous changes—changes that sound like improvements but are largely cosmetic—in attempts to attract enough votes to pass the bill without actually accomplishing anything that would annoy the Republicans' friends in the insurance industry.

I urge my colleagues to support meaningful, enforceable reform, not posturing. Support the Dingell-Ganske Patients' Bill of Rights and reject the Republican leadership's Managed Care Reform Lite.

Mr. TURNER. Mr. Speaker, Democrats initiated the effort in this Congress to protect patients and their doctors from interference by insurance company bureaucrats. The Dingell-Ganske bill provides these protections and eliminates the complete exemption from accountability that many HMOs enjoy today under the Federal ERISA law.

The Republican bill, on the other hand, is an effort to preserve the insurance companies' shield of protection from accountability for their mistakes. It creates a Federal bureaucracy in the Department of Labor and a complex appeals process diagrammed here on this chart to my right. Look at this. And endless maze of bureaucratic nightmare is created by the Republican bill.

Consider the example of Phyllis Cannon. In September of 1991, Ms. Cannon was diagnosed with leukemia. On August 10 of 1992, her doctor sought approval from her HMO for a bone marrow treatment. 43 days later, her doctor pleaded for authorization to treat her life-threatening condition and it was again denied. By the time the HMO finally agreed to authorize treatment, it was too late and Phyllis Cannon died.

Could she have gone through this maze under the Republican bill and done any better? I think not. And if she had made it through the maze under the Republican bill, after her death she would have been entitled to only $500 per day. Under the Republican bill, the total recovery for her family would have amounted to only $20,000.

Is this what we call protecting patients? Vote against this Republican bill. Vote for the Ganske-Dingell bill and prevent this kind of endless bureaucratic interference with medical decisions from happening to the patients of this country.

Mr. THOMPSON. Mr. Speaker, I rise today as the Representative from Mississippi's 2d Congressional District in support of H.R. 3605, the bipartisan Dingell-Ganske Patients' Bill of Rights. This bill guarantees that decisions will remain in the hands of doctors and nurses, not insurance companies; that people will have access to specialists; that there will be protection for women after mastectomy (minimum hospital stay); and the ability to hold plans accountable when abusive practices kills or injure patients.

I oppose the Republican HMO health care bill. Mr. Speaker, I am in support and committed to passing major managed care legislation. However, I do not support the Republican bill that covers too few people, provides limited patient protections, and contains unnecessary and irrelevant provisions. It undermines existing state consumer protections, leaves patients and small businesses with fewer protections than they already have. The Republican bill is being pushed through the House with almost no debate and virtually no amendments allowed in an attempt to stop the only real bipartisan managed care reform bill—the Dingell-Ganske Patients' Bill of Rights—from passing. Mr. Speaker, the Republicans are playing politics with the lives of Americans. Let's stop this ridiculous rhetoric and pass some meaningful legislation.

As I close, I would like to once again express my support for H.R. 3605 and thank Representative DINGELL and Representative GANSKE for their work in bringing this legislation forth to protect the interests of patients. I urge my colleagues to support this bill.

Mr. COYNE. Mr. Speaker, I rise in support of H.R. 3605, the bipartisan Patients' Bill of Rights. Today we have a tremendous opportunity to protect our constituents' right to receive quality health care.

More than half of all Americans are not offered a choice of health care providers by their employer. Under current law, many consumers have little recourse if their HMOs or insurance companies do not protect their most basic health care rights. I believe Congress must act to guarantee these rights.

I am proud to be an original cosponsor of the bipartisan Ganske-Dingell bill (H.R. 3605). It would ban ''gag rules'' and contracts in which doctors are paid less if they refer to needed specialists or suggest expensive treatment, guarantee access to specialty and emergency care, protected medical confidentiality, and give patients access to a free, timely appeals process if their HMOs deny them benefits. If patients are harmed by decisions made by their HMOs, they will be allowed to take the HMO to court and recover damages. H.R. 3605 also provides for speedy implementation. Americans need relief from badly managed care now, not 2 years from now.

On the other hand, H.R. 4250, the Republican alternative, is a step in the wrong direction. It actually weakens the protections patients have under current law. The association health plan proposal would increase the number of patients who are not allowed to sue their health plans if they are harmed or killed by decisions made by the plan. The bill also undermines current laws which protect medical confidentiality, allowing almost any insurance company official access to a wide range of personal medical records. By expanding medical savings accounts, they encourage

wealthy, healthy people to ''opt out'' of the current health insurance coverage insurance system, increasing the price of health insurance for everyone else. Finally, the Republican bill would maintain the status quo in which insurance companies, not doctors, decide what is ''medically necessary,'' and health plans can continue giving doctors financial incentives to deny necessary care.

I urge my colleagues to join me in supporting H.R. 3605, the Patients' Bill of Rights. We owe it to our constituents to use this opportunity to enact real reform.

Mr. BENTSEN. Mr. Speaker, I rise today to express my strong support for H.R. 3605, the bipartisan Patients' Bill of Rights, that is sponsored by Representatives DINGELL and GANSKE. Today, we will consider two different approaches to reform managed health care plans. I am a strong supporter and co-sponsor of H.R. 3605 because I believe that this bill provides essential consumer protections to all Americans. I urge my colleagues to reject the Republican leadership sponsored legislation, H.R. 4250, and vote for the real Patients' Bill of Rights.

Today, there are more than 160 million Americans enrolled in managed care plans, such as health maintenance organizations (HMOs). Of these enrollees, approximately 125 million Americans are enrolled in managed care health plans that are governed by federal law, the Employee Retirement and Insurance Security Act (ERISA). Under ERISA, these Americans cannot seek legal remedy if their health plans denies or delays access to care. In a time when many Americans believe that their health plans are arbitrarily denying care and services, the Dingell-Ganske substitute bill would ensure that health plans must provide an appeals process to their decisions. Under the Dingell-Ganske bill, patients would be guaranteed the right to seek both an internal and external appeals process with a deadline for decisions to be made. If both of these appeals are denied, consumers would have the right to hold their plans accountable for their decisions through a legal case in our court system. In my state of Texas, where a new law has recently been approved to provide this legal right for consumers under state-based health plans. This legislation would simply ensure that ERISA-based health plans are held accountable by consumers.

The Dingell-Ganske bill provides critical reforms that patients need. It guarantees that decisions will remain in the hands of doctors and nurses, not insurance companies. It guarantees access to specialists and ensures that doctors and nurses can talk freely with patients without interference from their health plans. The Dingell-Ganske bill also prohibits the use of financial incentives to limit medical care. The Dingell-Ganske bill also ensures that patients can seek care in emergency rooms without prior approval and when they are suffering severe pain.

I would like to highlight one main difference between these bills. The Dingell-Ganske substitute includes an important provision to ensure that all Americans can enroll in cutting-edge clinical trials if they need them. As the sponsor of legislation to ensure that Medicare beneficiaries can enroll in clinical trials, I believe we must guarantee this right to ensure that patients have access to the best, most-advanced care. As the Representative for the Texas Medical Center, where many of these clinical trials are conducted, I believe that this guarantee must be included as any consumer-protection legislation. The Dingell-Ganske substitute would require managed care plans to pay for the routine costs associated with clinical trials. The Republican majority legislation does not include this critical provision.

Finally, I would like to highlight one other critical point about the Patients' Bill of Rights. I believe the Patients' Bill of Rights is a cost-effective, reasonable approach to provide uniform federal standards for managed care health plans. I believe that consumers are willing to pay for these protections. The Congressional Budget Office has estimated that the Patients' Bill of Rights would add a total of $2 per month for these protections. Let me repeat that, for $2 per month, patients can be guaranteed real protections. I believe that consumers believe that this small price is worth its guarantees to ensure that consumers receive the health care services they need and deserve.

I urge my colleagues to reject the Republican leadership bill and vote for the Patients' Bill of Rights.

Mr. COSTELLO. Mr. Speaker, I rise today in strong support of the Dingell Patients' Bill of Rights. The Republican plan tries to give the appearance of reform without actually doing so. The Republican plan does not limit HMOs' and insurance companies' use of improper financial incentives to limit needed care, does not give access to specialists, does not allow women to choose their obstetrician or gynecologist as a primary care doctor and what is most important, the Republican bill provides no effective mechanism to hold HMOs accountable when a patient is killed or injured.

The American people have waited long enough to be granted the ability to sue HMO's when a patient or family member is injured or killed due to the negligence of their health plan. They deserve the right to take legal action. HMO's should not be exempted from legal liability. Most industries in the U.S. today have responsibility to provide safe products and safe work places and can be subjected to legal recourse if they intentionally harm an individual. HMO's are no different; we must pass legislation to make them responsible for their actions!

The Republicans use of scare tactics claiming that the Democratic bill will escalate the cost of managed care plans is bogus. Last week, the Republicans' own Congressional Budget Office (CBO) released an analysis of the Patients' Bill of Rights discrediting Republican claims. The CBO estimates that the Democratic proposal costs only $2 more a month for patients with managed care plans. The CBO also estimates that the Democratic provision allowing patients to sue their health plans will increase premiums by just 1.2%. That is a small price to pay to make sure HMO's understand they will face legal liability.

The Democratic bill has been endorsed by the American Medical Association, American Nurses Association, American Cancer Society, and the American Trial Lawyers Association. It's time we hold health plans accountable for their actions and give the American public back their right to quality health care. I strongly urge my colleagues to support the Ganske-Dingell substitute.

Ms. MCCARTHY of Missouri. Mr. Speaker, I rise today to speak in favor of H.R. 3605, the Dingell-Ganske Patients' Bill of Rights, of which I am a co-sponsor. I urge my colleagues on both sides of the aisle to join me in support of this bipartisan bill. This bill guarantees that medical decisions will be made by doctors and their patients, not by insurance companies. It ensures that doctors can inform patients of all of the treatment options available to them so that patients can make educated choices regarding their health care. It guarantees that a patient who goes to an emergency room with severe pain will be treated.

The Patients' Bill of Rights also extends important protections to women. This bill allows women direct access to obstetric and gynecological care, and it allows women to designate their own gynecologist as their primary care provider. This provision allows a woman to continue to be treated by a doctor with whom she has become comfortable and who knows her personal medical history.

Further, the Dingell-Ganske bill provides patient protection at an affordable price. The Congressional Budget Office has reported that most individuals would only pay about $2 more per month in premiums as a result of the Patients' Bill of Rights. The peace of mind and security that will result from this bill are well worth this small amount.

Last year, my home state of Missouri enacted legislation that ensure a patient's right to emergency room care, to choose a doctor, and to know about all of the options available to them for treatment, regardless of the cost. In addition, the Missouri law provides for well-child care, mammography screening, drug abuse and alcohol treatment, bone marrow transplants, and breast reconstruction.

With this legislation, Missouri took great strides to guarantee access to specialists and provide more rights for patients. If the Gingrich-Hastert bill is enacted, Missouri's law will be over-ridden, and the rights of the people of my state will be taken away. We must not let this happen. Instead, we should recognize successful efforts like Missouri's at the state level to guarantee patients basic rights and follow this lead by passing the Dingell-Ganske bill.

We must guarantee that insurance companies are held accountable for their actions when they deny patients the health care they need. We must guarantee that when patients need to go to the emergency room, they can go without worrying whether their insurance will allow them to be treated for their medical emergency. We must guarantee that doctors and not insurance companies are making the decisions about what is medically necessary for their patients.

In my district, at the Children's Mercy Hospital, social workers are fighting the current system to ensure that patients receive the care they need. For example, one little boy with an amputated arm needed a special kind of prosthesis. His insurance company deemed the special arm not medically necessary and refused to pay. The social worker at Children's Mercy was able to secure outside charitable funding for this little boy to get the arm he needed, but not all hospitals are able to provide this service, and frankly, they shouldn't have to.

Join with me in supporting H.R. 3605 and grant America's patients the basic medical rights they deserve.

Mr. OWENS. Mr. Speaker, I rise to oppose H.R. 4250, the Republican so-called Patient

Protection Act and to voice my enthusiastic support for H.R. 3605, the Patients' Bill of Rights Act. H.R. 4250 was conceived in the back room of the Speaker's special 15-member Task Force on Health Care and unveiled just last week. Although the bill was referred to several committees, in a transparently desperate political maneuver, the Republican leadership has put the bill on a fast-track basis and side stepped the traditional deliberative process. I am pleased, however, that many of the provisions that are included in several Democratic bills, including my own bill (H.R. 1191, the Patient and Health Care Professional Protection Act), have been included in today's Patient Protection Act. Yet, this bill, H.R. 4250, falls disgracefully short on ''protections'' for patients and health care workers. The authors of H.R. 4250 took great care to ensure the protection of the owners of the commerce of health care—managed care companies. At a time when the health care industry is completely re-engineering itself and a record 160 million Americans have fallen susceptible to the cost-saving strategies characterized by too many managed care plans, we must not support this phony ''Patients' Bill of Rights.'' We wish to note also that irrational Medicaid rate reductions by state Governors are also jeopardizing the health of patients.

Disappointingly, most of the new Federal protections in H.R. 4250, would cover merely 48 million Americans in self-insured, employer-sponsored health plans that fall under the purview of ERISA (the Employee Retirement Income Security Act of 1974). However, there are more than 160 million Americans who have private health insurance. Congress must act to ensure the protection of a broader range of health care consumers, including Medicaid recipients.

In addition, H.R. 4250 contains a bogus grievance mechanism for patients who my have disputes with their HMOs. Under the bill, a so-called internal and external appeals process would be established, Upon first glance, it appears that H.R. 4250 adequately provides for a fair process whereby patients can appeal any denials of care. However, upon a closer look at the bill language, it is clear that the so-called external process is not very independent of the HMO with whom the patient is in dispute. H.R. 4250 would stack the cards in favor of the HMO from the onset. An independent medical expert would be required to examine the dispute on the merits of whether or not the HMO followed its own rules. The independent medical expert would not be authorized to determine that the medical procedure is indeed, necessary. To add insult to injury, the bill would permit health plans to charge up to $100 to a patient who pursues the external appeals route.

Unlike the Democratic substitute (H.R. 3605 sponsored by Representatives DINGELL and GANSKE), H.R. 4250 would not allow patients to sue their health plans. (Currently ERISA does not permit patients in employer-sponsored plans to sue their health plans.) Republicans have demonized the right to sue as some kind of payoff to the trial lawyers of America. On the contrary, the right to sue is an appropriate remedy which allows for maximum enforcement against health plans, especially when great injury or death results from their cost-cutting decisions. Any true patient protection bill and patient advocacy language would arm the patient with this basic tool of American civil rights.

Moreover, H.R. 4250 contains no protection for the very individuals who are on the front lines of the health care delivery system—nurses, doctors, and other health care professionals. The bill does not have whistleblower protections for health care workers who are in the best position to witness and report patient safety concerns. The Service Employees International Union, the organization that represents the largest number of health care professionals in the country (1.3 million members) states, ''In a recent national survey of health care professionals, nearly 1 out of 4 reported that 'employees are penalized for, or afraid to speak up about problems in their workplace' '' Yet, H.R. 4250 ignores this fact by not protecting workers from discharge, demotion, or harassment when they decide to stand up for patient care.

It should be noted that my bill, H.R. 1191 which was originally introduced in the 104th Congress and reintroduced on March 20, 1997, addresses these issues and accomplishes the following: Provides strong whistleblower protection for nurses and doctors; ensures that managed care plans mandate that adequate staffing guidelines are implemented in every hospital across the country (This would stop the current practice of replacing registered nurses and licensed practical nurses with unlicensed aides.); mandates the compilation of public, uniform, national patient-outcome data collection and analysis; assures than no patient is denied care for non-medical reasons; establishes a Federal mechanism for the emergency investigation of egregious hospital cases involving death or life-threatening situations; and establishes well-funded, consumer-dominated, non-governmental genuine health care advocacy groups in each state.

Finally, H.R. 4250 would prematurely expand access to medical savings accounts (MSA). MSAs are tax-exempt savings accounts which may be used to pay for medical expenses. The Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) authorized a limited number of MSAs (750,000) under a demonstration program beginning on January 1, 1997. Many Members and consumer groups were vehemently opposed to the demonstration program, citing that MSAs work for those that are more healthy and more rich. The vast expansion of MSAs under H.R. 4250 is reckless and extreme given that the impact of the 1997 demonstration program has yet to be studied.

Health care is big business. Spending for health care totals approximately $1 trillion every year in the United States. Competition within the health care industry is fierce, and Congress has the unequivocal role in assuring that cutting costs and increasing one's profits are not priorities at the expense of patient care quality and safety. When I recently convened an extensive health care empowerment conference in my district, my constituents demanded reform. The 11th Congressional District Advisory Committee and the HMO Consumer Advisory Committee called for the formation of an ''HMO Certification Council'' to give a seal of approval to managed care plans. The conference participants stated their desire for greater access to doctors. The conference participants also called for the passage of state legislation that would hold managed care companies accountable and permit wronged patients to sue these companies. And when a group of nurses visited me two years ago and conducted a rally at the Capitol, they demanded protection for themselves and their colleagues and freedom to advocate on behalf of their patients. I urge my colleagues to carry out the will of the American people, and not the wishes of greedy American businesses. Vote ''no'' on H.R. 4250, and vote ''yes'' on H.R. 3605, the Democratic Dingell-Ganske substitute.

Mr. PAYNE. Mr. Speaker, I rise in support of the Patients' Bill of Rights, the Dingell-Ganske substitute. I do so because the substitute lives up to its name. Improving health care quality is what this debate is supposed to be about and that is what the Patients' Bill of Rights does.

This measure enjoys broad bipartisan support from the AFL–CIO to the American Medical Association. Unlike H.R. 4250, the Patients' Bill of Rights allows states to continue on their current course of expanding health care coverage to the uninsured and improving health care quality.

The bill ensures that treatment discussions stay between the doctor and their patient. It also requires that health plans have an adequate number and variety of health providers. This provision is especially important to me because African Americans and other minorities are consistently discriminated against in the treatment and provisions of care.

The Patients' Bill of Rights has critical safeguards to protect patients and providers from discrimination. Mr. Speaker, I urge my colleagues to protect the public health and support the Patients' Bill of Rights. Vote yes on the Dingell-Ganske substitute.

Mr. SANDLIN. Mr. Speaker, I rise in strong support of the Dingell-Ganske substitute and in opposition to H.R. 4250, the so-called Patient Protection Act. That bill does not protect patients. In fact, several provisions of their bill would harm patients. H.R. 4250 was rushed to the floor with no hearings, no markup, and not even so much as a CBO cost estimate until minutes ago.

One of the most critical differences in the two alternatives before us is who makes decisions. As we increase access to health care, we must not allow unqualified parties to make critical decisions about patient treatment. Patients need to feel confident that their doctors are giving them all necessary information and not restricting information because of requirements issued by a health insurance provider. Patients should make critical decisions about their health care with the advice of their doctor. These decisions should not be overridden or limited by insurance company bureaucrats. The Patients' Bill of Rights allows patients to make their critical care decisions.

As a strong supporter of local control, I support the Dingell-Ganske substitute because, unlike H.R. 4250, it will not override protections already enacted by the states. In my home state of Texas, the following protections would be overridden by H.R. 4250: well-child care; mammography screening; minimum maternity stays; breast reconstruction; diabetic supplies; prostate cancer screening; home health care; mental health care; alcoholism treatment; drug abuse treatment; Alzheimer's disease; formula for PKU; TMJ disorders; and bone mass measurement. The federal government should not be in the business of overriding state legislatures' decisions about consumer protections.

Recently, I received a letter from two Republican members of the Texas legislature

who were instrumental in the passage of recent Texas laws that provide strong consumer protections. I quote from that letter:

In 1995 managed care reform opponents called the patient protection act a billion-dollar health care tax, and in 1997 they claimed health care costs would skyrocket upwards of 30 percent. However, multiple independent studies, including an actuarial analysis by Milliman and Robertson, of Scott and White's HMO, show costs have increased by about 34 cents per member per month.

H.R. 4250, the House GOP bill, would weaken Texas' independent review provisions. Apparently, H.R. 4250's independent review is not binding compared to the Texas law that requires managed care organizations to provide care deemed appropriate by the independent review organization.

We also are concerned that H.R. 4250 weakens current Texas law regarding emergency care and gag clauses. As we understand it, the bill waters down Texas' prudent lay person by allowing a health plan to override the treatment decision by the emergency department physician. The gag clause provision does not protect health care providers from retaliation when they act as advocates for their patients.

One of the most important provisions of this legislation ensures that a new Texas law will not be overturned. That provision declares that the Employee Retirement Income Security Act of 1974 does not prevent a patient from suing his or her HMO in state court for personal injury or wrongful death damages. This provision makes insurance companies accountable for their actions. The laws in this country make every other industry accountable for their actions. If automobile manufacturers produce an inferior product that harms people, they are accountable for that damage. Doctors are accountable for the medical decisions they make that harm their patients. Why then are insurance companies not accountable for the decisions they make that harm the health of patients?

Allegations that the Dingell-Ganske substitute would make employers liable are simply not true. Clearly, employers cannot be held liable for the decisions of insurance companies and/or the decisions of others. The Dingell-Ganske substitute does not create a new right of action. It simply removes the provision of ERISA that protects insurance companies from being sued. It specifically states that employers cannot be held liable unless they exercise discretionary authority to make a decision on a claim for benefits covered under the plan. During the course of the last six months, I have met with many representatives of the business community. I have repeatedly asked them to bring me language that they believe would prevent employers from being sued and assured them that I would work with Mr. DINGELL and Mr. GANSKE to address their concerns. Not one of those people has taken me up on my offer. That is because there is no employer liability in the bill. Their answer instead is to oppose the entire bill and support H.R. 4250, and threaten Members who support Dingell-Ganske.

One of the most disturbing provisions of H.R. 4250 will severely undermine the patient's right to private medical records. This bill allows for the release and use of confidential health information without the patient's consent. Once that information is released, it can be sold without the patient's consent or knowledge. And once again, H.R. 4250 would preempt state laws that already have strong medical privacy protections. That's wrong and this Congress should not be subjecting the American people to such an outrageous position.

Mr. Speaker, I urge my colleagues to support the Dingell-Ganske substitute and oppose the disingenuous attempt by supporters of H.R. 4250 to pull the wool over the eyes of the American people.

Mr. MORAN of Virginia. Mr. Speaker, there must be certain provisions included in patients rights legislation in order to ensure true protections. For all health plans, there should be an outside review appeals mechanism. Patients should have the right to appeal adverse coverage decisions made by their health plans. Women should be able to choose their OBGYNs as their primary care physician, and chronically ill patients should not have to get referral from a primary care physician every time they need to see the specialist who treats their chronic illness. States should be able to protect consumers from breaches to consumer privacy. The Ganske-Dingell substitute provides these vital protections and more.

Although I have concerns about a provision in the bill which deals with the certification of class action law suits, I feel that the true protections the Ganske-Dingell substitute would provide are of greater benefit to health care consumers, our constituents, than my concerns could justify opposing the substitute. I am hopeful that the authors of this legislation would consider working to address these concerns in conference, but with the assurance of the patient protections guaranteed in the Ganske-Dingell substitute I am pleased to support its passage.

Ms. CHRISTIAN-GREEN. Mr. Speaker, as a physician, it is very important to me that we pass meaningful managed care reform, and that means passing the Ganske-Dingell bill.

Anyone who has heard me speak on health care issues has heard my concern about those Americans who are under or un-insured, because they are denied access to medical care.

Well Mr. Speaker, what the current managed care system has done is made a bad system worse.

Now even people who have insurance under managed care are being denied access to needed and appropriate medical care.

Mr. Speaker this has to change and the Ganske-Dingell bill—the Patients' Bill of Rights is the bill which will provide that access.

Further Mr. Speaker, if a health plan makes a decision about patient care and something goes wrong, it must be liable. To do anything less is patently unfair.

Mr. Speaker and colleagues, lets fix the mangled care system. Pass the Ganske-Dingell bipartisan bill.

Mr. CONYERS. Mr. Speaker, I rise today to oppose the Republican attack on the health care of millions of Americans. The Republican bill, which had no public hearings, no committee markup, and no CBO estimate of its costs is a slapdash, thrown together, cynical attempt to satisfy the American people's hunger for real managed care reform.

This Republican bill is a lie. It is titled the Patient Protection Act, but it has nothing to do with patient protection. This bill is all about protecting insurance companies from angry and injured patients who have been denied care because, in the view of their insurance company, their treatment was not ''medically necessary.'' Why are the Republicans trying to keep insurance companies from being held accountable for their mistakes? No other industry has the right to the same immunity from suit that insurance companies have, and no other industry should have that immunity. The thousands of men, women, and children across this country who have been hurt by an insurance company decision are crying out for justice, and we as their representatives should provide them with a way to achieve that justice.

The Dingell bill provides them with this justice. This bill will ensure that the next time an insurance bureaucrat has to decide whether a child he has never seen needs life saving treatment, he will think twice, instead of denying the treatment out of hand.

We need to reform the insurance industry, and make insurance companies care about the health of the patients that they cover. Our bill does this. Don't vote for the Republican's cynical lie. I urge my colleagues to support the Dingell bill, and provide Americans with the health justice they need and deserve.

Ms. LEE. Mr. Speaker, I rise in strong support of H.R. 3605, The Patients' Bill of Rights. Today we see appalling, devastating problems with HMO's. Instead of concern for patients, too many HMO's focus on making money at the expense of quality health care. They have denied medical procedures that they decide ''unnecessary'', even though patients' lives may have depended on them. They have refused to pay for medical procedures for children with terrible deformities, calling the operations ''cosmetic''. They have even taken away a doctor's right to authorize crucial procedures, dangerously yielding the most important decision-making responsibilities to a bureaucrat in an office building 3,000 miles away.

The Patients' Bill of Rights is a comprehensive bill which makes certain that health care providers do what is in the best interests of their customers, not their profits. It guarantees basic rights for all patients, placing health, well-being, and safety above all else, and valuing the patient-doctor relationship. Among the most important aspects of the bill is that it allows doctors, not insurance companies, to make crucial decisions regarding the health of patients. Another important safeguard in the bill guarantees that individuals are covered for *all* emergency services. No one should have to worry about insurance coverage for life-saving emergency care.

Furthermore, and very significant, the Patients' Bill of Rights calls for internal and external appeals processes to adequately address patients' grievances. These processes are crucial because they ensure that insurance companies are held accountable for providing quality care to people, or required to pay the consequence.

In contrast, H.R. 4250, the Republican version of a healthcare bill, is a vague and inadequate measure that fails to address many of the vital problems in the healthcare industry. Failing to focus on the needs of patients, it favors the multibillion-dollar insurance industry. Under H.R. 4250, insurance companies will not be held accountable for decisions that cause injury to a patient. Crucial health decisions will continue to be made by the patient's insurance company rather than the doctor. The Republican plan does not put patients first, but rather, serves insurance companies' interests at the cost of quality health care.

Furthermore, whereas the Patients' Bill of Rights expands healthcare to include provisions for patients who are seriously ill or require the expertise of the specialist, such as victims of HIV and cancer, the Republican plan puts at risk even the most basic and necessary measures. In my home state of California, current benefits such as mammography and cervical cancer screening, prenatal care, and mental health care could be overridden by H.R. 4250. It is unthinkable to me that these essential, preventative measures are threatened in this legislation. This would be a drastic step backward in caring for our people, and a further example of cutting cost at the expense of patient care.

Mr. Speaker, I have heard some of my colleagues on the other side of the aisle connect our current U.S. health care system to capitalism, stating that capitalism produces excellence in health care. This misguided mentality is frightening to me. Capitalism affords excellent healthcare only to the select few who are able to pay the most for it, and leaves all others without. This principle of the profit-making, market system is a devastating policy for health care. Health care is not a luxury to be afforded to the highest bidder. Providing health care is not about striving to make the greatest amount of money.

Health care is a basic right that all Americans deserve, yet the United States is the only Western industrialized country that does not have a national health program. In a wealthy nation such as ours, it is incredible to me that there are so many who lack access to this fundamental necessity. The Republican plan will serve only to increase the rift between those who have access to health care and those who are left behind, neglected and trapped without adequate care.

I urge your opposition of H.R. 4250 and support of H.R. 3605, the Patients' Bill of Rights.

Mr. ALLEN. Mr. Speaker, I rise in support of the Ganske-Dingell substitute to H.R. 4250, the Republican HMO health care bill.

We have an opportunity in this Congress to enact real reform in our health care system. Months ago, Democrats introduced the Patients' Bill of Rights Act to protect patients against HMO abuses. Now that we are a few months away from an election, the Republicans have decided that they need their own version of a managed care ''reform'' bill.

This republican bill is being rushed to the House floor without the benefit of even one public hearing or any committee mark-up. As of 1 a.m. this morning, this bill was still being drafted.

While the Republican leadership has been willing to spend more than a year and millions of dollars on committee investigations, they are not willing to allow even one hearing on legislation which could significantly affect Americans' lives.

Health care financing is in transition. Private and public purchasers of health care are turning to managed care.

The shift to managed care has raised concerns about the implications for health care quality. I believe that managed care must be more than managed cost.

Last month I held community health care forums in my district. This was an opportunity for my constituents to come and share their experiences. I wanted to hear from them about health care costs, quality and access for Maine children and families.

I did not hear the managed care horror stories to the extent that many of my colleagues have heard. Maine has been slow to move to managed care. People did, however, express their fears about this system.

I heard from a mother who works an extra job to pay for an indemnity health insurance policy for her daughter who has a severe disability. It was clear that purchasing this health plan was a financial hardship for this family. This mother was too fearful to move to a managed care plan which may be less expensive because it could limit the care that her daughter needs.

Others also shared their concerns about managed care. Could some of the same horror stories that they hear about on the national news happen to them?

My constituents are not alone in their fears about managed care. There is a crisis of confidence in American health care:

Eighty percent of all consumers believe that insurance plans often compromise the quality of care to save money.

The worst problems are often reported by those who need good care the most—those with chronic conditions who experienced an illness serious enough to require hospitalization. More than one half of this group reported problems with their health insurance.

36 percent said that their condition worsened as a result of the insurance problem.

35 percent said the problem led to an additional condition,

And 17 percent developed permanent disabilities. Problems ranged from delays in care to failure to refer to a specialist to problems with payment, billing, and coverage.

As I mentioned, Maine has not moved to managed care as rapidly as other areas. Furthermore, strong patient protections have been enacted at the state level. However, because of federal preemptions to state protections, at least 250,000 people in Maine are left unprotected. My constituents recognize that we need a national solution to a national problem.

The Republican legislation only applies to Americans in self insured plans. They ignore two-thirds of Americans with private health insurance. This means that Americans with individual policies, state and local government employees and people whose employers purchase coverage through an HMO or insurance policy are left unprotected. 113 million Americans are left out in the cold by the Republican bill.

The Republican bill is clearly designed for political cover rather than real patient protections. For example, the Republican bill does not:

Provide patients with access to clinical trials;

Permit doctors to prescribe prescription drugs that are not on an HMO's predetermined list;

Provide ongoing access to specialty care;

Protect health care workers who report quality problems;

Provide choice of doctors within a plan; or

Hold managed care plans accountable when a patient is injured by a plan's decision to withhold or limit care.

By contrast, the Patients' Bill of Rights Act does provide all of these protections.

In addition to empty promises, the Republican bill is laced with poison pills such as healthmarts and malpractice limits.

I plan to hold more community health care forums in my district during the August in district work period. It is my sincere hope that I will be able to assure my constituents that they do not need to fear the health care system in this country.

The American people have been clear. They want real protections. They do not want a watered down bill. They want the Ganske-Dingell substitute, the Patients' Bill of Rights Act.

Ms. KILPATRICK. Mr. Speaker, I rise today in strong, unequivocal and clear support of H.R. 3605, the Democratic Patient Protection Act, and oppose H.R. 4250, the Republican Politician Protection Act. The Republican Politician Protection Act provides too few patient protections, undermines existing state consumer protections, has not had a single hearing or mark-up, and contains unnecessary and irrelevant provisions. It is time that we, the Congress, stopped playing games with the health care of our constituents and get down to the real business of providing both doctors and patients with the protections that they need and deserve. I recently had a meeting with the Michigan State Medical Society, an organization made up of doctors in the State of Michigan, and they wholeheartedly endorse the Democratic Patient Protection Act, among more than 50 consumer protection, labor union, and health care organizations.

Let me take a minute to explain to you three key differences between the Democratic Patient Protection Act and the Republican Politician Protection Act:

The Republican Politician Protection Act allows medical insurance companies to give your confidential medical records to another agency—another insurance company, mortgage company, credit bureau, pharmacy, or health care bureaucrat—without your consent. This means that anyone—a person applying for a mortgage, someone looking to peer through your medical history before you start a job, a person looking for negative health information against a potential candidate for Congress—could have access to your medical records. The Democratic Patient Protection Act protects the confidentiality of your medical records. No one would be allowed to review or transfer your records without your express and written consent.

The Politician Protection Act usurps and supersedes state consumer protections. Mr. Speaker, before I was elected to this august body, I served for 18 years as a state legislator in the great State of Michigan. I abhorred and detested those rules, laws and regulations that superseded our rules, laws and regulations that were democratically arrived at and after many hearings, debate, and votes. Ostensibly, the Republican Party is one of respecting the rights of states to make the best decisions for themselves—or has posited themselves as such. The Republican Politician Protection Act would not allow states to decide for themselves the best consumer protections for their citizens. The Democratic Patient Protection Act does not usurp state law.

The Republican Politician Protection Act does not allow patients to sue their health insurance plans for wrongdoing. The Republican Politician protection act allows persons to sue for fiduciary damages, but not for pain and suffering or punitive damages. What does this mean? Well, it means that if your doctor in a managed care plan recommends that you have an additional mammogram, but the plan refuses to pay for it and the patient dies as a result, the family could sue for the cost of the

mammogram. The Democratic Patient Protection Act will ensure that patients can sue for compensatory and punitive damages, and let a jury—the same juries who register to vote and send us to Congress—decide the merits of these issues.

Adoption of the Democratic Patient Protection Act would be only a first step toward solving our health care crisis. We still need to address the more than 4 million families, women, children and adults over the past decade who do not have any health insurance. Guess who is footing the bill when these uninsured women, children and adults show up at the hospitals of our nation? That's right, you and I. Access to quality health care, before catastrophic diseases attack, has been proven to prolong the length and quality of life of Americans. The challenge of serving those persons who do not have access to health care is one of the many unfinished tasks facing us as a Congress and as a nation as we consider the reform of our health care system.

If you think that you don't know someone who is medically underserved, think again. The usual person who is defined as ''medically underserved'' is poor, elderly, has no health care, and does not have access to primary care physicians. In our land of plenty, over 43 million people are medically underserved, and only 24 percent of those persons are served through community health centers. What happens to more than three quarters of these people who do not have access to health care is simply this: immunizations are not given, and babies fall ill to preventable diseases; elderly citizens do not get their high blood pressure or diabetes cared for, and end up in the hospital, or women do not get a life-saving mammogram. Not having any health care, in our land of plenty, is almost criminal.

Taxpayers want, and need, long-range solutions to the challenge of access to affordable, quality health care. Taxpayers deserve an investment of resources and commitment to the goal of health care for all. It is the job and duty of Congress to address this issue now. The doors of health care must remain open to protect the public health, prevent disease, improve our quality of life and save scarce taxpayer dollars. Congress can, and must, improve access to health care for all. The Democratic Patient Protection Act is a strong, aggressive step toward the much needed reform of our health insurance system, but it is only a first step. I urge all of my colleagues to reject the Republican Politician Protection Act and vote for the Democratic Patient Protection Act.

The SPEAKER pro tempore (Mr. KOLBE). The question is on the amendment in the nature of a substitute offered by the gentleman from Michigan (Mr. DINGELL).

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. DINGELL. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 212, nays 217, not voting 6, as follows:

[Roll No. 336]

YEAS—212

Abercrombie
Ackerman
Allen
Andrews
Baesler
Baldacci
Barcia
Barrett (WI)
Becerra
Bentsen
Berman
Berry
Bilbray
Bishop
Blagojevich
Blumenauer
Boehlert
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (CA)
Brown (FL)
Brown (OH)
Capps
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Cramer
Cummings
Danner
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Fazio
Filner
Forbes
Fox
Frank (MA)
Frost
Furse
Ganske
Gejdenson
Gephardt
Goode
Gordon
Green
Gutierrez
Hall (OH)
Hall (TX)
Hamilton
Harman
Hastings (FL)
Hefner
Hilliard
Hinchey
Holden
Hooley
Horn
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson (WI)
Johnson, E. B.
Kanjorski
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kilpatrick
Kind (WI)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
LaTourette
Leach
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Luther
Maloney (CT)
Maloney (NY)
Manton
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McHale
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller (CA)
Minge
Mink
Moakley
Mollohan
Moran (VA)
Morella
Murtha
Nadler
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pickett
Pomeroy
Poshard
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roukema
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schumer
Scott
Serrano
Sherman
Sisisky
Skaggs
Skelton
Slaughter
Smith, Adam
Snyder
Spratt
Stabenow
Stark
Stenholm
Stokes
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson
Thurman
Tierney
Torres
Towns
Traficant
Turner
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Wexler
Weygand
Wise
Woolsey
Wynn

NAYS—217

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilirakis
Bliley
Blunt
Boehner
Bonilla
Bono
Brady (TX)
Bryant
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Castle
Chabot
Chambliss
Chenoweth
Christensen
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Crane
Crapo
Cubin
Cunningham
Davis (VA)
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Foley
Fossella
Fowler
Franks (NJ)
Frelinghuysen
Gallegly
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Goss
Graham
Granger
Greenwood
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayworth
Hefley
Herger
Hill
Hilleary
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Inglis
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King (NY)
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
Lazio
Lewis (CA)
Lewis (KY)
Linder
Livingston
LoBiondo
Lucas
Manzullo
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Moran (KS)
Myrick
Nethercutt
Neumann
Ney
Northup
Norwood
Nussle
Oxley
Packard
Pappas
Parker
Paul
Paxon
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Ramstad
Redmond
Regula
Riggs
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Royce
Ryun
Salmon
Sanford
Saxton
Scarborough
Schaefer, Dan
Schaffer, Bob
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Shimkus
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Smith, Linda
Snowbarger
Solomon
Souder
Spence
Stearns
Stump
Sununu
Talent
Tauzin
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Upton
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
White
Whitfield
Wicker
Wilson
Wolf
Young (AK)

NOT VOTING—6

Ford
Gonzalez
Hinojosa
Markey
Yates
Young (FL)

☐ 1352

Messrs. WHITE and EHLERS changed their vote from ''yea'' to ''nay.''

Ms. BROWN of Florida, Mr. SCHUMER and Mr. BOYD changed their vote from ''nay'' to ''yea.''

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

PERSONAL EXPLANATION

Mr. HINOJOSA. Mr. Speaker, during rollcall vote No. 336, The Dingell Substitute to H.R. 4250, I was unavoidably detained. Had I been present, I would have voted ''yes.''

The SPEAKER pro tempore (Mr. KOLBE). Pursuant to House Resolution 509, the previous question is ordered on the bill, as amended.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. BERRY

Mr. BERRY. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman from Arkansas opposed to the bill?

Mr. BERRY. Yes, Mr. Speaker, in its current form.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Berry moves to recommit the bill H.R. 4250 to the Committee on Ways and Means and to the Committee on Education and the Workforce with instructions to report back the same to the House forthwith with the following amendments to the portions of the same within their respective jurisdiction:

Page 38, beginning on line 9, strike ''does not meet the plan's requirements for medical appropriateness or necessity'' and insert ''is not medically necessary and appropriate''.

Page 39, beginning on line 16, strike ''does not meet the plan's requirements for medical appropriateness or necessity'' and insert ''is not medically necessary and appropriate''.

Page 48, beginning on line 17, strike ''does not meet the plan's requirements for medical appropriateness or necessity'' and insert ''is not medically necessary and appropriate''.

Page 53, beginning on line 17, strike ''meets, under the facts and circumstances at the time of the determination, the plan's requirement for medical appropriateness or necessity'' and insert ''is, under the facts and circumstances at the time of the determination, medically necessary and appropriate''.

Page 60, line 17, strike all that follows the first period.

Page 60, after line 17, insert the following new subparagraph:

''(V) MEDICAL NECESSITY AND APPROPRIATENESS.—The term 'medically necessary and appropriate' means, with respect to an item or service, an item or service determined by the treating physician (who furnishes items and services under a contract or other arrangement with the group health plan or with a health insurance issuer providing health insurance coverage in connection with such a plan), after consultation with a participant or beneficiary, to be required, according to generally accepted principles of good medical practice, for the diagnosis or direct care and treatment of an illness or injury of the participant or beneficiary.''.

Page 227, strike line 1 and all that follows through page 233, line 3, and insert the following (and conform the table of contents accordingly):

Subtitle C—Deduction for Health Insurance Costs of Self-Employed Individuals

SEC. 3201. DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—The table contained in subparagraph (B) of section 162(l)(1) of the Internal Revenue Code of 1986 is amended to read as follows:

In the case of taxable years beginning in calendar year:	The applicable percentage is:
1999, 2000, and 2001 ..	60 percent
2002	70 percent
2003 or thereafter ...	100 percent.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 1998.

Mr. BERRY (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Arkansas?

Mr. HASTERT. Mr. Speaker, I object.

The SPEAKER pro tempore. Objection is heard.

The Clerk will continue to read.

The Clerk continued reading the motion to recommit.

Mr. HASTERT. Mr. Speaker, I reserve all points of order.

The SPEAKER pro tempore. The gentleman reserves a point of order.

The gentleman from Arkansas (Mr. BERRY) is recognized for 5 minutes.

Mr. BERRY. Mr. Speaker, my motion makes the following two important changes: It strikes the Medical Savings Account provision from the Republican bill, saving billions of dollars a year.

The money saved in the MSA will be used to accelerate the health insurance deduction for the self-employed. This helps small businessmen by increasing the deduction for expenditures on health insurance to 60 percent in the next 3 years, 70 percent in the year 2002, and 100 percent thereafter.

The current deduction is 45 percent and will not increase to 100 percent until the year 2006.

It amends the Republican bill by putting the decision of ''medical necessity'' back in the hands of doctors. The new language allows for the doctor and the patient, not the insurance companies, to determine the proper care and treatment for the patient.

□ 1400

It also makes sure the care they receive is consistent with good medical practice, not insurance profits. The Republican version leaves this decision up to the insurance companies. The Republican bill would create a system where the insurance company would win every time. The deck is stacked against the patients before they even get in to see their doctor.

The bill would allow insurers to develop their own definitions and methods for determining medical necessity, which would make it virtually impossible for enrollees to challenge the plan's decision. A plan could define medical necessity to essentially be nothing more than the care defined under whatever treatment guidelines and utilization protocols the plan adopts, even if the guidelines and protocols are not backed up by any clinical evidence or good professional practice. Plans would always win under this scenario. The Republican bill would allow insurers to overturn physicians' treatment decisions on the basis of completely arbitrary standards that are not based on any credible medical evidence.

I do not think that that is the kind of care that we want for our families, our children, our parents or our friends. But that is just what this Republican bill would allow.

I yield to the gentleman from Michigan (Mr. DINGELL).

Mr. DINGELL. Mr. Speaker, I thank the gentleman for yielding to me. I would observe that here we are discussing the fundamental difference between the two bills. If you want to provide protection for the doctor-patient relationship, vote for the motion to recommit, because the motion to recommit assures that it will be medical necessity decided by the doctor that determines the course of treatment of a patient of an HMO, not some curious, insurance-oriented approach which would be decided by the Republican plan.

One of my friends who is one of the outstanding physicians and surgeons in the 16th District called me to tell me about something that happened to him recently. He was made an examiner of medical claims. He was fired by the HMO. The reason was that he was making medical decisions, not insurance decisions. That is exactly the issue which is before us.

If you want the doctor to decide what you and your family and your constituents are going to receive in the way of medical care, vote for the motion to recommit. If you want to have an unelected, unaccountable health care bureaucrat appointed by a health insurance company or an HMO, then vote against it. And what you will be doing, you will be vesting in the HMO the power to make a medical decision instead of seeing to it that that medical decision is made by the doctor in concert with his patient. Medical necessity should be decided by a doctor who is trusted by the patient, not by an unknown voice on the telephone who is neither doctor nor accountable, a health care bureaucrat. That is the point of this amendment.

If you believe in the doctor-patient relationship and if you believe it is worth protecting, then vote ''aye'' on the motion to recommit. That is what is at stake, the doctor-patient relationship, and the doctor making a decision with regard to what constitutes medical necessity and what constitutes the need of the patient. To vote ''no'' on this motion to recommit is to assure that medical necessity is decided by an anonymous voice on the telephone belonging to no one with a relationship to the patient.

POINT OF ORDER

The SPEAKER pro tempore (Mr. KOLBE). Does the gentleman from Illinois insist on a point of order?

Mr. HASTERT. Mr. Speaker, I insist on a point of order.

The SPEAKER pro tempore. The gentleman will state his point of order.

Mr. HASTERT. I yield to the gentleman from California (Mr. THOMAS).

The SPEAKER pro tempore. The Chair will recognize the gentleman from California (Mr. THOMAS) on the point of order.

Mr. THOMAS. Mr. Speaker, contained among the numerous provisions in the motion to recommit is striking the medical savings accounts. Notwithstanding the gentleman's representation that this will save billions of dollars a year, the Congressional Budget Office says that simply is not so. In fact, it will save less than $1 billion a year. That is the point on which the point of order turns, because the gentleman's addition of the acceleration of the self-employed deduction in fact scores more than $1 billion and therefore is subject to a 303 Congressional Budget Act point of order. It in fact increases the budget before the final

budget is adopted in a given fiscal year. It applies clearly in this particular instance. A point of order, therefore, lies against the gentleman and I would urge the Chair to sustain the 303(a) Congressional Budget Act point of order.

The SPEAKER pro tempore. The gentleman from California has made a point of order.

Does the gentleman from Arkansas (Mr. BERRY) wish to be heard on the point of order?

Does the gentleman from Maryland (Mr. CARDIN) wish to be heard on the point of order?

Mr. CARDIN. Yes, I do, Mr. Speaker.

The SPEAKER pro tempore. The gentleman from Maryland is recognized on the point of order.

Mr. CARDIN. If I understand the gentleman from California's point is that the striking of the medical savings account provision would not save as much money as accelerating the self-employed insurance deduction by 4 years.

Mr. Speaker, I would like to include in the RECORD a document that has been received from the Joint Committee on Taxation that shows that striking the medical savings account provision will save $4.1 billion, the self-employed health insurance deduction would cost $3.4 billion, for a net revenue savings to the treasury of $687 million.

The SPEAKER pro tempore. The gentleman from Maryland may insert the documents after the point of order but not during debate on the point of order.

Is there any other Member who wishes to be heard on the point of order?

Mr. CARDIN. Mr. Speaker, on that point, if I am correct, the point of order is being raised as it relates to having——

The SPEAKER pro tempore. That is correct. The Chair must rely on what is being said to the Chair and so insertion into the RECORD during the debate on the point of order is not in order at this time.

Mr. CARDIN. I would just quote into the record the document from the Joint Committee on Taxation dated July 23, 1998, and would be glad to make it available to the Parliamentarian.

The SPEAKER pro tempore. Does any other Member wish to be heard?

Mr. THOMAS. Mr. Speaker, on the point just registered, this is the House and not the Senate. The Senate just read 10-year numbers, the House operates on 5-year numbers, and the point of order still stands.

Mr. CARDIN. Mr. Speaker, let me put into the record the 5-year numbers. The 5-year numbers on striking the medical savings account provision would save $1.3 billion, the self-employed would cost $1.2 billion, for a net savings to the treasury of $56 million.

The SPEAKER pro tempore. Is there any other Member who wishes to be heard on the point of order? If not, the Chair is prepared to rule.

Mr. THOMAS. Mr. Speaker, the gentleman is reading from a document that I do not believe is current. Would he cite the number and the date?

Mr. CARDIN. If the gentleman would yield, it is dated July 23, 1998.

Mr. THOMAS. I tell the gentleman the numbers I just read come from a Joint Tax Committee publication July 24, 1998. But the gentleman is not bad being only one day behind.

Mr. CARDIN. Mr. Speaker, I have the July 25 numbers.

The SPEAKER pro tempore. Does the gentleman from Illinois insist upon his point of order?

Mr. HASTERT. Mr. Speaker, I insist on my point of order.

The SPEAKER pro tempore. Does any other Member wish to be heard on the point of order? Is there anybody else who wishes to be heard on the point of order? If not, the Chair is prepared to rule.

The amendment proposed in the motion to recommit would strike one of the revenue provisions from the bill. The amendment also would insert an alternate revenue change. In this latter respect, the amendment ''provides an increase or decrease in revenues'' within the meaning of section 303 of the Budget Act.

Because this revenue change would occur during fiscal year 1999, a year for which a budget resolution has yet to be finalized, the amendment violates section 303(a)(2) of the Act.

The point of order is sustained.

Mr. CARDIN. Mr. Speaker, this is not the point raised in the objection by the Member. I do not know how the Chair can on its own use as a basis for an appeal that was not raised and we did not have a chance to argue the point on. That is blatantly against the rules of the House, and I appeal the ruling of the Chair.

The SPEAKER pro tempore. The question is, Shall the decision of the Chair stand as the judgment of the House?

MOTION TO TABLE OFFERED BY MR. ARMEY

Mr. ARMEY. Mr. Speaker, I move to table the appeal.

The SPEAKER pro tempore. The question is on the motion to table offered by the gentleman from Texas (Mr. ARMEY).

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. ACKERMAN. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 222, noes 204, not voting 9, as follows:

[Roll No. 337]

AYES—222

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blunt
Boehlert
Boehner
Bonilla
Bono
Brady (TX)
Bryant
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Castle
Chabot
Chambliss
Chenoweth
Christensen
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Crane
Crapo
Cubin
Cunningham
Davis (VA)
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Foley
Fossella
Fowler
Fox
Franks (NJ)
Frelinghuysen
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gilman
Gingrich
Goodlatte
Goodling
Goss
Graham
Granger
Greenwood
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayworth
Hefley
Herger
Hill
Hilleary
Hobson
Hoekstra
Horn
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Inglis
Istook
Jenkins
Johnson, Sam
Jones
Kasich
Kelly
Kim
King (NY)
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Livingston
LoBiondo
Lucas
Manzullo
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Moran (KS)
Morella
Myrick
Nethercutt
Neumann
Ney
Northup
Norwood
Nussle
Oxley
Packard
Pappas
Parker
Paul
Paxon
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Ramstad
Redmond
Regula
Riggs
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Roukema
Royce
Ryun
Salmon
Sanford
Saxton
Scarborough
Schaefer, Dan
Schaffer, Bob
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Shimkus
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Smith, Linda
Snowbarger
Solomon
Souder
Spence
Stearns
Stump
Sununu
Talent
Tauzin
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Upton
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weller
White
Whitfield
Wicker
Wilson
Wolf
Young (AK)

NOES—204

Abercrombie
Ackerman
Allen
Andrews
Baesler
Baldacci
Barcia
Barrett (WI)
Becerra
Bentsen
Berman
Berry
Bishop
Blagojevich
Blumenauer
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (CA)
Brown (FL)
Brown (OH)
Capps
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Cramer
Cummings
Danner
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Fazio
Filner
Forbes
Frank (MA)
Frost
Furse
Gejdenson
Gephardt
Goode
Gordon
Green
Gutierrez
Hall (OH)
Hall (TX)
Hamilton
Harman
Hastings (FL)
Hefner
Hilliard
Hinchey
Hinojosa
Holden
Hooley
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson (WI)
Johnson, E. B.
Kanjorski

Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kilpatrick
Kind (WI)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Luther
Maloney (CT)
Maloney (NY)
Manton
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McHale
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller (CA)
Minge
Mink
Moakley
Mollohan
Moran (VA)
Murtha
Nadler
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pickett
Pomeroy
Poshard
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schumer
Scott
Serrano
Sherman
Sisisky
Skaggs
Skelton
Slaughter
Smith, Adam
Snyder
Spratt
Stabenow
Stark
Stenholm
Stokes
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson
Thurman
Tierney
Torres
Towns
Traficant
Turner
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Wexler
Weygand
Wise
Woolsey
Wynn

NOT VOTING—9

Ford
Gillmor
Gonzalez
Johnson (CT)
Linder
Markey
Weldon (PA)
Yates
Young (FL)

□ 1428

So the motion to table was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

MOTION TO RECOMMIT OFFERED BY MR. BERRY

Mr. BERRY. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore (Mr. KOLBE). Is the gentleman still opposed to bill?

Mr. BERRY. Mr. Speaker, in its current form, I am.

The SPEAKER pro tempore. The Clerk will report the motion.

The Clerk read as follows:

Mr. BERRY moves to recommit the bill H.R. 4250 to the Committee on Education and the Workforce with instructions to report back the same to the House forthwith with the following amendments:

Page 38, beginning on line 9, strike ''does not meet the plan's requirements for medical appropriateness or necessity'' and insert ''is not medically necessary and appropriate''.

Page 39, beginning on line 16, strike ''does not meet the plan's requirements for medical appropriateness or necessity'' and insert ''is not medically necessary and appropriate''.

Page 48, beginning on line 17, strike ''does not meet the plan's requirements for medical appropriateness or necessity'' and insert ''is not medically necessary and appropriate''.

Page 53, beginning on line 17, strike ''meets, under the facts and circumstances at the time of the determination, the plan's requirement for medical appropriateness or necessity'' and insert ''is, under the facts and circumstances at the time of the determination, medically necessary and appropriate''.

Page 60, line 17, strike all that follows the first period.

Page 60, after line 17, insert the following new subparagraph:

''(V) MEDICAL NECESSITY AND APPROPRIATENESS.—The term 'medically necessary and appropriate' means, with respect to an item or service, an item or service determined by the treating physician (who furnishes items and services under a contract or other arrangement with the group health plan or with a health insurance issuer providing health insurance coverage in connection with such a plan), after consultation with a participant or beneficiary, to be required, according to generally accepted principles of good medical practice, for the diagnosis or direct care and treatment of an illness or injury of the participant or beneficiary.''.

Mr. BERRY (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Arkansas?

Mr. HASTERT. Mr. Speaker, I object.

The SPEAKER pro tempore. Objection is heard.

The Clerk will continue reading the motion.

The Clerk continued reading the motion.

Mr. HASTERT. Mr. Speaker, I reserve a point of order against the motion.

The SPEAKER pro tempore. The gentleman from Arkansas (Mr. BERRY) is recognized for five minutes on his motion to recommit.

Mr. BERRY. Mr. Speaker, my motion to recommit is the same as the last motion, but deals solely with the definition of ''medical necessity.'' The motion to recommit will allow the doctor to determine what care is medically necessary. The doctor, not the insurance company, not a Federal bureaucrat, not a state bureaucrat, but the doctor, the person who went to medical school for many years to learn how to take care of you, would make that decision.

The motion to recommit would make sure that the health care that they receive from their managed care company is consistent with good medical practice, not accounting profit principles.

The motion to recommit will make sure that the decisions insurance companies are making regarding what it is or is not to be provided are supported by credible medical evidence. The motion to recommit puts medical care where it belongs, in the hands of doctors, not in the hands of Republican special interest friends.

The SPEAKER pro tempore. Does the gentleman from Illinois (Mr. HASTERT) insist on his point of order?

Mr. HASTERT. Mr. Speaker, I withdraw my point of order.

The SPEAKER pro tempore. Does the gentleman from Illinois (Mr. HASTERT) wish to be heard on the motion to recommit?

Mr. HASTERT. I do.

The SPEAKER pro tempore. Is the gentleman opposed to the motion?

Mr. HASTERT. I am opposed to the motion.

The SPEAKER pro tempore. The gentleman from Illinois (Mr. HASTERT) is recognized for five minutes.

Mr. HASTERT. Mr. Speaker, I yield to the gentleman from Georgia (Mr. GINGRICH), the Speaker of the House.

Mr. GINGRICH. Mr. Speaker, let me recapture for everybody we were are at here, because I think you have to put in context this interesting and inventive motion to recommit.

First of all, under the Patient Protection Act that will come to final passage, anybody who has a practical layman's feeling that they need emergency care, has a presumption they need it, automatically, you walk in, you say ''I have heart pain,'' or ''I have a chest pain,'' and you are covered.

When you walk in, under the Patient Protection Act, a medical doctor on the site looking at the patient makes a decision, do you need further treatment? For example, if it turns out you over-ate and in fact need bicarbonate, you probably do not get an MRI. But if they think you have a severe heart problem or they think you might have cancer, you immediately have an opportunity for whatever emergency room treatment is necessary on a medical basis defined by the medical doctor.

If you find out you have a longer-term problem, under the Patient Protection Act, if you happen to belong to an HMO that does not agree you should be treated, you immediately have an appeal internally, and within 72 hours they have to say ''yes,'' or ''no, you should get this.''

If you do not agree when they say no, you have an immediate external appeal to a medically appropriate group of specialists who fit the same topic, and they, within 72 hours, have to say yes, in fact you have pancreatic cancer, you deserve and need chemotherapy, period.

At that point, if the HMO is truly stupid, it can say they are not going to give it to you anyway, in which case you can go to court carrying with you the medical doctors who have already said you are right.

Now, that is what we do, notice at every stage; medical doctor, medical doctor, medical doctor.

But there is one hook, as I read this quite inventive proposal. I believe, and I am not a lawyer, I am just a historian, and for everybody who is grateful for a nonlawyer as Speaker, I understand it has been a rare event, but, anyway, as I understand this, from the brief few minutes we have had to look at it, this would in essence eliminate the concept of insurance coverage.

This would allow you, as worded, to walk in and have a doctor say, ''You know, I know you never paid for this insurance, I know you are not covered for this at all, but I am now going to do the following 12 medically necessary things.'' A terrific idea. It bankrupts every insurance company in America, it eliminates the employer-based system, it guarantees you go to government health care, and, literally, I do not know why you guys wrote it this way, this has no meaning in the real

world, except that you would be required to get everything open-ended as long as you found a doctor somewhere who said you should get it.

Now, this is in fact one of the nuttiest expansions of the right to charge for health care I have ever seen, and I am sure it is just because they got their earlier motion, which was clever and well-crafted, ruled out of order and they had to rush something to the floor.

I would encourage all of you, unless you want to bankrupt the whole country, just simply vote no. The details will come out later when they have a chance to rewrite it.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. BERRY. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 205, nays 221, not voting 9, as follows:

[Roll No. 338]

YEAS—205

Abercrombie
Ackerman
Allen
Andrews
Baesler
Baldacci
Barcia
Barrett (WI)
Becerra
Bentsen
Berman
Berry
Bishop
Blagojevich
Blumenauer
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (CA)
Brown (FL)
Brown (OH)
Capps
Cardin
Carson
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Cramer
Cummings
Danner
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Dixon
Doggett
Dooley
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Fazio
Filner
Forbes
Fox
Frank (MA)
Frost
Furse
Ganske
Gejdenson
Gephardt
Goode
Gordon
Green
Gutierrez
Hall (OH)
Hall (TX)
Hamilton
Hastings (FL)
Hefner
Hilliard
Hinchey
Hinojosa
Holden
Hooley
Hoyer
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson (WI)
Johnson, E. B.
Kanjorski
Kaptur
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kilpatrick
Kind (WI)
Kleczka
Klink
Kucinich
LaFalce
Lampson
Lantos
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Luther
Maloney (CT)
Maloney (NY)
Manton
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McDermott
McGovern
McHale
McIntyre
McKinney
McNulty
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller (CA)
Minge
Mink
Moakley
Mollohan
Moran (VA)
Morella
Murtha
Nadler
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Pickett
Pomeroy
Poshard
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Rothman
Roukema
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schumer
Scott
Serrano
Sherman
Sisisky
Skaggs
Skelton
Slaughter
Smith, Adam
Snyder
Spratt
Stabenow
Stark
Stenholm
Stokes
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson
Thurman
Tierney
Torres
Towns
Traficant
Turner
Velazquez
Vento
Visclosky
Waters
Watt (NC)
Waxman
Wexler
Weygand
Wise
Woolsey
Wynn

NAYS—221

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blunt
Boehlert
Boehner
Bonilla
Bono
Brady (TX)
Bryant
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Castle
Chabot
Chambliss
Chenoweth
Christensen
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Crane
Crapo
Cubin
Cunningham
Davis (VA)
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Foley
Fossella
Fowler
Franks (NJ)
Frelinghuysen
Gallegly
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Goss
Graham
Granger
Greenwood
Gutknecht
Hansen
Harman
Hastert
Hastings (WA)
Hayworth
Hefley
Herger
Hill
Hilleary
Hobson
Hoekstra
Horn
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Inglis
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King (NY)
Kingston
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Livingston
LoBiondo
Lucas
Manzullo
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Moran (KS)
Myrick
Nethercutt
Neumann
Ney
Northup
Norwood
Nussle
Oxley
Packard
Pappas
Parker
Paul
Paxon
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Ramstad
Redmond
Regula
Riggs
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Royce
Ryun
Salmon
Sanford
Saxton
Scarborough
Schaefer, Dan
Schaffer, Bob
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Shimkus
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Smith, Linda
Snowbarger
Solomon
Souder
Spence
Stearns
Stump
Sununu
Talent
Tauzin
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Upton
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
White
Whitfield
Wicker
Wilson
Wolf
Young (AK)

NOT VOTING—9

Ford
Gonzalez
John
Klug
Linder
Markey
Meehan
Yates
Young (FL)

□ 1455

Mr. BLAGOJEVICH changed his vote from ''nay'' to ''yea.''

So the motion to table the appeal of the ruling of the Chair was rejected.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore (Mr. KOLBE). The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. DINGELL. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 216, nays 210, not voting 9, as follows:

[Roll No. 339]

YEAS—216

Aderholt
Archer
Armey
Bachus
Baker
Ballenger
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blunt
Boehlert
Boehner
Bono
Bryant
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Cannon
Castle
Chabot
Chambliss
Christensen
Coble
Coburn
Collins
Combest
Cook
Cooksey
Cox
Crane
Cubin
Cunningham
Danner
Davis (VA)
Deal
DeLay
Diaz-Balart
Dickey
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Ensign
Everett
Ewing
Fawell
Foley
Fossella
Fowler
Fox
Franks (NJ)
Frelinghuysen
Gallegly
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Gingrich
Goode
Goodlatte
Goodling
Goss
Graham
Granger
Greenwood
Gutknecht
Hansen
Hastert
Hastings (WA)
Hayworth
Hefley
Herger
Hill
Hilleary
Hobson
Hoekstra
Horn
Hostettler
Houghton
Hulshof
Hunter
Hutchinson
Hyde
Inglis
Istook
Jenkins
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King (NY)
Kingston
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Lazio
Leach
Lewis (CA)
Lewis (KY)
Livingston
LoBiondo
Lucas
Manzullo
McCollum
McCrery
McDade
McHugh
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Moran (KS)
Myrick
Nethercutt
Neumann
Ney
Northup
Norwood
Nussle
Oxley
Packard
Pappas
Parker
Paxon
Pease
Peterson (PA)
Petri
Pickering
Pitts
Pombo
Porter
Portman
Pryce (OH)
Quinn
Radanovich
Ramstad
Redmond
Regula
Riggs
Riley
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Royce
Ryun
Salmon
Saxton
Scarborough
Schaefer, Dan
Schaffer, Bob
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Shimkus
Shuster
Skeen
Smith (MI)
Smith (NJ)
Smith (OR)
Smith (TX)
Smith, Linda
Snowbarger
Solomon
Souder
Spence
Stearns
Stump
Sununu
Talent
Tauzin
Taylor (NC)
Thomas
Thornberry
Thune
Tiahrt
Traficant
Upton
Walsh
Wamp
Watkins
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
White
Whitfield
Wicker
Wilson
Wolf
Young (AK)

NAYS—210

Abercrombie	Gephardt	Nadler
Ackerman	Gordon	Neal
Allen	Green	Oberstar
Andrews	Gutierrez	Obey
Baesler	Hall (OH)	Olver
Baldacci	Hall (TX)	Ortiz
Barcia	Hamilton	Owens
Barr	Harman	Pallone
Barrett (WI)	Hastings (FL)	Pascrell
Becerra	Hefner	Pastor
Bentsen	Hilliard	Paul
Berman	Hinchey	Payne
Berry	Hinojosa	Pelosi
Bishop	Holden	Peterson (MN)
Blagojevich	Hooley	Pickett
Blumenauer	Hoyer	Pomeroy
Bonilla	Jackson (IL)	Poshard
Bonior	Jackson-Lee (TX)	Price (NC)
Borski	Jefferson	Rahall
Boswell	Johnson (WI)	Rangel
Boucher	Johnson, E. B.	Reyes
Boyd	Kanjorski	Rivers
Brady (PA)	Kaptur	Roemer
Brady (TX)	Kennedy (MA)	Rothman
Brown (CA)	Kennedy (RI)	Roukema
Brown (FL)	Kennelly	Roybal-Allard
Brown (OH)	Kildee	Rush
Campbell	Kilpatrick	Sabo
Capps	Kind (WI)	Sanchez
Cardin	Kleczka	Sanders
Carson	Klink	Sandlin
Chenoweth	Kucinich	Sanford
Clay	LaFalce	Sawyer
Clayton	Lampson	Schumer
Clement	Lantos	Scott
Clyburn	Lee	Serrano
Condit	Levin	Sherman
Conyers	Lewis (GA)	Sisisky
Costello	Lipinski	Skaggs
Coyne	Lofgren	Skelton
Cramer	Lowey	Slaughter
Crapo	Luther	Smith, Adam
Cummings	Maloney (CT)	Snyder
Davis (FL)	Maloney (NY)	Spratt
Davis (IL)	Manton	Stabenow
DeFazio	Martinez	Stark
DeGette	Mascara	Stenholm
Delahunt	Matsui	Stokes
DeLauro	McCarthy (MO)	Strickland
Deutsch	McCarthy (NY)	Stupak
Dicks	McDermott	Tanner
Dingell	McGovern	Tauscher
Dixon	McHale	Taylor (MS)
Doggett	McIntyre	Thompson
Dooley	McKinney	Thurman
Doyle	McNulty	Tierney
Edwards	Meehan	Torres
Engel	Meek (FL)	Towns
Eshoo	Meeks (NY)	Turner
Etheridge	Menendez	Velazquez
Evans	Millender-McDonald	Vento
Farr	Miller (CA)	Visclosky
Fattah	Minge	Waters
Fazio	Mink	Watt (NC)
Filner	Moakley	Waxman
Forbes	Mollohan	Wexler
Frank (MA)	Moran (VA)	Weygand
Frost	Morella	Wise
Furse	Murtha	Woolsey
Ganske		Wynn
Gejdenson		

NOT VOTING—9

Ford	Klug	Rodriguez
Gonzalez	Linder	Yates
John	Markey	Young (FL)

□ 1512

Mr. PAUL changed his vote from ''present'' to ''nay.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

COMMUNICATION FROM THE HONORABLE MICHAEL P. FORBES, MEMBER OF CONGRESS

The SPEAKER pro tempore laid before the House the following communication from the Honorable MICHAEL P. FORBES, Member of Congress:

HOUSE OF REPRESENTATIVES,
Washington, DC, July 23, 1998.

Hon. NEWT GINGRICH,
Marietta, GA,

DEAR MR. SPEAKER: This is to formally notify you pursuant to Rule L (50) of the Rules of the House that I have been served with a subpoena issued by the United States District Court for the Eastern District of New York.

After consultation with the General Counsel, I will make the determinations required by Rule L.

Sincerely,

MICHAEL P. FORBES,
Member of Congress.

LEGISLATIVE PROGRAM

(Mrs. KENNELLY of Connecticut asked and was given permission to address the House for 1 minute.)

Mrs. KENNELLY of Connecticut. Mr. Speaker, I ask for this time to inquire of the gentleman from California (Mr. THOMAS) about next week's schedule.

Mr. THOMAS. Mr. Speaker, will the gentlewoman yield?

Mrs. KENNELLY of Connecticut. I yield to the gentleman from California.

Mr. THOMAS. Mr. Speaker, I am pleased to announce that we have concluded legislative business for this week. The House will next meet on Monday, July 27, at 10:30 a.m. for morning hour, and at 12 noon for legislative business. We do not expect any recorded votes before 5 p.m.

On Monday, July 27, we will consider a number of bills under suspension of the rules, a list of which will be distributed to Members' offices this afternoon.

After suspensions, Mr. Speaker, the House will continue consideration of H.R. 2183, the Bipartisan Campaign Integrity Act of 1997. We hope to, as we did last Monday, make extensive progress on the Shays-Meehan amendment in the nature of a substitute on Monday, and we also hope to return to campaign finance again at some point during the week.

On Tuesday, July 28, and the balance of the week, the House will consider the following legislation: H.R. 629, the Texas Low-Level Radioactive Waste Conference Report. We will finish H.R. 4194, the Veterans Administration, HUD and Independent Agencies Appropriations; H.R. 4276, Commerce, Justice Appropriations Act; the Transportation Appropriations Act; H.J. Res. 120, a Vietnam Trade Resolution; and House Resolution 507, a Resolution Providing Special Investigative Authority for the Committee on Education and the Workforce.

□ 1515

Mr. Speaker, Members should be prepared to work late next week on these appropriation bills. If we can do that, we hope to conclude legislative business for the week by 2 p.m. on Friday, July 31.

Mrs. KENNELLY of Connecticut. Mr. Speaker, I wish to further ask of the gentleman, we have heard in some places that there might not be votes until after 7 o'clock on Monday. Is there any truth to that?

Mr. THOMAS. Mr. Speaker, I believe if Members are not participating in the legislation, they should have a relatively high comfort level that there would be no votes on Monday prior to 7 p.m.

Mrs. KENNELLY of Connecticut. I thank the gentleman very much. How late does the gentleman expect the last vote to be on Monday?

Mr. THOMAS. As we did last Monday night, we are hopeful, under the unanimous consent agreement on Shays-Meehan, that we could go as late as possible, to cover as many amendments as possible, so that the rest of the week would have enough time to move to a conclusion. It will be a decision made by the participants.

As the gentlewoman knows, they went very late last Monday. Our goal would be to go as late as we could, to cover as many of the amendments as we could, on Monday night, but it would be achieved under some mutual agreement.

Obviously, if they go extremely late, Members would expect that any votes that would be ordered would be rolled.

Mrs. KENNELLY of Connecticut. Is it still the intention of the leadership on the majority side to finish the Shays-Meehan bill by the August recess?

Mr. THOMAS. I would tell the gentlewoman that is why we are going to take a major chunk of time on Monday and, as I stated, reserve another piece of time, so that, in fact, the leadership's commitment that the Shays-Meehan amendment be concluded prior to the House's August break, that is our goal, that is our commitment, and we will meet it.

Mrs. KENNELLY of Connecticut. Mr. Speaker, I thank the gentleman very much.

Mr. SKAGGS. Mr. Speaker, will the gentlewoman yield?

Mrs. KENNELLY of Connecticut. I yield to the gentleman from Colorado.

Mr. SKAGGS. Mr. Speaker, I thank the gentlewoman for yielding to me. I wanted to use this opportunity to advise colleagues of a social event for this body that will occur next Tuesday evening from 6 to 8 p.m. in the Cannon Caucus Room. It is our more or less regular summer House picnic for both Members and spouses and children.

So I hope since we will be in the middle of some appropriations work on Tuesday, it will be a nice opportunity to get together on a bipartisan basis, get to know our colleagues and our families a little bit. Conveniently located over in the Cannon Caucus Room, very reasonably priced.

Members may contact either my office or the office of the gentleman from Illinois (Mr. LAHOOD) or the Members and Family Room to make reservations.

Mrs. KENNELLY of Connecticut. Mr. Speaker, reclaiming my time, I was asking about final passage on campaign finance reform, and the gentleman from California (Mr. THOMAS)

did mention Shays-Meehan. I realize he insinuated that that might be acted upon. What about final passage?

Mr. THOMAS. Well, if the gentlewoman will continue to yield, our commitment was to the Shays-Meehan, which had the most amendments attached to it. Obviously, once that is dispensed with, in terms of the amendments, that is the only amendment that we have under unanimous consent agreement. Our hope is that we will have reached a level of comity that we could move through the rest of those substitutes relatively quickly. But since we do not have a unanimous consent agreement on the amendments or the structure, it is extremely difficult to pin it down. But our goal is to complete it.

We now have a clear assignment on Shays-Meehan, and to the degree we can meet that next week, we will have a much better understanding of what we need to do to agree to finish it. Obviously, my personal commitment is to get it done before we leave in its entirety.

Mrs. KENNELLY of Connecticut. Mr. Speaker, I thank the gentleman.

CONSIDERING MEMBER AS FIRST SPONSOR OF H.R. 1542

Mrs. BONO. Mr. Speaker, I ask unanimous consent that I may hereafter be considered as the first sponsor H.R. 1542, a bill originally introduced by Representative Bono of California, for the purposes of adding cosponsors and requesting reprintings pursuant to clause 4 of rule XXII.

The SPEAKER pro tempore (Mr. PEASE). Is there objection to the request of the gentlewoman from California?

There was no objection.

CONSIDERING MEMBER AS FIRST SPONSOR OF H.R. 2882

Mrs. BONO. Mr. Speaker, I ask unanimous consent that I may hereafter be considered as the first sponsor of H.R. 2882, a bill originally introduced by Representative Bono of California, for the purposes of adding cosponsors and requesting reprintings pursuant to clause 4 of rule XXII.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from California?

There was no objection.

ADJOURNMENT TO MONDAY, JULY 27, 1998

Mr. THOMAS. Mr. Speaker, I ask unanimous consent that when the House adjourns today, it adjourn to meet at 10:30 a.m. on Monday next for morning hour debates.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

DISPENSING WITH CALENDAR WEDNESDAY BUSINESS ON WEDNESDAY NEXT

Mr. THOMAS. Mr. Speaker, I ask unanimous consent that the business in order under the Calendar Wednesday rule be dispensed with on Wednesday next.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

PERSONAL EXPLANATION

Mr. FILNER. Mr. Speaker, on July 16 and July 17 last week I had to be in my Congressional District on official business and missed rollcall votes 288 through 296. Had I been present I would have voted in the following way:

Number 288, aye; number 289, no; number 290, aye; number 291, no; number 292, no; number 293, no; number 294, aye; number 295, aye; and number 296, no.

APPOINTMENT AS MEMBER OF NATIONAL BIPARTISAN COMMISSION ON FUTURE OF MEDICARE

The SPEAKER pro tempore. Pursuant to the provisions of section 4021(c) of Public Law 105–33, the Chair announces the Speaker's appointment of the following Member on the part of the House to the National Bipartisan Commission on the Future of Medicare to fill the existing vacancy thereon:

Mrs. Colleen Conway-Welch, Tennessee.

TRIBUTE TO ROBERT F. LANGFORD

(Mr. HINOJOSA asked and was given permission to address the House for 1 minute.)

Mr. HINOJOSA. Mr. Speaker, it is a great honor to stand before my colleagues today to pay homage to a man who has benefitted us all. Mr. Robert Langford, the senior vice president of production operations of Owens' Country Sausage has retired after 35 years of service.

Robert, a graduate of both Texas A&M University and Southern Methodist University was hired by Jerry Owens in 1963. Mr. Owens recognized Robert's talents and quickly promoted him to manager of engineering. In 1972, he became the general manager and was continually advanced through the ranks until he reached his present position, the senior vice president of production operations. Due in large part to his work and innovations, Robert led the Owens Corporation to gain the number one market share position in the Southwest, which it still enjoys to this day.

These accomplishments are quite impressive, yet they are only one aspect of Robert F. Langford's life. Robert also worked extensively with the Southwest Meat Association. He was the president of SMA from 1978 to 1980 and composed its bylaws and mission statement. But Robert was not content to merely serve the SMA. He wanted to serve his community as well. To realize this goal, Robert became one of the three founders of the Southwest Meat Association's Education Foundation as well as its chairman from 1982 to 1998. The Education Foundation provides scholarships to deserving students who display an interest and aptitude for a career in the meat industry. He believes education is a must.

Robert's commitment to promoting education in the community is shared by his wife Kathy, who dedicated 35 years of her life to teaching her young children. Kathy has zealously supported Robert every step of the way and she shares in all his numerous triumphs.

Robert F. Langford served his country in the United States Air Force as a fighter pilot for five years. He has served his community as the Chairman of the Fellowship of Deacons for Park Cities Baptist Church, and he has served us all by improving our quality of life through his work.

He has earned my admiration as a talented businessman and inventor. He has gained my respect as a dedicated family man and community leader. And he has won my friendship as a kindhearted and generous person.

I wish for Robert, his wife Kathy, and their children and grandchildren, all the blessings that are mine to give. From the bottom of my heart.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will entertain further 1-minute requests.

TAX SURPLUS DOES NOT BELONG TO CONGRESS

(Mr. GIBBONS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. GIBBONS. Mr. Speaker, the Democrats have known for a long time that a government that robs from Peter to pay Paul can always depend upon the support of Paul.

Our liberal colleagues want to rob the hard working taxpayers of America by taking their tax surplus and giving it to Washington bureaucrats.

Not so fast! That tax surplus does not belong to Congress, does not belong to the administration, and does not belong to the bureaucrats. Rather, it belongs to the taxpayers.

We must cut taxes so that families can take that much-needed vacation, spend some time with their kids, or even put some money aside for their education.

Now, recently, President Clinton labeled this idea of giving back the taxpayer some money the wrong course for America. Well, Mr. Speaker, the American people just are not going to accept the Democrats' liberal spin on this at this time.

The Republican Congress is determined to track down the mistakes of 60 years of liberals robbing from Peter to pay Paul. Republicans are determined to save the ship before it sinks from the weight and burdens of excess taxes.

Mr. Speaker, I yield back to the American public any much-needed tax break.

ATTORNEY GENERAL HAS NO CHOICE BUT TO APPOINT INDEPENDENT COUNSEL

(Mr. STEARNS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. STEARNS. Mr. Speaker, yesterday the lead editorial in The New York Times came out strongly against the Attorney General and her continued refusal to admit to the obvious. The law requires that an independent counsel be named to investigate allegations of illegal campaign money from Communist China into the Democratic Party in the 1996 election.

FBI Director Louie Freeh has pleaded with the Attorney General to do so. And now Charles Labella, the person who was hand picked by Janet Reno to lead the investigation of these charges, has told the Attorney General that she simply has no choice.

The New York Times in this editorial states, ''Ms. Reno can give her usual runaround about being hard-headed, but she cannot hide from the meaning of this development.''

Ms. Reno has ignored the advice of the FBI Director and her own handpicked investigator for too long. She is a lot like the character in Hogan's Heroes, that great TV series, Sergeant Schultz. When Colonel Hogan would say something to him about nefarious affairs, Sergeant Schultz would say, ''I know nothing, I see nothing, I hear nothing.''

Ms. Reno, it is time to appoint an independent prosecutor for campaign finance.

REGARDING THE 2000 CENSUS

(Mr. WELDON of Florida asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WELDON of Florida. Mr. Speaker, I would like to respond to the errant comments of my colleagues, ill-informed colleagues on the other side of the aisle, regarding the year 2000 census.

Let me suggest that the very same Democrats who self-righteously assure us that the Commerce Department under President Clinton will be immune from politics, if given the opportunity to conduct the census by sampling, would be the very same people who would be screaming, ''Don't play politics with the census'', if a Republican President were trying to do the same thing.

In fact, there is not a single Democrat who would be supporting sampling if the sampling computer magic were not being conducted by the political appointees of the Commerce Department. And let us not forget that the administration that my colleagues suggest is a paragon of integrity is the same administration that used the IRS to smear Billy Dale and the White House travel office employees, the same administration that politicized the Immigration and Naturalization Service in 1996 to illegally approve citizenship for criminal aliens, and, of course, it is the same administration that has done such a good job regarding missile technology secrets from the Communist Chinese.

□ 1530

AMERICAN PEOPLE DESERVE AND EXPECT AN EXPLANATION

(Mr. GUTKNECHT asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. GUTKNECHT. Mr. Speaker, of all the scandals coming out of this White House, one scandal above all is perhaps the most disturbing. This scandal is more disturbing than the 900 FBI files on Republicans that somehow showed up in the White House; more disturbing than the use of private investigators to smear political opponents; more disturbing than the use of the IRS and the FBI to smear Billy Dale and the Travel Office employees; more disturbing than the allegations of perjury and obstruction of justice; and even more disturbing than the vast left-wing coverup of all of the above.

I am talking about the shocking revelation that the White House has helped the Communist Chinese Government with its missile program. We do not know if this administration gave a waver to Loral Corporation because the chairman, Bernard Schwartz, was the Democrat's top donor in 1996 or not. But whether this administration did it for the money or not, the scandal is still almost beyond comprehension.

At best, the administration inadvertently helped the Communist Chinese Government to develop its Long March missiles. The American people expect and deserve an explanation.

AMERICA NEEDS TO ADDRESS CRISIS IN AGRICULTURE

(Mr. THUNE asked and was given permission to address the House for 1 minute.)

Mr. THUNE. Mr. Speaker, agriculture in the northern plains is in great crisis. Farmers are having to sell below the cost of production. People across America need to understand that there is a close connection between a healthy agricultural economy and a strong America.

We need to address the crisis in agriculture, but we need to do it without the partisan carping that is coming out of the Democrats in Congress. The level of the rhetoric that is coming out of the Democratic leadership in the Congress is shameful.

We need to work together to solve the cash-flow problems in agriculture, to more aggressively open markets overseas, and to improve the crop insurance program. Farmers do not care whether the Democrats or the Republicans get the credit. They only know that they need to stay in business.

I challenge my colleagues on the other side of the aisle to work with us cooperatively to find solutions to the crisis in agriculture. Let us quit playing politics with agriculture's future. Let us work together.

IRANIANS TEST INTERMEDIATE RANGE BALLISTIC MISSILE

(Mr. HUNTER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HUNTER. Mr. Speaker, when just a couple of days ago the Iranians tested an intermediate range ballistic missile, one that has the range to strike Israel, our administration was once more embarrassed, because they had predicted a number of times that the Iranians could not achieve this capability until sometime late next year.

Well, the Iranians were a year ahead of schedule. Only one person predicted they would be able to do it much earlier in this body, and that was the gentleman from Pennsylvania (Mr. WELDON). He is working on a piece of missile defense legislation. The gentleman from New Jersey (Mr. SAXTON) is putting in legislation a number of us are cosponsoring which directs the President to conduct an emergency program to build a defense against the systems the Iranians are developing right now.

Mr. Speaker, now is the time for the President to act. With the same urgency with which our enemies are building the ballistic missiles, we must act with the same urgency to build defenses against those missiles.

TODAY UTAH CELEBRATES ITS PIONEER HERITAGE

(Mr. CANNON asked and was given permission to address the House for 1 minute.)

Mr. CANNON. Mr. Speaker, 151 years ago today, Brigham Young led the first Mormon pioneers into the valley of the Great Salt Lake.

The next spring, malnourished Mormon settlers began planting corn, beans, wheat, and potatoes. But as soon as they sprouted, the shoots were attacked by hordes of crickets.

Dr. Priddy Meeks recorded in his journal that ''the crickets came so thick it made the earth black in places, and it did look like they would take away what little we had growing * * * and we a thousand miles away from supplies.''

Out of desperation, men, women and children poured into the fields to scare

the crickets away. They dug ditches around the field. They used fire. But it was all in vain.

Just as all seemed lost and starvation likely, help came from above in the form of thousands of seagulls. Eyewitness reports tell of the birds descending on the fields, gobbling up the crickets and sparing the precious crops.

Today, Utah celebrates its pioneer heritage. Many of the celebrations will center around Seagull Monument in downtown Salt Lake City, erected in honor of the event I have just described.

I encourage my colleagues to join me today in honoring the courageous spirit and the sacrifices of the Mormon pioneers.

A FOURTH INVESTIGATION OF THE INVESTIGATOR: D.C. BAR COUNSEL PROBES LEAKS BY INDEPENDENT COUNSEL STARR

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Michigan, Mr. CONYERS, is recognized for 5 minutes.

Mr. CONYERS. Mr. Speaker, by my count, Independent Counsel Kenneth Starr is now the subject of four separate investigations into whether he and his staff improperly leaked confidential information to the media. The first is being conducted by Chief Judge Norma Holloway Johnson of the federal court in the District of Columbia. The second involves Attorney General Janet Reno's referral of the issue to the Justice Department's Office of Professional Responsibility. The third is being conducted by Mr. Starr himself in response to complaints lodged by the President's lawyers. And the fourth, as reported in the media today, is in the hands of the District of Columbia Bar Counsel.

Back in early February, the President's lawyer, Mr. Kendall, wrote the Independent Counsel that the ''leaking by your office has reached an intolerable point.'' In response to that letter, the Independent Counsel struck an indignant tone. He called the letter from the President's lawyer ''strange and inappropriate,'' and accused Mr. Kendall of elevating ''mere suspicion to specific accusation without any facts other than the press's often-misleading attributions of sources.''

The Independent Counsel's response to Mr. Kendall added that: ''[i]n light of the unclear press attributions in some examples cited in your letter, I have undertaken an investigation to determine whether, despite my persistent admonitions, someone in this Office may be culpable. I have no factual basis—as you likewise do not have—even to suspect anyone at this juncture. I am undertaking this investigation with deep regret, because I know how demoralizing it is to a staff of highly professional and experienced federal prosecutors. You do an extreme disservice to these men and women—and to the legal profession and the public—by your unsupported charges.''

Mr. Starr has never reported the results of his ''investigation.'' But in light of his later admissions that he and his deputy, Mr. Bennett, routinely talk to the press on an off-the-record basis, I assume he did not have to look far to find the source of these leaks. Judge Johnson, the Attorney General, and now the District of Columbia Bar Counsel, have all treated this issue far more seriously than the Independent Counsel. In fact, media reports say that Judge Johnson has ordered Mr. Starr to show cause why he should not be held in contempt for his inappropriate release of information.

The Independent Counsel's indifference to this issue is very troubling. To date, Mr. Starr has defended his actions with the technical claim that rules regarding grand jury secrecy apply only after information is presented to a grand jury. I do not agree with that claim, and I do not believe that D.C. Circuit law allows the kind of off-the-record conversations that happened here. We will see whether Mr. Starr can survive the scrutiny of these outside investigators.

EXCHANGE OF SPECIAL ORDER TIME

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise to ask unanimous consent to claim the time of the gentleman from Michigan (Mr. CONYERS).

The SPEAKER pro tempore (Mr. PEASE). Is there objection to the request of the gentlewoman from Texas?

There was no objection.

EXPANSION OF MEDICAL AND PATIENT RIGHTS FOR ALL AMERICANS

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes.

Ms. JACKSON-LEE of Texas. Mr. Speaker, with all of the pandemonium that transpired just a few short minutes ago, I imagine that some of my colleagues might have gathered from the discourse that many of us do not come to the floor of the House with passion and concern and personal stories. And, so, I thought it was extremely important that we cleared the dust and put a face on the debate that we had today.

Sadly, we lost that debate, those of us who care about the expansion of medical rights and patient rights for all Americans. This morning as I rose, I was determined not to share my personal story, for the people send us to this Congress to stand and to represent their interests, but I do think it is important for the people to realize that we are human, too.

I have had a personal story and personal loss. For, recognizing that all of us care about our loved ones, I experienced the denial of service in the care of my father. So this is not a frivolous and baseless debate for me, but I thought it was more important to share with my colleagues the story of the Chiang family.

This young couple, with a husband and wife, left a position and the father was the sole breadwinner, and the mother was determined to keep a certain HMO so that her son could continue to go to that same pediatrician. They kept that HMO, and the son had the pediatrician, but the mother became ill.

She had constant pain in her stomach. She went to the HMO doctor, and continuously he said, ''We will put you on a certain diet.'' But the pain became so debilitating she went back again because she thought it was something that had to do with her ability to give birth again.

She went back and further service was denied, until finally, some three months later, she was sent to a specialist and it was then determined that that mother, 34 years old, had colon cancer. And subsequent to that late determination, after the denial of service, that 34-year-old died.

Today I read to my colleagues a letter from Lula Somers, a senior citizen who has been in the medical profession for many, many years from Pasadena, Texas, the community that I come from. She said, ''This letter is directed to you from a working senior citizen who has served a lifetime in the medical profession and who is deeply concerned about the direction we are heading. Dedicated healing physicians are having their once regarded highest standard of ethics and devotion be dictated to by people who have not the first clue of the onerous problem being cast upon innocent citizens.''

She said she worked at a time when doctors saved a gravely ill child, sutured bleeding patients, sat at the bedside of someone dying, and maybe wound up with vegetables or eggs from someone's farm.

We may not be able to go to that, my colleagues, but the Patients' Bill of Rights the Democrats and bipartisan Republicans were supporting realizes that we must stand with the physicians and the providers of health care like nurses and nurses assistants and the patients.

The bill we pass today will hurt my State of Texas. It will probably hurt my colleagues'. Texas already has provisions for well-child care, mammography screening, minimum maternity care, breast reconstruction, diabetes supplies, alcohol abuse treatment, drug abuse treatment. The bill we pass today will overcome all of that, supercede that. Mental health care and bone mass measurement. All of that Texas had. Now with this Federal bill that the Republicans will pass, we do not have it.

Just think for a moment if they have a heart attack and go straight to the nearest hospital but the hospital does not participate in their plan. The Republican bill will allow their plan to force them right out of the hospital. That is what we passed today.

If their plan denied them an X-ray for a broken arm because the plan did not think the X-rays were medically necessary, they could not appeal on the basis of merit. They can only appeal on the basis of what the plan says is a necessary medical condition. It takes away that decision of the physician and their pain and the need for service and puts it in the hands of some accountant in an office far, far away.

If they are a woman and they want direct access to their nurse midwife,

their plan does not have to give it to them. They can only require them to see a physician. So many women want nurse midwives and have found that to be a comfortable way to give birth.

If they are terminally ill and their only hope is an approved clinical trial, the Republican bill would not allow it. So many of my constituents have said, ''I beg of you to allow me to participate in a clinical trial. I will go anywhere, do anything to save my life or that of my loved one.''

If they are about to deliver their baby at a hospital and their health plan drops their doctor, the Republican bill allows their plan to make them get a new doctor at the very time that they are in need. And if they are scheduled for a cancer operation and their health plan drops their doctor, under the Republican plan they have to find a new doctor.

My colleagues, what we did today was a travesty. I hope that we will be able to repair that and pass a bill, Mr. Speaker, that really responds to the life and the death of Mrs. Chiang.

UNIVERSITY OF MISSISSIPPI CONCERT SINGERS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Mississippi (Mr. WICKER) is recognized for 5 minutes.

Mr. WICKER. Mr. Speaker, I rise today to share with my colleagues the wonderful news that the University of Mississippi Concert Singers won top honors last week at the World Choral Competition in Rome, Italy.

The group from Ole Miss, led by Dr. Jerry Jordan, is the first American choir ever to have qualified for this exclusive international competition and, of course, the first to win the top prize. Today, they are considered the best amateur choir on the face of the Earth.

To reach the Super Bowl of choral competitions in Italy, groups from around the world first had to qualify for and then win 1 of 6 international events. On their way to the finals, the Ole Miss singers won the grand prize in May of 1997 in a competition in Bulgaria. Then last week, the group outperformed choirs from Sweden, Hungary, Estonia and Taiwan, all of which had won international choral events in past years.

The Ole Miss concert singers are no strangers to performing on the international stage. During Dr. Jordan's 18 years at Ole Miss, his choral groups have toured on nine occasions; they have participated in international competition three times; and, in 1994, earned their only other trip to the grand event.

The Collegiate Choir Program at the University of Mississippi is recognized among the best in the Nation. Dr. Jerry Jordan is one of the country's most accomplished directors. He has conducted the American Symphony Orchestra at Lincoln Center in New York and is a regular conductor at Carnegie Hall.

Dr. Jordan's leadership and the exceptional talents of these students produced an unprecedented result in Rome. The judges said the group performed an extremely difficult and diverse program and did so flawlessly. The 50-member group sang seven songs in five different languages over the span of its allotted 30-minute program.

Mr. Speaker, there are at least five alumni from the University of Mississippi in the House of Representatives. And at this point, I am pleased to yield 1 minute to the distinguished gentleman from Mississippi my colleague (Mr. PICKERING).

Mr. PICKERING. Mr. Speaker, I thank the gentleman from Mississippi (Mr. WICKER) for yielding.

I rise with him to recognize the Mississippi Concert Singers and their accomplishment. They come from the University of Mississippi, the same place where the new director of the National Endowment for Humanities, Dr. William Ferris, the author of the Encyclopedia of Southern Culture.

In Mississippi, where we have the tradition of being the birthplace of blues, of rock and roll, and in my district, Meridian, the birthplace of country music with the grandfather of country music, Jimmy Rogers.

And today we celebrate our additional contribution to our State's culture and our Nation's culture to the world, the Mississippi Choral Singers, and the great achievement that they have won by being the first American choir to win this preeminent distinction and competition in Rome.

So I rise with the gentleman from Mississippi (Mr. WICKER) and to acknowledge and to appreciate this great accomplishment.

Mr. WICKER. Mr. Speaker, reclaiming my time, I thank my colleague for his remarks. And one final word, Mr. Speaker.

This outstanding group of performers from the University of Mississippi has earned an honor reserved for a select few. They have earned the right to be called the best in the world, and they have made all Americans proud. I salute them today.

□ 1545

EXCHANGE OF SPECIAL ORDER TIME

Mr. LAMPSON. Mr. Speaker, I ask unanimous consent to claim the time of the gentleman from New York (Mr. ENGEL).

The SPEAKER pro tempore (Mr. TAYLOR of North Carolina). Is there objection to the request of the gentleman from Texas?

There was no objection.

MISSING AND EXPLOITED CHILDREN

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Texas (Mr. LAMPSON) is recognized for 5 minutes.

Mr. LAMPSON. Mr. Speaker, as a father, one of my biggest fears over the years has been discovering perhaps that one of my daughters would be missing.

Sadly, last November, one of my constituents was living mine and every parent's nightmare when she frantically called the Texas City Texas Police Department after her ten year old daughter did not arrive home from school.

Recently, my district has been stricken with a stream of missing children. This issue has become my highest priority as well as that of the police departments in my area to try to put an end to this. The chief of police for Texas City, Texas, Jerry Purdon, last year visited the National Center for Missing and Exploited Children and underwent training on developing a program for responding to a missing child alert.

One of the key elements in the department's new program was the actual response time, which they felt had been a key factor in previous failures. In this Texas City case, the department was able to flood the area with both police and informed neighbors to search for any sign of the missing child.

Hours went by until a man appeared in the middle of the neighborhood with the missing girl, stating that he had found her under some stairs. She was immediately rushed to the hospital while the man was questioned by the police.

Suspicious from the start, they were able to obtain a full confession. This man, who knew the girl, picked her up from school and returned to his home with her and after sexually abusing her he admitted that he intended to kill her and dispose of the body. In his words, he was prevented from carrying out his plan because, quote, every time I looked out my front window I saw a police car and every time I looked out the back, I saw a neighbor who knew what was happening, unquote.

Thanks to the quick response and organization of Chief Purdon and his officers, that little girl was returned to her family. I stand here proud of their efforts and would like to applaud each and every one who helped save the little girl. It is with forceful reactions to crimes like this that we hope to end the disappearances of our children and prevent all parents from experiencing this nightmare.

TRIBUTE TO HORACE ELLIS JONES

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Georgia (Mr. COLLINS) is recognized for 5 minutes.

Mr. COLLINS. Mr. Speaker, I rise to honor an individual, no not a Georgian by birth but is the essence of a Georgia gentleman.

Horace Ellis Jones is the grandfather of one of my legislative staff members. Today I pay tribute to Mr. Jones through the eyes of his grandson.

Born on February 7, 1916, in Spring City, Pennsylvania, to Russell and Mary Ellis Jones, Horace Ellis Jones spent his childhood days growing up in the suburbs of Philadelphia.

He was known for his wide grin smile and his charming demeanor. He was very active in the Boy Scouts, earning the distinction of an Eagle Scout.

After attending Spring City High School and Stanton Military Academy in Virginia, Mr. Jones decided on Duke University and became a true Blue Devil. A couple of days before he was to leave for Durham, Mr. Ellis dropped by a local cafe just outside of Pottstown, Pennsylvania, with friends.

As he entered, his eyes focused on Olive Hammer. One look at her put Ellis Jones in a spin. He immediately put money in the juke box and asked Olive to dance. The music has not stopped for 57 years.

After they were married in 1941, Mr. Jones worked with his father in automobile sales in Reading, Pennsylvania. Very soon after their marriage, like so many of our distinguished citizens at the time, he answered America's call to duty and served in the United States Army during World War II.

Lieutenant Jones was stationed at Newport News, Virginia, as a member of the Army Transportation Corps. From there, he returned home to Pennsylvania, began his work with his uncle in the family business, the Jones Motor Company.

For almost 30 years, he played an instrumental role in the success of the business, one that grew to be among the largest trucking companies east of the Mississippi River. Jones Motor boasted 59 terminals, almost 4,000 employees and more than 3,500 pieces of equipment. This was an amazing feat considering it all started with a single horse and wagon back in the 1800s.

Along the path of hard work, Ellis and Olive welcomed a new generation of Joneses, their children, Mary Ellis and Donald. In the mid-seventies, Jones and his brothers decided to sell the company and retire. Retirement lasted a brief 6 months, after which Mr. Jones entered the lucrative real estate business and became very active in many charitable organizations such as the American Hospital Association and the Pottstown Hospital Association.

During his spare time, he could continue to pursue the major nonfamily passion of his life, the game of golf. After picking up the first set of clubs at the age of 7, Mr. Jones' devotion to the sport culminated with his presidency of the Philadelphia Golf Association in the 1960s.

During that tenure, he worked to provide scholarships and opportunities for many hard working young people. He also served on countless boards of the United States Golf Association and as a member of many country clubs and golf societies throughout the world.

When he finally decided to slow down from all of this activity, Ellis and Ollie relocated to the State of Georgia. They chose the quiet coastal beauty of Sea Island, a spot that they had first visited in their honeymoon. The environment there was proven to be the ultimate spot to pursue new opportunities.

While preserving their already acquired interests, it also served as a meeting place for the entire Jones' family to congregate and forge new memories. With all of that said, to really know the tale of Ellis Jones is to realize that his greatest accomplishment continues to be his capacity as a person.

Amidst all of the challenges and successes of life, Mr. Jones always conducts himself in the highest degree of courtesy, generosity and integrity. He is concerned with the happiness and the well-being of others at every turn, as a leader, as a businessman, a father, a grandfather, a husband or a friend.

Recently, Mr. Jones has been battling the evils of cancer, a war he has been waging for some 7 years. It has been a difficult time for him and his loved ones, but through it all he has maintained his positive attitude built upon the love of his family.

Ellis Jones' life is nothing short of remarkable, an American dream come true that seems to guide the brush strokes of my Norman Rockwell painting. One need only look to his family and friends to see the reflection of his charmed life.

Mr. Speaker, I would like to extend my heartfelt best wishes to Mr. Jones as he watches today from Georgia, as well as members of the Jones family throughout the country.

In closing, I would like to read a piece Mr. Jones wrote just a few weeks ago. I think it is an appropriate testament to the life of this great man and is something from which we all can learn, and I quote: I have always believed that the game of life, like the game of golf, was the last gentleman's game and I have tried to play both as such, a gentleman. If I have been successful, it is because of my love from and my love for my wonderful wife, our blessed children and grandchildren and my many loyal and supportive friends. Looking back over the entire course, I can say in all honesty, what a game, what a life, what a lucky guy I have been, end of quote.

Mr. Speaker, our prayers are with Mr. Jones and his family and for the blessings all have received from the life of Horace Ellis Jones.

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from the District of Columbia (Ms. NORTON) is recognized for 5 minutes.

(Ms. NORTON addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

EXPORT OF AG PRODUCTS STIFLED

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Minnesota (Mr. GUTKNECHT) is recognized for 5 minutes.

Mr. GUTKNECHT. Mr. Speaker, you may have seen in the Washington Post, the Wall Street Journal, the New York Times and other newspapers, articles about the current farm crisis. The hard times in farm country are real and demand immediate attention.

The $5.5 billion package introduced by the chairman of the House Committee on Agriculture and the half billion dollars approved by the Senate are good starters.

Unfortunately, some folks cannot resist making a political football out of the misfortune of others. These folks say that the 1996 farm bill, which the President signed, is to blame for all the woes in farm country.

Mr. Speaker, I would have preferred to avoid the blame game, but if the goal of the Democrats is to place the blame they do not have to look very far. How about the congressional Democrats' unwilling less to pass fast track trade negotiating authority with their president? At least he used to say this was so critical to U.S. farmers and ranchers. When one-third of our farmers' cash receipts come from exports, how can congressional Democrats defend their opposition to fast track?

When EU subsidies in 1997 were at their highest level in this decade, at nearly $47 billion compared to $5.3 billion here in the United States, how can they oppose fast track?

When the start of the next World Trade talks are only 5 months away, why would Democrats oppose the President's request for fast track so that the United States can have a seat at the negotiating table in order to tear down these trade barriers?

The answer may be the Democrats are more interested in collecting big labor PAC checks for their reelections than protecting their own farmers.

Mr. Speaker, the fact is, fast track is not my only priority but it is one of our most important priorities. It is the priority also of most of the U.S. leading farm and ranch organizations.

It only makes sense. In 1996, when ag exports were at their all time high, $60 billion, farm income was up, but now that ag exports have dropped over the last 2 years by an estimated $5 billion, farm income is down.

How about trade sanctions? Over the past 60 years, Mr. Speaker, we have imposed approximately 120 different sanctions. Despite relatively peaceful times, guess which administration has imposed over half of these sanctions in just the past 6 years? You guessed it. This one.

This administration is willing to impose unilateral sanctions at the drop of a hat, and I am not sure what these sanctions have accomplished in the way of national security. What I do know is that it forecloses U.S. ag sales to millions of the world consumers. If we still want to place the blame, what has the administration been up to while ag exports have been precipitously dropping?

You would think they would be scrambling to sell ag commodities using the ag export enhancement tools authorized under that dreadful 1996 farm bill, but according to a recent General Accounting Office report, that is not true. The administration has used only 44 percent under the dairy export incentive programs to promote U.S. dairy exports. This is despite a mandate in the horrible farm bill that says that the DEIP program should be used to the maximum extent practical under GATT. Despite an annualized $5 billion authorization under the 1996 farm bill for the GSM export program to move our ag products, this administration has used only $3.2 billion and $2.9 billion in the 1996 and 1997 fiscal years respectively.

In other words, $3.9 billion in GSM export assistance went to waste while our ag exports have tumbled.

Guess how much of the 1.5 billion export enhancement program dollars authorized under the farm bill have actually been used by this administration? If you guessed only $7 million, you would be right.

Mr. Speaker, the President and congressional Democrats know that the success of the 1996 farm bill depends on favorable tax and regulatory policy, improved research and crop insurance and perhaps, most importantly, trade. The Democrats resisted and continue to resist tax relief for farmers or for anyone else, as far as that goes.

The administration is talking about a new EPA program with more regulations that could strangle many of my dairy, beef and pork producers who are already overregulated. The President held hostage ag research money until he got food stamp money for legal aliens. He also held hostage critical crop insurance money to fix funding problems that he created back in 1994.

□ 1600

When it comes to trade, the President and Congressional Democrats are AWOL.

Democrats also charged that Republicans somehow have taken away the safety net for farmers. As a former Democratic Chairman of the House Agriculture Committee, Mr. DE LA GARZA pointed out, over the last decade on the Democrat's watch, Congress has cut the agriculture farm bill by more than $60 billion.

Importantly, the Republican House budget resolution does not call for a single cut in support of U.S. farmers and ranchers.

Mr. Speaker, I could remind our Congressional Democrat friends that if we go back to supply management, for every acre we leave unplanted, Argentina will be happy to plant one.

Mr. Speaker, it is time to cut the rhetoric and work together. It is time to get the job done for American farmers. It is time to open our trade relations with our partners and get more export enhancement programs going so that we get more farm income to our farmers.

The SPEAKER pro tempore (Mr. TAYLOR of North Carolina). Under a previous order of the House, the gentlewoman from New York Ms. SLAUGHTER is recognized for 5 minutes.

(Ms. SLAUGHTER addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.)

THE NEED FOR AN ASIAN STRATEGY

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Nebraska (Mr. BEREUTER) is recognized for 5 minutes.

Mr. BEREUTER. Mr. Speaker, today this Member will introduce legislation that requires the administration to establish a $100 million assistance and food security initiative for Indonesia and Southeast Asia in fiscal year 1999. I would say it very much happens to compliment what the gentleman from Minnesota just said about coping with our own farm crisis or difficulties at the same time that we are reaching out to help for a food shortage problem which is expected to be severe this year in Indonesia.

This legislation, in the works for several weeks by this Member, is consistent with recent urgent proposals or suggestions by distinguished Indonesian experts in America, like Ambassador Paul Wolfowitz of the Brookings Institution, and the former Ambassador, Robert Zoellick, President and CEO of the Center for Strategic and International Studies, for a prompt Congressional response to the Asian financial crisis, and, more specifically, to Indonesia's current plight.

In an opinion piece published in the Washington Post on July 23, 1998, Mr. Zoellick, former Undersecretary of State during the Bush Administration, eloquently argues that now is a definitive moment in the lives of a generation of Asians, and that America's response to the current crisis could be as important as America's response to Europe 50 years ago.

Because Ambassador Zoellick makes the case for a coherent foreign policy strategy better than anyone so far, I would say, this Member would include excerpts from his op-ed piece entitled ''An Asian Strategy.'' I would like to read two paragraphs from it at this point.

He says as follows: First, Congress should enact a major humanitarian package for Indonesia. The need is urgent. The combination of drought and economic collapse has not only impoverished half of the world's fourth-most populous country, but raised the real danger of famine. Indonesia's new president already is urging his 200 million citizens to fast twice a week to conserve supplies. All the talk of IMF packages and economic recovery will be only chatter until there is political stability in Indonesia, and there will be no stability if people cannot eat. Indeed, Indonesia's ethnic peace, even its very coherence as a Nation is at risk. And if Indonesia sinks further, the rest of Southeast Asia will bear the burden of its dead weight.''

''America has a proud tradition of humanitarian relief for people in need; it also has farmers who would welcome a boost in prices. If Congress expands the administration's recently announced grain purchases into a full-fledged relief plan, it can draw in Japan, the European Union and even some private U.S. business people who have signaled a willingness to contribute. This initiative would send a powerful, symbolic and practical message about America's concern for the plight of average Asians, not just bankers and magnates.''

That is what Mr. Zoellick has to say.

Mr. Speaker, now is not the time, I would say, for the United States to balk at its responsibilities as the world's only superpower. The United States fought a Cold War and spent hundreds of billions of dollars, perhaps trillions of dollars, to advance our ideology of global capitalism and democracy.

In Asia, capitalism was adopted with an enthusiasm that has proven so strong that authoritarian leaders found democracy following right behind. From Taiwan to the Republic of Korea and Indonesia, for example, our most important principles are being embraced and tested by people willing to put their lives on the line.

As Mr. Zoellick rightly states, we have an important choice to make that will affect an entire Asian generation's perception of us and what we stand for. We can tell hard working Indonesians that they can sell their products here, or we can close our markets. We can join the rest the world in providing humanitarian assistance, or we can turn our back. We can send our experts to help them rebuild their economy, or we can wait until it is too late. We can pool resources and share risk with the world's industrialized countries to the regional capital markets or we can let them dry up.

Mr. Speaker, the United States can pay now or it can pay later. If the U.S. Congress and the president agree to develop a proper response to the current crisis in Asia, the costs will be minimal and the rewards unfathomable. Can one put a price on democracy in Indonesia or stability in the Asia Pacific region? Or, we can wait and see how the troubled Asian economies do own their own without our assistance.

Perhaps they will recuperate in several years through excellent management and astute decision making. But what if they do not? What will be the costs if we do nothing and find the region still in crisis in five years? How much will it cost us to maintain our security umbrella in an insecure region? What will happen to the U.S. economy if the Asian Pacific region slips into depression? Most importantly, will Asians continue to look to the United States for leadership if they do nothing?

Mr. Speaker, I urge Members to cosponsor this new Indonesian assistance legislation, which will also be very important to our export base and to our entire economy and foreign policy.

A CHRONOLOGY OF IMPORTANT POLITICAL AND CULTURAL EVENTS IN PUERTO RICO (1493–1997)

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New York (Mr. SERRANO) is recognized for 5 minutes.

Mr. SERRANO. Mr. Speaker, I rise today to speak about a subject which is of great importance to many of us in my community, and certainly should be of great importance to all Americans.

Tomorrow we will observe, July 25, 1998, the 100th anniversary of the relationship between the United States and Puerto Rico. One hundred years ago, the United States troops, during the Spanish-American War, invaded Puerto Rico, and since then Puerto Rico for these 100 years has been a territory of the United States.

Tomorrow, throughout the 50 states and on the island of Puerto Rico, there will be different groups involved in different forms of observances or celebrations. Some will celebrate the day claiming that, in their belief, this relationship has been the best thing that ever happened to the Island of Puerto Rico. Others, on the other hand, will lament the relationship and feel that it has been totally unfair.

Some groups on one side, as I said, will claim that nothing has gone wrong for these 100 years, and some folks on the other side will say that nothing has gone right for these 100 years.

I believe that somewhere in between is the truth. But in order to really speak about this subject and how we got here and where we are and where all Americans should begin to deal with this issue, I think it is important to take just a couple of minutes to talk a little bit about the history of how we got here.

Puerto Rico, as so many of you may know, was discovered in 1493 by Christopher Columbus, and from then to 1898 it was a colony of Spain. In 1508, the first Governor in Puerto Rico was assigned, and his name was Juan Ponce de Leon, or, as he is better known within the 50 states, as Ponce de Leon.

The years went on, and Puerto Rico remained no better than a full colony of Spain. But by 1865, nearly 400 years later, there was already discussion between the Spanish government and the Island of Puerto Rico in terms of creating a new arrangement.

Therefore in 1865, a royal decree was issued convoking delegates from Cuba and Puerto Rico to Madrid to discuss possible reforms to the colonial regime. The Puerto Rican delegates go there and they speak about decentralizing the municipal government, having more powers as people, taking some of the powers from the Governor, who was appointed by Spain, and abolishing slavery. No accord is reached, and the delegates who speak out for such reforms are in fact persecuted. Meanwhile, back in New York, the Republican Society of Cuba and Puerto Rico is established to promote the cause of independence for both islands.

In 1895 the Puerto Rican section of the governing body of the Cuban Revolutionary Party is established in New York, and Puerto Ricans at that time adopt their own flag, which is the same as the Cuban flag, with the colors reversed. Jose Marti is the leader of the party, and it is right here within the 50 states, in New York, that the movement against Spain for independence for Puerto Rico comes into play.

However, something happens on the way to 1898. Spain, for whatever reason, begins to realize that times have to change, and so Spain begins to discuss the possibility of granting autonomy to the Island of Puerto Rico.

On February 9, 1898, Puerto Rico's autonomous government is inaugurated with a provisional cabinet. It provided a high degree of administrative autonomy for Puerto Rico, and, under the charter, the Island was governed by the local parliament, composed of two chambers and a Governor general. The chambers were the Administrative Council, which were elected, and a version of the House of Representatives, popularly elected.

These chambers had full legislative authority except over such matters that the Spanish government wanted to keep, and these folks were then allowed to go to Spain and represent the Puerto Rican community, the Island of Puerto Rico, in Spain.

It is interesting to note that in this agreement the people representing Puerto Rico in Spain had actually reached more autonomy and more powers than the current delegate from Puerto Rico enjoys as a Member of the U.S. Congress.

But that could not take place, because, in the meantime, on February 15, the sinking of the American ship the *Maine* provided an immediate reason for the Spanish-American war. During that war, elections are held in Puerto Rico and this government, which then will represent Puerto Rico in Spain with many more powers, is elected.

On July 25, after the defeat of the Spanish in Cuba, General Nelson Miles leads an American landing in Guanica on the southern coast of Puerto Rico. On October 18th of that year, San Juan surrenders, and a U.S. military government is established in Puerto Rico.

On December 10, the treaty of Paris is signed and the Spanish-American War ends, and Puerto Rico is given to the United States, the political and civil rights of its inhabitants to be determined by the U.S. Congress.

From then on, Puerto Rico and the United States for a couple of years try to figure out what that relationship will be. But through 1899, in a few years, a military government continues.

Nothing really changes until 1900, when a new act is passed here which ended the military administration and set up a civil government. Very little self-government, however, was granted. The President would appoint a Governor, the members of the upper legislative house in Puerto Rico, and the executive council, where no Puerto Rican was allowed to serve, and the judges of the Supreme Court. Only the House of Representatives on the island was wholly elected by the people in Puerto Rico, and then it was determined that Puerto Rico would have a commissioner who would serve in the House of Representatives with no voting status.

In 1904, Puerto Ricans at that time are not granted U.S. citizenship. They become in fact citizens of Puerto Rico. An argument, by the way, that continues to be dealt with today, because many people still wonder if in imposing American citizenship later, that Puerto Rican citizenship in fact was done away with. Everything then is run by the United States Congress.

□ 1615

In 1917, a very important day in the history, on March 2, the Jones Act comes into effect, and by it, Congress determines that all Puerto Ricans born in Puerto Rico will be American citizens. Since that date, everybody born on the island of Puerto Rico is an American citizen. The only difference and the most important difference, and perhaps the tragic difference, is that if you are born in Puerto Rico you are an American citizen and you move to any of the 50 States, you enjoy the same rights as any citizen within those 50 States, but if you remain on the island of Puerto Rico, still an American citizen, you do not enjoy the same rights as the other 50 States.

That puts into play then the question, what kind of American citizenship is it? Is it possible for us to actually have granted different kinds of American citizenship, one for those who live within the 50 States, and one for those who live outside? To this day, there are very bright people arguing that it is impossible to have granted 2 different kinds, but the effect is that there are 2 different kinds of citizenship, and they express themselves differently.

Nothing then really changes in Puerto Rico until 1950. What happens in those years is that a governor is appointed, and there are different situations that are created. But during that period of time, an independence movement grows, which continues to demand, as it did during the period with Spain, that Puerto Rico be liberated and in fact be given its independence.

That independence movement is persecuted heavily, to the point where its leader, Pedro Albizu Campos, is a man who is jailed for over 27 years for advocating for independence of Puerto Rico

during that time. Also, there are incidents where violent acts are committed and force is used both by the government and by citizens.

At that time also a party grows, various parties grow in Puerto Rico, one of them being the Republican Party, a statehood party, an independence party, a party that wants to take the present status in the 1930s and 1940s and bring it to a new relationship, one that is not statehood or independence.

Finally in the early 1950s it is decided that Congress will offer the Puerto Rico community in Puerto Rico something called commonwealth status. Commonwealth allows for certain rights to be carried out on the island, but commonwealth still does not provide for the ability to vote for President, for the ability to vote for 6 or 7 Members of Congress as Puerto Rico would be entitled to, or for the ability to vote for 2 Senators. On the other hand, commonwealth also does not allow for Puerto Rico's independence. So I think we have to fully understand, and I think the problem that we face these days when we discuss this issue and as we celebrate, commemorate, observe or lament over the 100-year relationship, tomorrow, July 25, is the fact that such a large number of Americans, if not the vast majority, have no idea what the relationship is between the United States and Puerto Rico.

If one goes through any neighborhood in this country and you ask people, are you aware that all people who live on the island of Puerto Rico are citizens like you, you would be shocked to find a large number of people do not have the slightest idea. If you then ask them, do you know that Puerto Ricans served in our wars and participated in our wars and were drafted just like all other Americans when we had a draft, the answer would be no, I did not know that. If you then tell them that they were and that they are citizens and they still do not vote for President, that would shock anywhere, I would say, from 75, 80, 90 percent of the American people who are not aware of the relationship. I think what will happen tomorrow and throughout the rest of this year is more and more people will become aware of the relationship and become aware of the need to speak about where the future of that relationship should take us.

Now, let me digress for a second and just set myself up as an example of the uniqueness or the embarrassment of that relationship. I was born in Puerto Rico. I came to New York, as so many Puerto Ricans did, when I was a very young child. I studied in New York, I became involved in politics, I served in the State assembly; I then came here in 1990. I am a Member of Congress. One cannot really express better fulfillment of one's citizenship than what I have accomplished personally, yet my cousins who live on the island of Puerto Rico do not have the same rights I have, the difference being that I moved and they did not.

That is almost to suggest that if one stays in Texas or one stays in New York, one would have less rights than if one came to California. Well, I am sure there are probably some Californians who would like Texans and New Yorkers to have less rights, but that is just the way we behave in this country. The fact of life is that these folks are there with a totally different system of government overseeing them.

So the commonwealth came in and the commonwealth was set up basically to tell the United Nations, I believe, look, we are obeying the rules, we are doing what you wanted us to do; we do not have a situation that can create a problem for anybody. Puerto Rico is not a colony.

Now, in order to fully understand how people feel about the different status options, one has to understand that in the early 1950s there was a strong, and in the 1940s and 1930s, a strong nationalist movement, a movement that wanted independence for Puerto Rico, and that movement in history will speak to this more and more every day, was discredited, both by people here in Washington and people who lent themselves to that in Puerto Rico.

It was suggested somehow that if one wanted independence for Puerto Rico, one wanted the worst for the island, one was not a good American, one was not a good Puerto Rican, and that was the way people were treated. So many of its leadership was jailed. Within a democracy, Puerto Rico being an arm of the United States, if you will, is supposed to behave in a democratic fashion, and yet to the folks who supported independence, they were, many of them were just discredited and many of them were jailed.

In 1952, after the commonwealth issue came in, and by the way, the way commonwealth came in was the United States gave the people of Puerto Rico a choice: Commonwealth, yes or no. There has never been, and we should note this at this moment, there has never been a congressionally, federally sponsored vote on the island of Puerto Rico which has asked the people of Puerto Rico, do you support independence, do you support Statehood, or do you support remaining the way you are now, or making changes? There have been different kinds of votes to speak to that, but never the full question asked.

So in the early 1950s, the question was, do you want to become a commonwealth, or do you want to remain the kind of territory you are now? Yes or no. So, of course, most of the people voted yes to better the conditions, because as my friend from Guam, BOB UNDERWOOD has said at times, there are bad colonies and there are slightly better off colonies, and people at that time opted to become I guess a better off colony, but still did not have the rights of an independent nation or a State. They were allowed to pick their own Constitution, write their own Constitution. But get this: Anything in the Constitution had to be approved by the Federal Government, and Puerto Rico cannot pass any laws that will not be accepted by Congress. If so, then they just cannot continue to be as laws in Puerto Rico.

So for all of these 40 years, 50 years, Puerto Rico has been a commonwealth of the United States, and during that time, on many occasions, there have been attempts to solve the present status dilemma.

On July 23, 1967, based on the recommendation of the Commission on the Status of Puerto Rico, a plebiscite, an election was held, to determine which status Puerto Ricans want among commonwealth, Statehood or independence. Little more than 66 percent of all registered voters participated.

Now, for us in the States 66 percent is a large turnout, but Puerto Rico is a place where 85, 90 percent of the people vote, so when 66 percent turns out, it means there was kind of dissent on the issue on the ballot. The popular Democratic Party which defends commonwealth defended commonwealth in the campaign. A problem developed in the Republican Party which supported statehood with the old guard saying we will not participate and the younger guard saying we will, and then the Independence Party abstained from the election at all.

So basically we had half of the Statehood Party saying we will not participate, all of the independence movement saying, it is not a fair plebiscite, and only the Commonwealth Party participating, and the results indicated just that: Commonwealth received 60 percent of the vote, statehood nearly 39, and independence less than 1 percent.

The statehooders who participated in the plebiscite and went on and formed their own party, the new Progressive Party which got the governor reelected, and it was the first defeat for the Democratic Party in 28 years. By the way, just for clarification, the fact that they call themselves Popular Democrats has really nothing to do with the Democratic Party in this country, it is just a title.

In 1970, President Nixon said it is time to do something, let us talk about statehood or independence for Puerto Rico, but nothing happened. Again, in 1971 the same thing. In 1977, and every year since then there has been a discussion as to what the future of Puerto Rico will be. Then, finally, this year, for the first time in a long time, and a bill was passed here by one of our colleagues, sponsored by one of our colleagues on the Republican side, the gentleman from Alaska (Mr. YOUNG), which would allow the choice between the present commonwealth, statehood or independence.

The bill was supported and is supported by those who support statehood; it is supported by those who support independence; it is not supported by the Commonwealth Party, because

they feel that in no way does it really speak to what they wish to be. What the bill does is speak to what we are, to what Puerto Rico is, to what the relationship is, and therein lies the problem.

The United States has spent, our country has spent a lot of time and a lot of energy basically suggesting to the world what democratic principles they should follow, and I think that there is not a single person listening or watching us that does not agree that we have a role to play in promoting democracy throughout the world.

I think the big question we have to ask ourselves, and especially the younger people in this country who will be around for a long, long time have to ask is, is it right for this country on one hand to preach democracy throughout the world and on the other hand hold for 100 years tomorrow a colony, a territory in the Caribbean. For the Puerto Rican community, the pain goes deeper. Before these 100 years which will be culminated tomorrow, we spent 405 years with Spain. That is 505 years of a colonial status, the longest running colony in the world.

Now, understand that our government, for the first time in passing the bill on the House floor, admitted in legislation, in writing that Puerto Rico, in fact, was a territory of the United States. For years we have been telling the U.N. that we were something else. No, Puerto Rico is a commonwealth that has a special understanding. Look, it is very simple. If you do not have the same rights other American citizens have, you can call it what you want, it is not a state, it is not an independent nation, it is a colony.

Why should this be important to all Americans? Why should all Americans be concerned with this issue? Well, because we have invaded Puerto Rico, Puerto Rico did not invade us, so we have to eventually come to a conclusion on this subject.

Secondly, one cannot have nearly 4 million, 3.8 American citizens living in Puerto Rico not enjoying the same rights that other Americans have.

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So I think the time has come, and perhaps that is what this observance will begin tomorrow. For this Congress, for this Senate, for the American people, for the American media to become aware of the issue and begin to discuss the possibility of finding a solution.

For this Congressman, the solution is very simple. Either we take Puerto Rico in as the 51st State of the Union, or we grant them, work with them on attaining full independence.

I believe, unlike some of my colleagues and unlike some people on the island or in the Puerto Rican communities in the United States, I believe that the Puerto Rican people on the island are fully equipped, talented enough, and intelligent enough to be the 51st State of the Union. I also believe that those folks are talented enough, educated enough, to be a successful independent Nation.

What they should not continue to be is a people in limbo. And we should not continue to profess to be the safekeepers of democracy and democratic principles and allow that situation to exist.

On many occasions on this House Floor I mix, to the dismay of some of my colleagues, I relate the issues of Cuba and Puerto Rico. People say what is the relationship? Well, the relationship is very simple. We spend a lot of time and energy demanding, quote-unquote, democratic changes in Cuba. How will those democratic changes satisfy us? If they become the kind of changes which allow for people to vote and deal with the issues. That is what we claim.

Well, the same thing has to happen in Puerto Rico. And tomorrow as people observe, lament, or celebrate this relationship, I think it is important that we Americans take a step back and analyze what role, if any, we want to play in this issue.

I do not think, in all honesty, that the American educational system on this issue has done the job it should do. I know for a fact that not enough time is taken, not enough energy is expended, not enough resources, if any, are spent on dealing with this issue in our school system. To educate young people to the fact that we have this situation.

There are, of course, concerns. Most people in this Congress are concentrating on the issue of statehood and they will not move on the issue of Puerto Rico because they are dealing with the issue of statehood.

Mr. Speaker, I said a few seconds ago that the issue could be independence. It does not have to be statehood. Either way, it has to be solved and the problem is that too many people spend too much time determining what kind of a state Puerto Rico would be.

I have two things to say about that. One is if we do not want a state that looks and sounds and acts like Puerto Rico, independence is the solution. Just do that. But if we are now going to question Puerto Ricans to see what kind of good American citizens they would make, it might be 100 years too late. After all, not a single Puerto Rican was question on the issue of language when he was sent off to World War I, World War II, Korea, Vietnam, the Gulf War. That was never a question. Now that has become a question.

Do Puerto Ricans speak English? Should we have a state where the majority of the people do not speak English? I hate to tell my colleagues, but there are states in this country where a majority of people who do not speak English. They speak an English, but the English that they have been speaking for a while now has been badly put together.

We could easily suggest that the time for the relationship has come to a point where it is time that we solve it simply by taking an up-or-down vote, independence or statehood, and not play with anything in between, and I mean that.

This present status is neither here nor there, neither for us or for the people who live in Puerto Rico. It is an unfair status for us, because we should not have a colony in the Caribbean. And it is an unfair status for the people in Puerto Rico, because they should take their place in the world as a free Nation or take the place as a State of the Union.

And so I am hopeful, Mr. Speaker, that as we continue to deliberate on this issue, and as the news media covers the fact that tomorrow there will be everything, as I said, from laments to celebration, from joy to sadness, from demonstrations to joyous exuberant demonstrations that we will see on TV and in the newspapers. We will see pictures and video of people celebrating their citizenship and people questioning what kind of citizenship they have. We will see people in Puerto Rico and in the New York community and other Puerto Rican communities throughout the Nation showing glee at the fact that we have reached 100 years with the U.S., and we will also see people lamenting the fact that we have spent these 100 years in this kind of a condition.

Mr. Speaker, I think it is important for all Americans to try to reach a point. So I would hope that all Americans begin to speak to their representatives and to tell them that we have to solve this situation. I would hope that within the next few years, Puerto Rico and the United States can reach an agreement. An agreement to either bring it in as the 51st state, or to grant it independence. Nothing else is acceptable.

The present status is embarrassing to us. It is embarrassing to the Puerto Rican people. It is wrong. It is unfair.

I can think back, and I will close with this, Mr. Speaker. I can think back to my father and to my mother. They came to New York from Puerto Rico. He, with 2 years of school, and my mother with 6 years of school. They came in 1950, and they brought up my brother and me, my brother Eli and me.

They always told us to do everything that good families do. To work hard, obey the law, to study, and to be good citizens. But those two folks, as much lacking formal education as they were, were always very much aware of the fact that there was something wrong with the relationship and that they would always tell us that that relationship some day had to come to a conclusion.

They are no longer with me. They were not here on March 28, 1990, 38 years exactly to the date when they came from Puerto Rico, when I was elected to Congress and got sworn in. And, in fact, I held my swearing in. I asked then Speaker Foley to swear me

in a day after I was supposed to, so that I could pay tribute to their arrival in New York and their fight to create a community and create a family and to celebrate my accomplishment in their honor.

They always told us that this had to be settled somehow. Tomorrow, as we commemorate the 100th year anniversary, I think it behooves the United States Congress to move ahead and create a better situation for itself and for Puerto Rico. To do anything else would be a shame. To do anything else would be an undemocratic act.

CONFERENCE REPORT ON H.R. 4059

Mr. PACKARD submitted the following conference report and statement on the bill (H.R. 4059) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 1999, and for other purposes:

CONFERENCE REPORT (H. REPT. 105–647)

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 4059) ''making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 1999, and for other purposes'', having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate, and agree to the same with an amendment, as follows:

In lieu of the matter stricken and inserted by said amendment, insert:

That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for military construction, family housing, and base realignment and closure functions administered by the Department of Defense, for the fiscal year ending September 30, 1999, and for other purposes, namely:

MILITARY CONSTRUCTION, ARMY

For acquisition, construction, installation, and equipment of temporary or permanent public works, military installations, facilities, and real property for the Army as currently authorized by law, including personnel in the Army Corps of Engineers and other personal services necessary for the purposes of this appropriation, and for construction and operation of facilities in support of the functions of the Commander in Chief, $868,726,000, to remain available until September 30, 2003: Provided, That of this amount, not to exceed $64,269,000 shall be available for study, planning, design, architect and engineer services, and host nation support, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

MILITARY CONSTRUCTION, NAVY

For acquisition, construction, installation, and equipment of temporary or permanent public works, naval installations, facilities, and real property for the Navy as currently authorized by law, including personnel in the Naval Facilities Engineering Command and other personal services necessary for the purposes of this appropriation, $604,593,000, to remain available until September 30, 2003: Provided, That of this amount, not to exceed $60,846,000 shall be available for study, planning, design, architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

MILITARY CONSTRUCTION, AIR FORCE

For acquisition, construction, installation, and equipment of temporary or permanent public works, military installations, facilities, and real property for the Air Force as currently authorized by law, $615,809,000, to remain available until September 30, 2003: Provided, That of this amount, not to exceed $38,092,000 shall be available for study, planning, design, architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

MILITARY CONSTRUCTION, DEFENSE-WIDE

(INCLUDING TRANSFER OF FUNDS)

For acquisition, construction, installation, and equipment of temporary or permanent public works, installations, facilities, and real property for activities and agencies of the Department of Defense (other than the military departments), as currently authorized by law, $553,114,000, to remain available until September 30, 2003: Provided, That such amounts of this appropriation as may be determined by the Secretary of Defense may be transferred to such appropriations of the Department of Defense available for military construction or family housing as he may designate, to be merged with and to be available for the same purposes, and for the same time period, as the appropriation or fund to which transferred: Provided further, That of the amount appropriated, not to exceed $26,005,000 shall be available for study, planning, design, architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

DEPARTMENT OF DEFENSE MILITARY UNACCOMPANIED HOUSING IMPROVEMENT FUND

(RESCISSION OF FUNDS)

Of the funds appropriated for ''Department of Defense Military Unaccompanied Housing Improvement Fund'' under Public Law 104–196, $5,000,000 is hereby rescinded.

MILITARY CONSTRUCTION, ARMY NATIONAL GUARD

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Army National Guard, and contributions therefor, as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $142,403,000, to remain available until September 30, 2003.

MILITARY CONSTRUCTION, AIR NATIONAL GUARD

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Air National Guard, and contributions therefor, as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $169,801,000, to remain available until September 30, 2003.

MILITARY CONSTRUCTION, ARMY RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Army Reserve as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $102,119,000, to remain available until September 30, 2003.

MILITARY CONSTRUCTION, NAVAL RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the reserve components of the Navy and Marine Corps as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $31,621,000, to remain available until September 30, 2003.

MILITARY CONSTRUCTION, AIR FORCE RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Air Force Reserve as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $34,371,000, to remain available until September 30, 2003.

NORTH ATLANTIC TREATY ORGANIZATION SECURITY INVESTMENT PROGRAM

For the United States share of the cost of the North Atlantic Treaty Organization Security Investment Program for the acquisition and construction of military facilities and installations (including international military headquarters) and for related expenses for the collective defense of the North Atlantic Treaty Area as authorized in Military Construction Authorization Acts and section 2806 of title 10, United States Code, $154,000,000, to remain available until expended.

FAMILY HOUSING, ARMY

For expenses of family housing for the Army for construction, including acquisition, replacement, addition, expansion, extension and alteration and for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, as follows: for Construction, $135,290,000, to remain available until September 30, 2003; for Operation and Maintenance, and for debt payment, $1,094,697,000; in all $1,229,987,000.

FAMILY HOUSING, NAVY AND MARINE CORPS

For expenses of family housing for the Navy and Marine Corps for construction, including acquisition, replacement, addition, expansion, extension and alteration and for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, as follows: for Construction, $295,590,000, to remain available until September 30, 2003; for Operation and Maintenance, and for debt payment, $912,293,000; in all $1,207,883,000.

FAMILY HOUSING, AIR FORCE

For expenses of family housing for the Air Force for construction, including acquisition, replacement, addition, expansion, extension and alteration and for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, as follows: for Construction, $280,965,000, to remain available until September 30, 2003; for Operation and Maintenance, and for debt payment, $783,204,000; in all $1,064,169,000.

FAMILY HOUSING, DEFENSE-WIDE

For expenses of family housing for the activities and agencies of the Department of Defense (other than the military departments) for construction, including acquisition, replacement, addition, expansion, extension and alteration, and for operation and maintenance, leasing, and minor construction, as authorized by law, as follows: for Construction, $345,000, to remain available until September 30, 2003; for Operation and Maintenance, $36,899,000; in all $37,244,000.

DEPARTMENT OF DEFENSE FAMILY HOUSING IMPROVEMENT FUND

For the Department of Defense Family Housing Improvement Fund, $2,000,000, to remain available until expended, as the sole source of

funds for planning, administrative, and oversight costs incurred by the Housing Revitalization Support Office relating to military family housing initiatives undertaken pursuant to 10 U.S.C. 2883, pertaining to alternative means of acquiring and improving military family housing and supporting facilities.

BASE REALIGNMENT AND CLOSURE ACCOUNT, PART III

For deposit into the Department of Defense Base Closure Account 1990 established by section 2906(a)(1) of the Department of Defense Authorization Act, 1991 (Public Law 101–510), $427,164,000, to remain available until expended: Provided, That not more than $271,800,000 of the funds appropriated herein shall be available solely for environmental restoration, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

BASE REALIGNMENT AND CLOSURE ACCOUNT, PART IV

For deposit into the Department of Defense Base Closure Account 1990 established by section 2906(a)(1) of the Department of Defense Authorization Act, 1991 (Public Law 101–510), $1,203,738,000, to remain available until expended: Provided, That not more than $426,036,000 of the funds appropriated herein shall be available solely for environmental restoration, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

GENERAL PROVISIONS

SEC. 101. None of the funds appropriated in Military Construction Appropriations Acts shall be expended for payments under a cost-plus-a-fixed-fee contract for construction, where cost estimates exceed $25,000, to be performed within the United States, except Alaska, without the specific approval in writing of the Secretary of Defense setting forth the reasons therefor.

SEC. 102. Funds appropriated to the Department of Defense for construction shall be available for hire of passenger motor vehicles.

SEC. 103. Funds appropriated to the Department of Defense for construction may be used for advances to the Federal Highway Administration, Department of Transportation, for the construction of access roads as authorized by section 210 of title 23, United States Code, when projects authorized therein are certified as important to the national defense by the Secretary of Defense.

SEC. 104. None of the funds appropriated in this Act may be used to begin construction of new bases inside the continental United States for which specific appropriations have not been made.

SEC. 105. No part of the funds provided in Military Construction Appropriations Acts shall be used for purchase of land or land easements in excess of 100 percent of the value as determined by the Army Corps of Engineers or the Naval Facilities Engineering Command, except: (1) where there is a determination of value by a Federal court; or (2) purchases negotiated by the Attorney General or his designee; or (3) where the estimated value is less than $25,000; or (4) as otherwise determined by the Secretary of Defense to be in the public interest.

SEC. 106. None of the funds appropriated in Military Construction Appropriations Acts shall be used to: (1) acquire land; (2) provide for site preparation; or (3) install utilities for any family housing, except housing for which funds have been made available in annual Military Construction Appropriations Acts.

SEC. 107. None of the funds appropriated in Military Construction Appropriations Acts for minor construction may be used to transfer or relocate any activity from one base or installation to another, without prior notification to the Committees on Appropriations.

SEC. 108. No part of the funds appropriated in Military Construction Appropriations Acts may be used for the procurement of steel for any construction project or activity for which American steel producers, fabricators, and manufacturers have been denied the opportunity to compete for such steel procurement.

SEC. 109. None of the funds available to the Department of Defense for military construction or family housing during the current fiscal year may be used to pay real property taxes in any foreign nation.

SEC. 110. None of the funds appropriated in Military Construction Appropriations Acts may be used to initiate a new installation overseas without prior notification to the Committees on Appropriations.

SEC. 111. None of the funds appropriated in Military Construction Appropriations Acts may be obligated for architect and engineer contracts estimated by the Government to exceed $500,000 for projects to be accomplished in Japan, in any NATO member country, or in countries bordering the Arabian Gulf, unless such contracts are awarded to United States firms or United States firms in joint venture with host nation firms.

SEC. 112. None of the funds appropriated in Military Construction Appropriations Acts for military construction in the United States territories and possessions in the Pacific and on Kwajalein Atoll, or in countries bordering the Arabian Gulf, may be used to award any contract estimated by the Government to exceed $1,000,000 to a foreign contractor: Provided, That this section shall not be applicable to contract awards for which the lowest responsive and responsible bid of a United States contractor exceeds the lowest responsive and responsible bid of a foreign contractor by greater than 20 percent: Provided further, That this section shall not apply to contract awards for military construction on Kwajalein Atoll for which the lowest responsive and responsible bid is submitted by a Marshallese contractor.

SEC. 113. The Secretary of Defense is to inform the appropriate committees of Congress, including the Committees on Appropriations, of the plans and scope of any proposed military exercise involving United States personnel thirty days prior to its occurring, if amounts expended for construction, either temporary or permanent, are anticipated to exceed $100,000.

SEC. 114. Not more than 20 percent of the appropriations in Military Construction Appropriations Acts which are limited for obligation during the current fiscal year shall be obligated during the last two months of the fiscal year.

(TRANSFER OF FUNDS)

SEC. 115. Funds appropriated to the Department of Defense for construction in prior years shall be available for construction authorized for each such military department by the authorizations enacted into law during the current session of Congress.

SEC. 116. For military construction or family housing projects that are being completed with funds otherwise expired or lapsed for obligation, expired or lapsed funds may be used to pay the cost of associated supervision, inspection, overhead, engineering and design on those projects and on subsequent claims, if any.

SEC. 117. Notwithstanding any other provision of law, any funds appropriated to a military department or defense agency for the construction of military projects may be obligated for a military construction project or contract, or for any portion of such a project or contract, at any time before the end of the fourth fiscal year after the fiscal year for which funds for such project were appropriated if the funds obligated for such project: (1) are obligated from funds available for military construction projects and (2) do not exceed the amount appropriated for such project, plus any amount by which the cost of such project is increased pursuant to law.

(TRANSFER OF FUNDS)

SEC. 118. During the five-year period after appropriations available to the Department of Defense for military construction and family housing operation and maintenance and construction have expired for obligation, upon a determination that such appropriations will not be necessary for the liquidation of obligations or for making authorized adjustments to such appropriations for obligations incurred during the period of availability of such appropriations, unobligated balances of such appropriations may be transferred into the appropriation ''Foreign Currency Fluctuations, Construction, Defense'' to be merged with and to be available for the same time period and for the same purposes as the appropriation to which transferred.

SEC. 119. The Secretary of Defense is to provide the Committees on Appropriations of the Senate and the House of Representatives with an annual report by February 15, containing details of the specific actions proposed to be taken by the Department of Defense during the current fiscal year to encourage other member nations of the North Atlantic Treaty Organization, Japan, Korea, and United States allies bordering the Arabian Gulf to assume a greater share of the common defense burden of such nations and the United States.

(TRANSFER OF FUNDS)

SEC. 120. During the current fiscal year, in addition to any other transfer authority available to the Department of Defense, proceeds deposited to the Department of Defense Base Closure Account established by section 207(a)(1) of the Defense Authorization Amendments and Base Closure and Realignment Act (Public Law 100–526) pursuant to section 207(a)(2)(C) of such Act, may be transferred to the account established by section 2906(a)(1) of the Department of Defense Authorization Act, 1991, to be merged with, and to be available for the same purposes and the same time period as that account.

SEC. 121. No funds appropriated pursuant to this Act may be expended by an entity unless the entity agrees that in expending the assistance the entity will comply with sections 2 through 4 of the Act of March 3, 1933 (41 U.S.C. 10a–10c, popularly known as the ''Buy American Act'').

SEC. 122. (a) In the case of any equipment or products that may be authorized to be purchased with financial assistance provided under this Act, it is the sense of the Congress that entities receiving such assistance should, in expending the assistance, purchase only American-made equipment and products.

(b) In providing financial assistance under this Act, the Secretary of the Treasury shall provide to each recipient of the assistance a notice describing the statement made in subsection (a) by the Congress.

(TRANSFER OF FUNDS)

SEC. 123. Subject to thirty days prior notification to the Committees on Appropriations, such additional amounts as may be determined by the Secretary of Defense may be transferred to the Department of Defense Family Housing Improvement Fund from amounts appropriated for construction in ''Family Housing'' accounts, to be merged with and to be available for the same purposes and for the same period of time as amounts appropriated directly to the Fund: Provided, That appropriations made available to the Fund shall be available to cover the costs, as defined in section 502(5) of the Congressional Budget Act of 1974, of direct loans or loan guarantees issued by the Department of Defense pursuant to the provisions of subchapter IV of chapter 169, title 10, United States Code, pertaining to alternative means of acquiring and improving military family housing and supporting facilities.

SEC. 124. None of the funds appropriated or made available by this Act may be obligated for Partnership for Peace Programs or to provide support for non-NATO countries.

SEC. 125. Payments received by the Secretary of the Navy pursuant to subsection (b)(1) of section 2842 of the National Defense Authorization Act, 1993 (Public Law 102–484) are appropriated and shall be available for the purpose authorized in subsection (d) of that section.

SEC. 126. (a) Not later than 60 days before issuing any solicitation for a contract with the private sector for military family housing, the Secretary of the military department concerned shall submit to the congressional defense committees the notice described in subsection (b).

(b)(1) A notice referred to in subsection (a) is a notice of any guarantee (including the making of mortgage or rental payments) proposed to be made by the Secretary to the private party under the contract involved in the event of—

(A) the closure or realignment of the installation for which housing is provided under the contract;

(B) a reduction in force of units stationed at such installation; or

(C) the extended deployment overseas of units stationed at such installation.

(2) Each notice under this subsection shall specify the nature of the guarantee involved and assess the extent and likelihood, if any, of the liability of the Federal Government with respect to the guarantee.

(c) In this section, the term ''congressional defense committees'' means the following:

(1) The Committee on Armed Services and the Military Construction Subcommittee, Committee on Appropriations of the Senate.

(2) The Committee on National Security and the Military Construction Subcommittee, Committee on Appropriations of the House of Representatives.

(TRANSFER OF FUNDS)

SEC. 127. During the current fiscal year, in addition to any other transfer authority available to the Department of Defense, amounts may be transferred from the account established by section 2906(a)(1) of the Department of Defense Authorization Act, 1991, to the fund established by section 1013(d) of the Demonstration Cities and Metropolitan Development Act of 1966 (42 U.S.C. 3374) to pay for expenses associated with the Homeowners Assistance Program. Any amounts transferred shall be merged with and be available for the same purposes and for the same time period as the fund to which transferred.

SEC. 128. It is the sense of the Congress that the Secretary of the Army should name the ''All American Parkway'' at Fort Bragg, North Carolina, as the ''W.G. 'Bill' Hefner All American Parkway''.

This Act may be cited as the ''Military Construction Appropriations Act, 1999''.

And the Senate agree to the same.

RON PACKARD,
JOHN EDWARD PORTER,
DAVID L. HOBSON,
ROGER F. WICKER,
JACK KINGSTON,
MIKE PARKER,
TODD TIAHRT,
ZACH WAMP,
BOB LIVINGSTON,
W.G. (BILL) HEFNER,
JOHN W. OLVER,
CHET EDWARDS,
BUD CRAMER,
NORMAN DICKS,
DAVID OBEY,
Managers on the Part of the House.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 4059) making appropriations for the Department of Defense for the fiscal year ending September 30, 1999, and for other purposes, submit the following joint statement to the House of Representatives and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report.

The Senate deleted the entire House bill after the enacting clause and inserted the Senate bill (S. 2160). The conference agreement includes a revised bill.

ITEMS OF GENERAL INTEREST

Matters Addressed by Only One Committee.—The language and allocations set forth in House Report 105–578 and Senate Report 105–213 should be complied with unless specifically addressed to the contrary in the conference report and statement of the managers. Report language included by the House which is not changed by the report of the Senate or the conference, and Senate report language which is not changed by the conference is approved by the committee of conference. The statement of the managers, while repeating some report language for emphasis, does not intend to negate the language referred to above unless expressly provided herein. In cases in which the House or the Senate have directed the submission of a report from the Department of Defense, such report is to be submitted to both House and Senate Committees on Appropriations.

Financial Management.—The conferees agree that general reductions included in the conference agreement are based on such factors as savings through favorable bids, reduced overhead costs, downsizing or cancellation due to force structure changes (if any), other administrative cost reduction initiatives, revised economic assumptions, and inflation re-estimates. The conferees direct that no project for which funds were previously appropriated, or for which funds are appropriated in this bill, may be cancelled as a result of general reductions included in the conference agreement.

The conference agreement includes reductions totaling $21,300,000 which result from re-estimation of inflation undertaken by the Office of Management and Budget as part of the mid-session review of the budget request. The conferees direct the Department to distribute these reductions proportionally against each project and activity in each account, as follows:

Reductions resulting from economic assumptions in OMB's mid-session review of the budget request

Account	*Amount*
Military Construction, Army	$2,000,000
Military Construction, Navy	1,000,000
Military Construction, Air Force	1,000,000
Military Construction, Defense-wide	1,300,000
NATO Security Investment Program	1,000,000
Family Housing Operations, Army	3,000,000
Family Housing Construction, Navy	1,000,000
Family Housing Operations, Navy	3,000,000
Family Housing Construction, Air Force	1,000,000
Family Housing Operations, Air Force	2,000,000
Base Realignment and Closure, Part III	2,000,000
Base Realignment and Closure, Part IV	3,000,000
	$21,300,000

Real Property Maintenance: Reporting Requirement.—The conferees agree to the following general rules for repairing a facility under Operation and Maintenance account funding:

Components of the facility may be repaired by replacement, and such replacement can be up to current standards or codes.

Interior arrangements and restorations may be included as repair, but additions, new facilities, and functional conversions must be performed as military construction projects.

Such projects may be done concurrent with repair projects, as long as the final conjunctively funded project is a complete and usable facility.

The appropriate Service Secretary shall submit a 21-day notification prior to carrying out any repair project with an estimated cost in excess of $10,000,000.

MILITARY CONSTRUCTION, ARMY

The conference agreement appropriates $868,726,000 for Military Construction, Army, instead of $780,599,000 as proposed by the House, and $810,476,000 as proposed by the Senate. Within this amount, the conference agreement earmarks $64,269,000 for study, planning, design, architect and engineer services, and host nation support instead of $63,792,000 as proposed by the House and $67,269,000 as proposed by the Senate.

Kentucky—Fort Campbell: Sabre Heliport.—The conferees recognize the critical importance of the Sabre Heliport to military operations at Fort Campbell and understand that this facility needs essential renovations in order to operate both safely and efficiently. The U.S. Army Aeronautical Services Agency (USAASA) has issued a temporary waiver that allows the facility to continue normal operations until April 2001. Accordingly, the conferees direct the Secretary of the Army to report to the congressional defense committees not later than January 15, 1999, on their plan and timetable to make the necessary airfield improvements.

New York—Fort Drum: Consolidated Soldier/Family Support Center.—The conferees have deferred funding for this project, without prejudice, and the Army is encouraged to include this project in the budget request for fiscal year 2000.

Unspecified Minor Construction.—Within the increased funds appropriated above the budget request for Army, Unspecified Minor Construction, the Army is directed to provide the needed athletic facilities, such as ball fields and a running track, at Camp McGovern, Bosnia-Herzegovina.

MILITARY CONSTRUCTION, NAVY

The conference agreement appropriates $604,593,000 for Military Construction, Navy, instead of $570,643,000 as proposed by the House, and $565,030,000 as proposed by the Senate. Within this amount, the conference agreement earmarks $60,846,000 for study, planning, design, architect and engineer services instead of $60,346,000 as proposed by the House and $62,146,000 as proposed by the Senate.

Florida—Key West Naval Air Station: Compatible Use Easements.—The conferees direct the Navy to report on the need for continuation of existing compatible use easements which prevent construction of facilities on privately owned land in connection with the operation of the Key West Naval Air Station. This report is to be submitted within 30 days of enactment of this Act.

MILITARY CONSTRUCTION, AIR FORCE

The conference agreement appropriates $615,809,000 for Military Construction, Air Force, instead of $550,475,000 as proposed by the House, and $627,874,000 as proposed by the Senate. Within this amount, the conference agreement earmarks $38,092,000 for study, planning, design, architect and engineer services instead of $37,592,000 as proposed by

the House and $39,522,000 as proposed by the Senate.

California—Beale AFB: Flightline Fire Station.—The conferees direct the Air Force to accelerate design and to include this project in the budget request for fiscal year 2000.

Kansas—McConnell AFB: KC–135 Squadron Operations/Aircraft Maintenance Unit #3.—The conferees direct the Air Force to accelerate design and to include this project in the budget request for fiscal year 2000.

New York—Rome Labs: Consolidated Intelligence and Reconnaissance Laboratory.—The conferees direct the Air Force to accelerate the design of the Consolidated Intelligence and Reconnaissance Research Site at the Department's Rome Laboratory in New York and include this project in its fiscal year 2000 Military Construction budget request.

MILITARY CONSTRUCTION, DEFENSE-WIDE

The conference agreement appropriates $553,114,000 for Military Construction, Defense-wide, instead of $611,075,000 as proposed by the House, and $571,485,000 as proposed by the Senate. Within this amount, the conference agreement earmarks $26,005,000 for study, planning, design, architect and engineer services instead of $24,866,000 as proposed by the House and $25,066,000 as proposed by the Senate.

Chemical Demilitarization Program.—The conference agreement includes full funding of all requested projects related to the chemical demilitarization program, and also includes a general reduction of $50,500,000 against the entire program based on unobligated prior year funds, delays in obtaining the required environmental and construction permits, and possible delays in equipment delivery.

Energy Conservation Investment Program.—In future budget submissions, the conferees expect project-level information on the Energy Conservation Investment Program (ECIP) to be presented in tabular form, rather than in Form 1391 detail.

MILITARY UNACCOMPANIED HOUSING IMPROVEMENT FUND

Military Unaccompanied Housing Improvement Fund.— The conferees agree to rescind $5,000,000 from the Military Unaccompanied Housing Improvement Fund. The House and Senate bills had no similar provision. This rescinds the full unobligated balance of funds, due to the absence of any programmed or anticipated projects under this account.

MILITARY CONSTRUCTION, ARMY NATIONAL GUARD

The conference agreement appropriates $142,403,000 for Military Construction, Army National Guard, instead of $70,338,000 as proposed by the House, and $124,599,000 as proposed by the Senate.

Iowa-Camp Dodge: Damaged and Destroyed Facilities.—The conferees direct the National Guard Bureau to report on tornado and wind damage sustained on June 29, 1998. This report is to be submitted within 30 days of enactment of this Act, and is to include an assessment of requirements for repair and replacement.

Montana—Fort Harrison: Sewer System.—The conferees agree to grant the Army National Guard reprogramming approval up to the amount of $1,200,000 to cover the Army National Guard's contribution for connecting the Fort Harrison complex to the city sewer system, subject to approval of the proposed source of funds.

Montana—Helena: Armed Forces Reserve Center.—The conferees direct that the total funding provided for this facility shall include the purchase and installation of prewired workstations and furnishings.

North Carolina—Fort Bragg: Military Education Facility.—The conferees recognize the importance of the Military Education Facility to the Army National Guard and direct the National Guard Bureau to begin the planning and design and site preparation for this National Guard facility. The conferees direct the Department to include this project in the Future Year Defense Plan (FYDP).

MILITARY CONSTRUCTION, AIR NATIONAL GUARD

The conference agreement appropriates $169,801,000 for Military Construction, Air National Guard, instead of $97,701,000 as proposed by the House, and $163,161,000 as proposed by the Senate.

California—Moffett Federal Airfield: Composite Maintenance Hangar.—The conferees acknowledge the urgent and compelling need to replace the existing World War II facility at Moffett Federal Airfield and encourage the Department to include this project in the fiscal year 2000 budget request.

Georgia—Savannah IAP: Composite Support Complex.—The conferees direct the Air National Guard to include this project in the budget request for fiscal year 2000, as programmed in the Future Year Defense Plan submitted in support of the fiscal year 1999 budget.

MILITARY CONSTRUCTION, ARMY RESERVE

The conference agreement appropriates $102,119,000 for Military Construction, Army Reserve, instead of $71,894,000 as proposed by the House, and $114,349,000 as proposed by the Senate.

Utah—Salt Lake City: U.S. Army Reserve Center (Phase II).—The conferees agree to provide $5,076,000 as the second and final funding phase for a U.S. Army Reserve Center / Organizational Maintenance Shop / Direct Support-General Support Facilities / Equipment Concentration Site. Together with $12,714,000 appropriated in fiscal year 1998 as the first funding phase, this provides a total of $17,790,000 for this project.

MILITARY CONSTRUCTION, NAVAL RESERVE

The conference agreement appropriates $31,621,000 for Military Construction, Naval Reserve, instead of $33,721,000 as proposed by the House, and $21,621,000 as proposed by the Senate.

MILITARY CONSTRUCTION, AIR FORCE RESERVE

The conference agreement appropriates $34,371,000 for Military Construction, Air Force Reserve, instead of $35,371,000 as proposed by the House, and $22,835,000 as proposed by the Senate.

NORTH ATLANTIC TREATY ORGANIZATION SECURITY INVESTMENT PROGRAM

The conference agreement appropriates $154,000,000 for the North Atlantic Treaty Organization Security Investment Program (NSIP), instead of $169,000,000 as proposed by the House, and $152,600,000 as proposed by the Senate.

North Atlantic Treaty Organization Security Investment Program Funds.—The conferees agree to a provision renumbered Section 124, proposed by the Senate, which prohibits the use of NSIP funds for any aspect of the Partnership for Peace Program or support to non-NATO countries. The President's budget request for fiscal year 1999 included $56,900,000 for the Department of Defense and an additional $80,000,000 of foreign military financing, administered by the Department of State, for the Partnership for Peace Program. The proposed funding level should provide sufficient resources for any expansion initiatives anticipated by the Administration.

FAMILY HOUSING—OVERVIEW

Reprogramming Criteria.—The reprogramming criteria that apply to military construction projects (25 percent of the funded amount or $2,000,000, whichever is less) also apply to new housing construction projects and to improvement projects over $2,000,000.

Family Housing Operation and Maintenance.—The conferees direct that the details of all expenditures from the Family Housing Operation and Maintenance accounts which exceed $20,000 per unit, per year for major maintenance and repair of non-general and flag officer quarters be included as part of the budget justification material.

Exclusion of Costs Associated with Environmental Hazard Remediation from Maintenance and Repair Limits.—The conferees revise the requirement for an after-the-fact notification for projects when the costs associated with environmental hazard remediation such as asbestos removal, radon abatement, lead-based paint removal or abatement, and any other legislated environmental hazard remediation cause the maintenance and repair thresholds of $20,000 for a military family housing unit, or $25,000 for a General or Flag Officer Quarter to be exceeded. The notification shall include work, scope, cost breakout and other details pertinent to the environmental hazard remediation and shall be reported on a semi-annual basis. An after-the-fact notification is acceptable provided that such remediation requirements could not be reasonably anticipated at the time of the budget submission. This exclusion applies to projects appropriated in this budget year, and also projects appropriated in prior years for which construction contracts have not been completed.

FAMILY HOUSING, ARMY

The conference agreement appropriates $135,290,000 for Construction, Family Housing, Army, instead of $82,840,000 as proposed by the House and $124,490,000 as proposed by the Senate.

The conferees direct that the following projects are to be accomplished within the increased amount provided for construction improvements:

Alaska-Fort Richardson (40 units)	$7,400,000
Kentucky-Fort Campbell (104 units)	8,800,000
New Mexico-White Sands Missile Range (36 units)	3,650,000

The conference agreement appropriates $1,094,697,000 for Operation and Maintenance, Family Housing, Army, instead of $1,097,697,000 as proposed by the House and $1,104,733,000 as proposed by the Senate.

The conference agreement appropriates a total of $1,229,987,000 for Family Housing, Army, instead of $1,180,537,000 as proposed by the House and $1,229,223,000 as proposed by the Senate.

FAMILY HOUSING, NAVY AND MARINE CORPS

The conference agreement appropriates $295,590,000 for Construction, Family Housing, Navy and Marine Corps, instead of $130,457,000 as proposed by the House and $286,590,000 as proposed by the Senate.

The conferees direct that the following projects are to be accomplished within the increased amount provided for construction improvements:

California—Camp Pendleton (171 units)	$10,000,000
Washington—Whidbey Island NAS (80 units)	5,800,000

The conference agreement appropriates $912,293,000 for Operation and Maintenance, Family Housing, Navy and Marine Corps, instead of $915,293,000 as proposed by the House and Senate.

The conference agreement appropriates a total of $1,207,883,000 for Family Housing, Navy and Marine Corps, instead of $1,045,750,000 as proposed by the House and $1,201,883,000 as proposed by the Senate.

Washington—Naval Station Puget Sound, Everett: Real Property Conveyance.—Section 125 of this Act provides an appropriation of

$6,000,000 in proceeds from the sale of land and family housing units at Paine Field. This funding shall be used for the acquisition of land and/or housing units in the vicinity of, or for, Naval Station Everett as authorized in Section 2842 of Public Law 102–484.

FAMILY HOUSING, AIR FORCE

The conference agreement appropriates $280,965,000 for Construction, Family Housing, Air Force, instead of $207,880,000 as proposed by the House and $297,475,000 as proposed by the Senate.

The conferees direct that the following projects are to be accomplished within the increased amount provided for construction improvements:

Georgia—Moody AFB (68 units)	$5,220,000
North Carolina—Seymour Johnson AFB (70 units)	8,000,000
South Carolina—Charleston AFB (94 units)	9,110,000

The conference agreement appropriates $783,204,000 for Operation and Maintenance, Family Housing, Air Force, instead of $785,204,000 as proposed by the House and $789,995,000 as proposed by the Senate.

The conference agreement appropriates a total of $1,064,169,000 for Family Housing, Air Force, instead of $993,084,000 as proposed by the House and $1,087,470,000 as proposed by the Senate.

FAMILY HOUSING, DEFENSE-WIDE

The conference agreement appropriates $345,000 for Construction, Family Housing, Defense-wide, as proposed by the House and Senate.

The conference agreement appropriates $36,899,000 for Operation and Maintenance, Family Housing, Defense-wide, as proposed by the House and Senate.

The conference agreement appropriates a total of $37,244,000 for Family Housing, Defense-wide, as proposed by the House and Senate.

DEPARTMENT OF DEFENSE FAMILY HOUSING IMPROVEMENT FUND

The conference agreement appropriates $2,000,000 for the Department of Defense Family Housing Improvement Fund instead of $242,438,000 as proposed by the House and $7,000,000 as proposed by the Senate. The reduction from the level proposed by the House reflects full funding of construction projects and construction improvement projects in the traditional family housing accounts, rather than in the Family Housing Improvement Fund. Transfer authority is provided for the execution of any qualifying project under privatization authority which resides in the Fund.

The conferees note that the Housing Revitalization Support Office (HRSO) proposed to expend 90 percent of the $7,000,000 budget request for consultant support. Further, HRSO will expend $14,150,000 for consultant support for fiscal years 1996 through 1998, which represents 90 percent of all resources available for HRSO overhead. These expenditures for consultant services have not produced any contracts awarded under the 1996 privatization authorities.

The conferees support the Department's privatization efforts, and recommend an appropriation of $2,000,000 based on available balances and excessive allocation for consultant services.

The conferees continue to be concerned over the delay in execution of family housing construction projects for which funds have been appropriated, for possible privatization efforts. The new authorities were signed into law in February 1996, yet no new agreements have been finalized to build or renovate military family housing. Several projects are being considered, yet only one project, at Lackland AFB, is close to contract signing. The conferees strongly believe that the Department needs to use all available tools to address the family housing program in an optimum manner. This includes the traditional construction program, privatization, and adequate use of existing private sector housing. The conferees remind the Department that Congress approved the new privatization authorities as a pilot project, and that these authorities will expire on February 10, 2001. It was never the intent of the House and Senate Appropriations Committees for this program to become a substitute for the traditional housing construction program.

The conferees direct the Office of the Under Secretary of Defense for Acquisition and Technology to carefully review the planned privatization efforts and narrow the scope to a reasonable number of projects which may be executed prior to the expiration of the pilot project authority. The conferees expect to be notified on October 1, 1998, of a revised, scaled-back, reasonable plan for the privatization effort. In addition, the conferees anticipate that all prior year appropriated family housing construction projects which have been placed on hold will be released for construction at that time, unless specific justification is provided to Congress. Following the October 1st report, the Department is expected to report quarterly to the House and Senate Appropriations Committees on the status of all privatization efforts and the status of all family housing construction and construction improvement projects for which funds have been appropriated.

The conferees direct the Department to display all family housing construction and construction improvement projects which are anticipated for privatization as such in the fiscal year 2000 budget. This display should include a detailed plan of the time frame for execution of each privatization effort.

In addition, the Secretary of Defense is directed to report to the House and Senate Committees on Appropriations by December 1, 1998, on an integrated family housing strategy for the Department of Defense. This strategy should focus on the maximum use of existing civilian housing, the use of enhanced housing referral services, coordination of housing allowances, and appropriate use of privatization and traditional construction options. In particular, this report should include a detailed plan for integrating the DOD offices which have responsibilities for the military's family housing program. Responsibility for privatization and for construction, operation and maintenance lies with the Under Secretary of Defense for Acquisition and Technology. Appropriations for military-owned and leased family housing are included in the Services' family housing accounts. Responsibility for housing allowances is under the Under Secretary for Defense for Personnel and Readiness, and housing allowances are included in the Services' military personnel accounts. The conferees are concerned that privatization shifts funding from military family housing construction, operations, and maintenance accounts to military personnel accounts to pay for increased housing allowances, which are used to pay rent to developers of privatized housing. The conferees believe that this is not being coordinated by the Department, nor is it being budgeted for adequately. The conferees believe that in order to have a truly integrated family housing policy, these functions need to be overseen by one office within the Department.

The conferees request the Comptroller General to monitor the progress of the Department of Defense's and individual Services' implementation of the family housing privatization initiative. The monitoring of the program shall include, but not be limited to, obtaining information on the status of family housing projects, reviewing life-cycle costs analyses for projects, and determining whether the privatization initiative is being integrated and coordinated with the Department's other family housing programs. The conferees request that the Comptroller General keep the House and Senate Committees on Appropriations apprised of the progress and submit a report to the Congress no later than March 31, 2000.

HOMEOWNERS ASSISTANCE FUND, DEFENSE

The conference agreement appropriates no funds for the Homeowners Assistance Fund, Defense instead of $7,500,000 as proposed by the House and $12,800,000 as proposed by the Senate.

The conferees have included a new provision, Section 127, as proposed by the Senate, which allows the transfer of funds from the Base Realignment and Closure account into the Homeowners Assistance Fund, Defense. Any amounts transferred into the fund shall be available to pay for expenses associated with the program. Due to this transfer authority, the conferees believe a direct appropriation to this account for fiscal year 1999 is not necessary. The total estimated requirements for fiscal year 1999 are estimated at $109,735,000 and will be funded with transfer of appropriated funds, revenue from sales of acquired property and prior year unobligated balances. The Comptroller of the Department of Defense is to notify the House and Senate Subcommittees on Military Construction twenty-one days prior to the use of the transfer authority.

BASE REALIGNMENT AND CLOSURE—OVERVIEW

Construction Projects: Administrative Provision.—The conferees agree that any transfer of funds which exceeds reprogramming thresholds for any construction project financed by any Base Realignment and Closure Account shall be subject to a 21-day notification to the Committees, and shall not be subject to reprogramming procedure.

Construction Budget Data.—The conferees are concerned about the accuracy and reliability of the base realignment and closure (BRAC) construction budget data provided annually to the Congress. The Office of the Department of Defense Inspector General and the General Accounting Office recently found that the Services submitted BRAC military construction data in the fiscal years 1997 and 1998 military construction budgets based on overstated requirements and unsupported specifications and costs. They also found that the major commands of the Services did not effectively implement management control procedures established for the BRAC military construction planning, programming and budgeting process. This has resulted in overstated and invalid BRAC requirements and lack of supporting documentation. The conferees direct the Department to take the necessary corrective action to ensure that these deficiencies are corrected in the fiscal year 2000 budget submission.

Future Costs of Environmental Restoration.—The conferees direct the Department of Defense to submit a legislative proposal for the establishment of a Treasury account entitled ''Base Realignment and Closure Environmental Restoration'', rather than budgeting for future costs in the Operation and Maintenance accounts. The conferees direct that future costs for environmental restoration related to the four rounds of base closure conducted from 1988 through 1995 shall be programmed and budgeted in this new account.

BASE REALIGNMENT AND CLOSURE ACCOUNT, PART III

The conference agreement appropriates $427,164,000 for the Base Realignment and

Closure Account, Part III instead of $433,464,000 as proposed by the House and Senate. Within the amount appropriated, the conference agreement earmarks $271,800,000 for environmental restoration, as proposed by the House and Senate.

Reprogramming Action.—The Committees have approved a reprogramming request which accelerated one construction project from fiscal year 1999 to fiscal year 1998, allowing the program to absorb a reduction of $4,300,000 from the budget request.

Revised Economic Assumptions.—As described earlier in this report, the conferees recommend a reduction of $2,000,000 from the budget request based on reestimation of inflation.

BASE REALIGNMENT AND CLOSURE ACCOUNT, PART IV

The conference agreement appropriates $1,203,738,000 for the Base Realignment and Closure Account, Part IV instead of $1,297,240,000 as proposed by the House and Senate. Within the amount appropriated, the conference agreement earmarks $426,036,000 for environmental restoration, as proposed by the House and Senate.

Reprogramming Actions.—The Committees have approved reprogramming requests which accelerated four construction projects from fiscal year 1999 to fiscal year 1998, allowing the program to absorb a reduction of $28,802,000 from the budget request.

Revised Economic Assumptions.—As described earlier in this report, the conferees recommend a reduction of $3,000,000 from the budget request based on reestimation of inflation.

Unreported Proceeds.—The Services have collected $35,700,000 more in proceeds from land sales and leases at closing or realigning bases than reported in the fiscal year 1999 budget request. Statutes and Department of Defense guidance state that proceeds from the transfer, lease, or disposal of property due to the Base Realignment and Closure process shall be deposited into the Base Closure Accounts. The conferees understand that, because such proceeds were collected after the development of the budget, the Air Force did not report $21,000,000 worth of proceeds, the Army did not report $3,900,000, and the Navy did not report $10,800,000. The conferees direct the Services to deposit these proceeds into the Base Realignment and Closure Account, and have reduced the Base Realignment and Closure Account, Part IV fiscal year 1999 appropriation by $35,700,000 to reflect this action.

Funds Previously Withheld.—The conferees recommend a reduction of $26,000,000 to the Base Realignment and Closure Account, Part IV. This reduction is based on funds that were previously withheld from obligation based on an inflation rate that was lower than expected. At the time the fiscal year 1999 budget was submitted to Congress, these funds were withheld from obligation, but have subsequently been made available. Thus, the budget request is overstated by $26,000,000.

Kentucky—Louisville Naval Ordnance Station: Environmental Restoration.—The conferees urge the Navy to pursue the feasibility for use of bioremediation technologies (such as treatment by microbes and plants) for cleanup of sub-surface contamination of soils and groundwater, and to utilize such technologies if they are proven to be cost-effective.

GENERAL PROVISIONS

The conference agreement includes general provisions that were in both the House and Senate versions of the bill that were not amended.

The conference agreement includes Section 101, as proposed by the House, prohibiting the expenditure of funds for payments under a cost-plus-a-fixed-fee contract for construction, where cost estimates exceeded $25,000, to be performed within the United States, except Alaska, without the specific approval in writing of the Secretary of Defense, instead of similar language as proposed by the Senate.

The conference agreement includes Section 105, as proposed by the House, which makes a technical correction to the word ''per centum'', instead of language as proposed by the Senate.

The conference agreement includes Section 112 as proposed by the House, which makes a technical correction to the word ''per centum'', instead of language as proposed by the Senate.

The conference agreement includes Section 114, as proposed by the House, which makes a technical correction to the word ''per centum'', instead of language as proposed by the Senate.

The conference agreement includes a provision, Section 121, as proposed by the House, which prohibits the expenditure of funds except in compliance with the Buy American Act. The Senate bill contained no similar provision.

The conference agreement includes a provision, Section 122, as proposed by the House, which states the Sense of the Congress notifying recipients of equipment or products authorized to be purchased with financial assistance provided in this Act to purchase American-made equipment and products. The Senate bill contained no similar provision.

The conference agreement includes a provision renumbered Section 123, as proposed by the Senate, permitting the transfer of funds from Family Housing, Construction accounts to the DOD Family Housing Improvement Fund, instead of language as proposed by the House.

The conference agreement includes a provision renumbered Section 124, as proposed by the Senate, stating that none of the funds appropriated or made available by this Act may be obligated for Partnership for Peace Programs or to provide support for non-NATO countries.

The conference agreement includes a provision renumbered Section 127, as proposed by the Senate, providing transfer authority from the Base Realignment and Closure (BRAC) accounts to the Homeowners Assistance Program (HAP). The House bill contained no similar provision.

The conference agreement includes a provision renumbered Section 128, as proposed by the House, stating that it is the sense of the Congress that the Secretary of the Army should name the ''All American Parkway'' at Fort Bragg, North Carolina, as the ''W.G. ''Bill'' Hefner All American Parkway''.

Those general provisions that were not included in the conference agreement follow:

The conference agreement deletes the Senate provision stating that the sole source of funds for planning, administrative, and oversight costs incurred by the Housing Revitalization Support Office must come from the DOD Family Housing Improvement Fund. This provision is included in the appropriations paragraph for the ''Department of Defense Family Housing Improvement Fund'' as proposed in the House bill.

The conference agreement deletes the Senate provision increasing the ''Military Construction, Army National Guard'' appropriation and decreasing the ''Military Construction, Army Reserve'' appropriation. The House bill contained no similar provision.

The conference agreement deletes the Senate provision increasing the ''Military Construction, Navy'' appropriation and the ''Family Housing, Air Force'' appropriation and decreasing the ''Military Construction, Defense-wide'' appropriation. The House bill contained no similar provision.

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
ALABAMA		
ARMY		
ANNISTON ARMY DEPOT		
AMMUNITION CONTAINERIZATION COMPLEX	3,550	3,550
FORT RUCKER		
AVIATION WARFIGHTING SIMULATION CENTER	---	10,000
PROVOST MARSHAL/FIRE STATION COMPLEX	---	4,300
REDSTONE ARSENAL		
AIRFIELD OPERATIONS CENTER	---	1,550
MISSILE SOFTWARE ENGINEERING ANNEX (PHASE II)	13,600	13,600
AIR FORCE		
MAXWELL AFB		
FIRE TRAINING FACILITY	1,837	1,837
OFFICER TRAINING SCHOOL DINING FACILITY	4,796	4,796
OFFICER TRAINING SCHOOL STUDENT DORMITORIES	12,765	12,765
ARMY NATIONAL GUARD		
MONTGOMERY		
US PROPERTY AND FISCAL OFFICE	---	6,000
AIR FORCE RESERVE		
MAXWELL AFB		
CONSOLIDATED AIRCRAFT MAINTENANCE FACILITY	5,200	5,200
TOTAL, ALABAMA	41,748	63,598
ALASKA		
ARMY		
FORT WAINWRIGHT		
CENTRALIZED VEHICLE WASH FACILITY	---	3,100
WHOLE BARRACKS RENEWAL (PHASE I)	---	16,000
AIR FORCE		
EIELSON AFB		
CONSOLIDATED MUNITIONS FACILITY	4,352	4,352
DEFENSE-WIDE		
ELMENDORF AFB		
REPLACE HYDRANT FUEL SYSTEM (PHASE I)	19,500	19,500
AIR NATIONAL GUARD		
KULIS ANGB (ANCHORAGE)		
VEHICLE MAINTENANCE/FIRE STATION COMPLEX	---	10,400
TOTAL, ALASKA	23,852	53,352
ARIZONA		
NAVY		
FLAGSTAFF NAVAL OBSERVATORY		
OPTIC INTERFEROMETER SUPPORT FACILITY	990	990
YUMA MARINE CORPS AIR STATION		
BACHELOR ENLISTED QUARTERS	11,010	11,010
AIR FORCE		
LUKE AFB		
CONTROL TOWER	---	3,400
ARMY NATIONAL GUARD		
PAPAGO MILITARY RESERVATION (PHOENIX)		
COMBINED SUPPORT MAINTENANCE SHOP	10,640	10,640
AIR NATIONAL GUARD		
TUSCON INTERNATIONAL AIRPORT AGS		
COMPOSITE SUPPORT COMPLEX	---	7,500
TOTAL, ARIZONA	22,640	33,540
ARKANSAS		
ARMY		
PINE BLUFF ARSENAL		
AMMUNITION DEMILITARIZATION FACILITY (PHASE III)	16,500	---
AIR FORCE		
LITTLE ROCK AFB		
UPGRADE SEWAGE TREATMENT PLANT	---	1,500
DEFENSE-WIDE		
PINE BLUFF ARSENAL		
AMMUNITION DEMILITARIZATION FACILITY (PHASE III)	---	16,500
ARMY NATIONAL GUARD		
BENTON		
READINESS CENTER	---	1,988
TOTAL, ARKANSAS	16,500	19,988

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
CALIFORNIA		
ARMY		
FORT IRWIN		
CHILD DEVELOPMENT CENTER	---	5,100
EDUCATION CENTER	---	2,700
HELIPORT (PHASE III)	7,000	7,000
NAVY		
CAMP PENDLETON MARINE CORPS BASE		
BACHELOR ENLISTED QUARTERS	12,400	12,400
BACHELOR ENLISTED QUARTERS	15,840	15,840
FITNESS CENTER	---	5,010
HELICOPTER OUTLYING LANDING FIELD	---	7,180
CHINA LAKE NAVAL AIR WARFARE CENTER WEAPONS DIVISION		
MISSILE MAGAZINES	3,240	3,240
SURVIVABILITY LIVE FIRE COMPLEX	---	6,900
LEMOORE NAVAL AIR STATION		
AIRFRAMES FACILITY MODIFICATIONS	1,510	1,510
HANGAR RENOVATIONS	5,430	5,430
TRAINING FACILITY ADDITION	4,270	4,270
WEAPONS ASSEMBLY FACILITY IMPROVEMENTS	9,430	9,430
MIRAMAR MARINE CORPS AIR STATION		
BACHELOR ENLISTED QUARTERS	29,570	29,570
NAVAL FACILITY SAN CLEMENTE ISLAND		
BACHELOR ENLISTED QUARTERS	8,350	8,350
SAN DIEGO NAVAL SUBMARINE BASE		
SUBMARINE SUPPORT FACILITY	11,400	11,400
AIR FORCE		
EDWARDS AFB		
RENOVATE AIRCRAFT MAINTENANCE FACILITY	10,361	10,361
TRAVIS AFB		
CONTROL TOWER	---	4,250
VANDENBERG AFB		
ADD/ALTER MISSILE MAINTENANCE FACILITY	9,500	9,500
SPACE INITITAL QUALIFICATION TRAINING ACADEMIC FAC	9,209	9,209
DEFENSE-WIDE		
BEALE AFB		
ADD/ALTER PHYSIOLOGICAL SUPPORT FACILITY	3,500	3,500
CAMP PENDLETON MARINE CORPS BASE		
MEDICAL/DENTAL CLINIC REPLACEMENT (MARGARITA)	3,100	3,100
MEDICAL/DENTAL CLINIC REPLACEMENT (SAN MATEO)	3,200	3,200
EDWARDS AFB		
ADD/ALTER AEROSPACE MEDICAL CLINIC	6,000	6,000
NAVAL AMPHIBIOUS BASE, CORONADO		
SOF AMPHIBIOUS OPERATIONS FACILITY	3,600	3,600
SAN DIEGO NAVAL HOSPITAL		
WATER STORAGE TANK	1,350	1,350
TRAVIS AFB		
PATIENT MOVEMENT ITEMS/OPERATIONS AND DIST CENTER	1,700	1,700
TOTAL, CALIFORNIA	159,960	191,100
COLORADO		
ARMY		
FORT CARSON		
RAILYARD EXPANSION (PHASE II)	---	23,000
AIR FORCE		
FALCON AFB		
OPERATIONAL SUPPORT FACILITY	9,601	9,601
US AIR FORCE ACADEMY (COLORADO SPRINGS)		
ADD/ALTER PREP SCHOOL BUILDINGS	4,413	4,413
ARMY RESERVE		
FORT CARSON		
ADD/ALTER ORGANIZATIONAL MAINTENANCE SHOP/ EQUIPMENT CONCENTRATION SITE	1,101	1,101
TOTAL, COLORADO	15,115	38,115
CONNECTICUT		
NAVY		
NSB NEW LONDON		
WATERFRONT IMPROVEMENTS	---	11,330
ARMY RESERVE		
WEST HARTFORD		
LAND ACQUISITION	1,491	1,491
TOTAL, CONNECTICUT	1,491	12,821

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
DELAWARE		
ARMY NATIONAL GUARD		
DAGSBORO		
READINESS CENTER	---	3,609
DISTRICT OF COLUMBIA		
NAVY		
COMMANDANT, NAVAL DISTRICT (WASHINGTON, DC)		
FITNESS CENTER	790	790
AIR FORCE		
BOLLING AFB		
HONOR GUARD TECHNICAL SCHOOL	2,948	2,948
TOTAL, DISTRICT OF COLUMBIA	3,738	3,738
FLORIDA		
ARMY		
MIAMI		
SOUTHCOM HEADQUARTERS AND LAND ACQUISITION	26,700	---
NAVY		
JACKSONVILLE NAVAL AIR STATION		
ADD/ALTER BUILDING #118	---	1,500
KEY WEST NAVAL AIR STATION		
CHILD DEVELOPMENT CENTER	3,730	3,730
MAYPORT NAVAL STATION		
AFLOAT TRAINING GROUP FACILITY	---	3,163
WHARF ELECTRICAL IMPROVEMENTS	---	3,000
WHITING FIELD NAVAL AIR STATION		
AIRFIELD ALTERATIONS	---	1,400
AIR FORCE		
EGLIN AFB		
DORMITORY	7,866	7,866
SANTA ROSA ISLAND TEST SITES	12,571	12,571
EGLIN AFB AUXILIARY FIELD 9 (HURLBURT FIELD)		
CONTROL TOWER	2,014	2,014
FIRE TRAINING FACILITY	1,823	1,823
MACDILL AFB		
DINING FACILITY	---	4,800
FIRE TRAINING FACILITY	2,494	2,494
KC-135 SIMULATOR FACILITY	2,514	2,514
TYNDALL AFB		
CONTROL TOWER	---	3,600
DEFENSE-WIDE		
DEF FUEL SUPPORT POINT JACKSONVILLE-MAYPORT ANNEX		
REPLACE FUEL TANKS	11,020	11,020
DEFENSE FUEL SUPPORT POINT JACKSONVILLE		
REPLACE FUEL TANKS	11,000	11,000
EGLIN AFB		
CENTRAL ENERGY PLANT (EGLIN HOSPITAL)	9,200	9,200
EGLIN AFB AUXILIARY FIELD 9 (HURLBURT FIELD)		
CLEAR WATER AIRCRAFT RINSE	2,400	2,400
EGLIN AFB AUXILIARY FIELD 3 (DUKE FIELD)		
ASSAULT STRIP RUNWAY	---	5,100
GENERAL PURPOSE AIRCRAFT MAINTENANCE SHOP	2,210	2,210
MACDILL AFB		
RENOVATE COMMAND AND CONTROL FACILITY	8,400	8,400
PENSACOLA NAVAL AIR STATION		
ADD/ALTER HOSPITAL/LIFE SAFETY UPGRADES	25,400	25,400
AIR FORCE RESERVE		
HOMESTEAD ARB		
DORMITORY RENOVATION	---	4,600
TOTAL, FLORIDA	129,342	129,805
GEORGIA		
ARMY		
FORT BENNING		
WHOLE BARRACKS COMPLEX RENEWAL	28,600	28,600
NAVY		
ALBANY MARINE CORPS LOGISTICS BASE		
CHILD DEVELOPMENT CENTER	---	2,800
KINGS BAY NAVAL SUBMARINE BASE		
MAGNETIC SILENCING FACILITY MODIFICATIONS	---	2,550

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
AIR FORCE		
ROBINS AFB		
DEPOT PLANT SERVICES FACILITY	11,894	11,894
DEFENSE-WIDE		
MOODY AFB		
ALTER CENTRAL MEDICAL FACILITY/ADD DENTAL CLINIC	11,000	11,000
FORT STEWART		
MEDICAL/DENTAL CLINIC REPLACEMENT	10,400	10,400
AIR NATIONAL GUARD		
ROBINS AFB		
B1 WEAPONS RELEASE SYSTEMS/LOAD CREW TRAINING FAC.	3,250	3,250
NAVY RESERVE		
ATLANTA NAVAL AIR STATION		
HANGAR ADDITION	---	4,100
TOTAL, GEORGIA	65,144	74,594
HAWAII		
ARMY		
SCHOFIELD BARRACKS		
LAND ACQUISITION, KAHUKU TRAINING AREA	---	23,500
WHOLE BARRACKS COMPLEX RENEWAL	47,500	47,500
NAVY		
KANEOHE BAY MARINE CORPS AIR STATION		
BACHELOR ENLISTED QUARTERS	27,410	27,410
BACHELOR ENLISTED QUARTERS (PHASE I)	---	15,000
PEARL HARBOR NAVAL SUBMARINE BASE		
BACHELOR ENLISTED QUARTERS MODERNIZATION	8,060	8,060
PEARL HARBOR FLEET AND INDUSTRIAL SUPPLY CENTER		
CENTRAL RECEIVING FACILITY	9,730	9,730
PEARL HARBOR NAVAL STATION		
ELECTRICAL DISTRIBUTION SYSTEM UPGRADES	18,180	18,180
PEARL HARBOR NAVAL SHIPYARD		
ENGINEERING MANAGEMENT BUILDING	11,400	11,400
PEARL HARBOR NAVY PUBLIC WORKS CENTER		
SEWER OUTFALL EXTENSION	22,877	22,877
STEAM CONDENSATE RETURN SYSTEM	6,090	6,090
WAHIAWA NAVAL COMPUTER AND TELECOM AREA MASTER STATION (EASTERN PACIFIC)		
FIRE STATION	1,970	1,970
AIR FORCE		
HICKAM AFB		
REPAIR AIRFIELD PAVEMENT	5,890	5,890
AIR NATIONAL GUARD		
HICKAM AFB		
REPLACE BASE CIVIL ENG. MAINTENANCE FACILITY	---	5,100
TOTAL, HAWAII	159,107	202,707
IDAHO		
AIR FORCE		
MOUNTAIN HOME AFB		
B1-B CONVENTIONAL MUNITIONS SHOP	---	4,100
B1-B MUNITIONS STORAGE IGLOOS	---	1,500
DORMITORY	8,897	8,897
LAND ACQUISITION	1,000	1,000
RANGE IMPROVEMENTS	2,400	2,400
ARMY NATIONAL GUARD		
GOWEN FIELD (BOISE)		
ADD/ALTER READINESS CENTER	4,224	4,224
TOTAL, IDAHO	16,521	22,121
ILLINOIS		
ARMY		
ROCK ISLAND ARSENAL		
ELECTRICAL DISTRIBUTION SYSTEM	5,300	5,300
NAVY		
GREAT LAKES NAVAL TRAINING CENTER		
APPLIED INSTRUCTION BUILDING MODIFICATIONS	5,750	5,750
GAS TURBINE TRAINING FACILITY	7,410	7,410
SMALL ARMS RANGE	---	6,790

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
DEFENSE-WIDE		
GREAT LAKES NAVAL STATION		
HOSPITALMAN SCHOOL ADDITION	7,100	7,100
TOTAL, ILLINOIS	25,560	32,350
INDIANA		
ARMY		
CRANE ARMY AMMUNITION ACTIVITY		
AMMUNITION CONTAINERIZATION COMPLEX (PHASE II)	7,100	7,100
NEWPORT ARMY AMMUNITION PLANT		
AMMUNITION DEMILITARIZATION FACILITY (PHASE I)	27,500	---
AMMUNITION DEMILITARIZATION SUPPORT	2,000	---
NAVY		
CRANE NAVAL SURFACE WARFARE CENTER		
AIRBORNE ELECTRONIC WARFARE CENTER	---	11,110
DEFENSE-WIDE		
NEWPORT ARMY AMMUNITION PLANT		
AMMUNITION DEMILITARIZATION FACILITY (PHASE I)	---	27,500
AMMUNITION DEMILITARIZATION SUPPORT	---	2,000
AIR NATIONAL GUARD		
HULMAN REGIONAL AIRPORT (TERRE HAUTE)		
FUEL CELL CORROSION CONTROL AND FIRE STATION	---	6,000
TOTAL, INDIANA	36,600	53,710
IOWA		
ARMY NATIONAL GUARD		
CAMP DODGE		
FUEL DISPENSING FACILITY	737	737
AIR NATIONAL GUARD		
DES MOINES		
REPLACE SECURITY POLICE OPERATION FACILITY	---	4,000
SIOUX GATEWAY AIRPORT (SIOUX CITY)		
ADD/ALTER AIRCRAFT CORROSION CONTROL FACILITY	---	6,500
TOTAL, IOWA	737	11,237
KANSAS		
ARMY		
FORT LEAVENWORTH		
US DISCIPLINARY BARRACKS (PHASE II)	29,000	29,000
FORT RILEY		
WHOLE BARRACKS COMPLEX RENEWAL	---	16,500
AIR FORCE		
MCCONNELL AFB		
WATER STORAGE AND PUMPING FACILITY	---	4,450
AIR NATIONAL GUARD		
FORBES FIELD AGS (PAULINE)		
KC-135 MAINTENANCE HANGAR UPGRADE	---	9,800
MCCONNELL AFB		
ADD/ALTER AVIONICS SHOP	---	5,900
TOTAL, KANSAS	29,000	65,650
KENTUCKY		
ARMY		
BLUEGRASS ARMY DEPOT (RICHMOND)		
AMMUNITION CONTAINERIZATION COMPLEX	5,300	5,300
FORT CAMPBELL		
WHOLE BARRACKS COMPLEX RENEWAL	41,000	41,000
WHOLE BARRACKS COMPLEX RENEWAL (PHASE II)	---	7,000
FORT KNOX		
MULTI-PURPOSE DIGITAL TRAINING RANGE (PHASE I)	---	7,000
DEFENSE-WIDE		
FORT CAMPBELL		
AIRCRAFT MAINTENANCE HANGAR	15,000	15,000
ARMY NATIONAL GUARD		
WESTERN KENTUCKY TRAINING SITE (GREENVILLE)		
TRAINING COMPLEX (PHASES IV AND V)	5,435	5,435
AIR NATIONAL GUARD		
STANDIFORD FIELD, LOUISVILLE		
REPLACE COMPOSITE AERIAL PORT/AIRLIFT CONTROL ELEMENT FACILITY	---	4,100
TOTAL, KENTUCKY	66,735	84,835

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
LOUISIANA		
ARMY		
FORT POLK		
CONSOLIDATED RAIL COMPLEX	---	8,300
AIR FORCE		
BARKSDALE AFB		
PHYSICAL FITNESS CENTER	---	9,300
DEFENSE-WIDE		
BARKSDALE AFB		
ADD/ALTER MEDICAL CLINICS	3,450	3,450
NAVY RESERVE		
NEW ORLEANS NAVAL AIR STATION		
BACHELOR ENLISTED QUARTERS	---	9,520
ENGINE TEST CELL MODIFICATIONS	2,200	2,200
NEW ORLEANS NAVAL SUPPORT ACTIVITY		
GALLEY ADDITION	---	1,730
AIR FORCE RESERVE		
NEW ORLEANS NAVAL AIR STATION		
RENOVATE MAINTENANCE HANGAR #4	---	5,200
TOTAL, LOUISIANA	5,650	39,700
MARYLAND		
ARMY		
ABERDEEN PROVING GROUND		
AMMUNITION DEMILITARIZATION FACILITY (PHASE I)	26,500	---
AMMUNITION DEMILITARIZATION SUPPORT	1,850	---
FORT DETRICK		
PHYSICAL FITNESS TRAINING CENTER	3,550	3,550
FORT MEADE		
EMERGENCY SERVICES CENTER	---	5,300
NAVY		
INDIAN HEAD NAVAL SURFACE WARFARE CENTER DIVISION		
ANNEALING OVEN FACILITY	6,680	6,680
CONTINUOUS PROCESSING SCALE-UP FACILITY	---	6,590
U.S. NAVAL ACADEMY		
DEMOLISH NAVAL RADIO TRANSMITTER FACILITY TOWERS	---	4,300
AIR FORCE		
ANDREWS AFB		
CHILD DEVELOPMENT CENTER	4,448	4,448
DEFENSE-WIDE		
ABERDEEN PROVING GROUND		
AMMUNITION DEMILITARIZATION FACILITY (PHASE I)	---	26,500
AMMUNITION DEMILITARIZATION SUPPORT	---	1,850
FORT MEADE		
PERIMETER FENCE (WEST)	668	668
TOTAL, MARYLAND	43,696	59,886
MASSACHUSETTS		
AIR FORCE		
HANSCOM AFB		
RENOVATE ACQUISITION MANAGEMENT FACILITY	---	10,000
ARMY NATIONAL GUARD		
BARNES ANGB (WESTFIELD)		
ARMY AVIATION SUPPORT FACILITY	---	9,274
ARMY RESERVE		
FORT DEVENS		
RESERVE REGIONAL SUPPORT COMMAND HEADQUARTERS FAC.	3,335	3,335
NAVY RESERVE		
FORT DEVENS		
RESERVE CENTER RENOVATIONS	840	840
TOTAL, MASSACHUSETTS	4,175	23,449
MICHIGAN		
AIR NATIONAL GUARD		
ALPENA COUNTY REGIONAL AIRPORT (ALPENA)		
FIRE STATION	---	5,100
SANITARY SEWER SYSTEM	3,900	3,900
SELFRIDGE ANGB (MT CLEMENS)		
REPLACE CONTROL TOWER/RADAR APPROACH CONTROL CTR.	5,200	5,200
INFRASTRUCTURE UPGRADE	---	9,800

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
ARMY RESERVE		
WALKER		
US ARMY RESERVE CENTER/ORGANIZATIONAL MAINT SHOP..	9,439	9,439
TOTAL, MICHIGAN.....	18,539	33,439
MINNESOTA		
ARMY NATIONAL GUARD		
CAMP RIPLEY		
MULTI-PURPOSE MACHINE GUN/SNIPER RANGE.....	1,023	1,023
NAVY RESERVE		
NAVAL RESERVE READINESS COMMAND (MINNEAPOLIS)		
ADMINISTRATIVE HEADQUARTERS BUILDING.....	3,630	3,630
AIR FORCE RESERVE		
MINNEAPOLIS-ST PAUL INTERNATIONAL AIRPORT		
CONSOLIDATED LODGING FACILITY (PHASE I).....	---	3,236
TOTAL, MINNESOTA.....	4,653	7,889
MISSISSIPPI		
NAVY		
GULFPORT NAVAL CONSTRUCTION BATTALION CENTER		
BACHELOR ENLISTED QUARTERS REPLACEMENT.....	10,670	10,670
MERIDIAN NAVAL AIR STATION		
AIR OPERATIONS FACILITY.....	---	3,280
AIR FORCE		
COLUMBUS AFB		
BACHELOR OFFICERS QUARTERS.....	---	5,700
KEESLER AFB		
STUDENT DORMITORIES (2).....	29,770	29,770
TRAINING SUPPORT FACILITY.....	5,756	5,756
DEFENSE-WIDE		
CAMP SHELBY		
REPLACE BULK FUEL FACILITY.....	5,300	5,300
KEESLER AFB		
BIOENVIRONMENTAL ENGINEERING FACILITY.....	700	700
STENNIS SPACE CENTER		
SOF OPERATIONS SUPPORT FACILITY.....	---	5,500
ARMY NATIONAL GUARD		
BROOKHAVEN		
REGIONAL TRAINING CENTER/OMS.....	---	5,247
TOTAL, MISSISSIPPI.....	52,196	71,923
MISSOURI		
ARMY		
FORT LEONARD WOOD		
ENGINEER QUALIFICATION RANGE.....	5,200	5,200
RECEPTION BARRACKS.....	---	23,000
AIR NATIONAL GUARD		
ROSECRANS MEMORIAL AIRPORT (ELWOOD)		
UPGRADE AIRCRAFT PARKING APRON (PHASE I).....	---	9,600
TOTAL, MISSOURI.....	5,200	37,800
MONTANA		
AIR FORCE		
MALMSTROM AFB		
REPLACE DORMITORY.....	---	7,900
ARMY NATIONAL GUARD		
HELENA		
RESERVE CENTER.....	---	21,690
TOTAL, MONTANA.....	---	29,590
NEBRASKA		
AIR NATIONAL GUARD		
LINCOLN MUNICIPAL AIRPORT		
JOINT MEDICAL TRAINING FACILITY.....	---	3,350
NEVADA		
AIR FORCE		
INDIAN SPRINGS AUXILIARY AIR FIELD		
UNMANNED AERIAL VEHICLE LOGISTICS AND TRAINING FAC	3,965	3,965

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
UNMANNED AERIAL VEHICLE SQUADRON OPERATIONS/ AIRCRAFT MAINTENANCE UNIT	7,059	7,059
UNMANNED AERIAL VEHICLE COMMUNICATION MAINTENANCE FACILITY/INFRASTRUCTURE/UTILITIES	3,989	3,989
NELLIS AFB		
DORMITORY	6,378	6,378
ARMY NATIONAL GUARD		
CARSON CITY		
READINESS CENTER	---	5,860
TOTAL, NEVADA	21,391	27,251
NEW JERSEY		
ARMY		
FORT MONMOUTH		
SOFTWARE ENGINEERING CENTER ADDITION	---	7,600
PICATINNY ARSENAL		
PRECISION MUNITIONS FACILITY	---	8,400
AIR FORCE		
MCGUIRE AFB		
DINING FACILITY	6,044	6,044
ARMY RESERVE		
FORT DIX		
AMMUNITION SUPPLY POINT	---	8,731
TOTAL, NEW JERSEY	6,044	30,775
NEW MEXICO		
AIR FORCE		
HOLLOMAN AFB		
PHYSICAL FITNESS CENTER	---	11,100
KIRTLAND AFB		
NUCLEAR WEAPONS INTEGRATION FACILITY	---	6,800
FIRE TRAINING FACILITY	1,774	1,774
DEFENSE-WIDE		
HOLLOMAN AFB		
WAR READINESS MATERIAL WAREHOUSE	1,300	1,300
ARMY NATIONAL GUARD		
TAOS		
READINESS CENTER	---	3,300
TOTAL, NEW MEXICO	3,074	24,274
NEW YORK		
ARMY		
FORT DRUM		
AERIAL GUNNERY RANGE (PHASE II)	---	9,000
INDOOR FIRING RANGE	---	4,650
U S MILITARY ACADEMY (WEST POINT)		
CADET PHYSICAL DEVELOPMENT CENTER (PHASE I)	12,000	12,000
DEFENSE-WIDE		
U S MILITARY ACADEMY (WEST POINT)		
ELEMENTARY SCHOOL ADDITION/RENOVATION	2,840	2,840
AIR NATIONAL GUARD		
HANCOCK FIELD (SYRACUSE)		
UPGRADE PARKING APRON AND TAXIWAYS	---	9,500
ARMY RESERVE		
FORT WADSWORTH		
ADD/ALTER US ARMY RESERVE CENTER (PHASE I)	6,424	6,424
AIR FORCE RESERVE		
NIAGARA FALLS ARS		
CONSOLIDATED MAINTENANCE FACILITY	---	3,900
TOTAL, NEW YORK	21,264	48,314
NORTH CAROLINA		
ARMY		
FORT BRAGG		
BARRACKS UPGRADE	---	10,600
DEPLOYMENT STAGING COMPLEX	30,000	30,000
FORCE PROTECTION FACILITIES	---	8,300
WHOLE BARRACKS COMPLEX RENEWAL	47,000	47,000
NAVY		
CAMP LEJEUNE MARINE CORPS BASE		
FIRE STATION	1,830	1,830

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
INFRASTRUCTURE PHYSICAL SECURITY	12,770	12,770
CHERRY POINT MARINE CORPS AIR STATION		
AIRCRAFT FIRE AND RESCUE STATION ADDITION	1,620	1,620
CHILD DEVELOPMENT CENTER	4,420	4,420
AIR FORCE		
SEYMOUR JOHNSON AFB		
EDUCATION CENTER AND LIBRARY	---	6,100
DEFENSE-WIDE		
FORT BRAGG		
WAR READINESS MATERIAL WAREHOUSE	6,500	6,500
CAMP LEJEUNE MARINE CORPS BASE		
BREWSTER MIDDLE SCHOOL	16,900	16,900
POPE AFB		
HYDRANT FUEL SYSTEM	4,100	4,100
TOTAL, NORTH CAROLINA	125,140	150,140
NORTH DAKOTA		
AIR FORCE		
GRAND FORKS AFB		
ADD TO PHYSICAL FITNESS CENTER	---	8,800
FIRE TRAINING FACILITY	2,686	2,686
MINOT AFB		
TAXIWAY REPAIR	---	8,500
DEFENSE-WIDE		
GRAND FORKS AFB		
ADD/ALTER MEDICAL/DENTAL CLINIC	5,600	5,600
ARMY NATIONAL GUARD		
BISMARCK		
ARMY AVIATION SUPPORT FAC/READINESS CTR EXPANSION	6,240	6,240
AIR NATIONAL GUARD		
HECTOR FIELD (FARGO)		
ADD/ALTER BASE SUPPLY COMPLEX	---	3,650
REGIONAL FIRE TRAINING FACILITY	800	800
TOTAL, NORTH DAKOTA	15,326	36,276
OHIO		
AIR FORCE		
WRIGHT-PATTERSON AFB		
ACQUISITION MANAGEMENT COMPLEX (PHASE IV-A)	22,000	22,000
AIR NATIONAL GUARD		
SPRINGFIELD-BECKLEY MUNICIPAL AIRPORT		
BASE CIVIL ENGINEER/SECURITY FORCES COMPLEX	---	5,000
ARMY RESERVE		
GAHANNA		
US ARMY RESERVE CENTER PURCHASE	3,115	3,115
AIR FORCE RESERVE		
WRIGHT-PATTERSON AFB		
ALTER C-141C FLIGHT SIMULATION TRAINING FACILITY	---	1,600
TOTAL, OHIO	25,115	31,715
OKLAHOMA		
ARMY		
MCALESTER ARMY AMMUNITION PLANT		
AMMUNITION CONTAINERIZATION COMPLEX	10,800	10,800
FORT SILL		
TACTICAL EQUIPMENT SHOP (PHASE I)	13,800	13,800
WHOLE BARRACKS COMPLEX RENEWAL	20,500	20,500
AIR FORCE		
ALTUS AFB		
RAMP AND AIRFIELD LIGHTING	---	5,300
CONTROL TOWER	---	4,000
TINKER AFB		
COMBAT COMMUNICATIONS SQUADRON OPERATIONS FACILITY	5,085	5,085
SQUADRON OPERATION AND MOBILITY CENTER	---	10,800
DORMITORY	9,100	9,100
VANCE AFB		
ADD/ALTER PHYSICAL FITNESS CENTER	---	4,400
FIRE TRAINING FACILITY	1,823	1,823
DEFENSE-WIDE		
FORT SILL		
REPLACE FUEL STORAGE FACILITY	3,500	3,500

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
ARMY NATIONAL GUARD		
LEXINGTON		
ARMY AVIATION SUPPORT FACILITY EXPANSION	7,382	7,382
TOTAL, OKLAHOMA	71,990	96,490
OREGON		
ARMY		
UMATILLA ARMY DEPOT		
AMMUNITION DEMILITARIZATION FACILITY (PHASE IV)	50,950	---
DEFENSE-WIDE		
UMATILLA ARMY DEPOT		
AMMUNITION DEMILITARIZATION FACILITY (PHASE IV)	---	50,950
PENNSYLVANIA		
NAVY		
PHILADELPHIA NAVAL SURFACE WARFARE CENTER SHIP SYSTEMS ENGINEERING STATION		
INTEGRATED SHIP CONTROL AND DIAGNOSTIC FACILITY	---	2,410
NAVICP MECHANICSBURG		
CHILD DEVELOPMENT CENTER	---	1,600
NAVICP PHILADELPHIA		
CHILD DEVELOPMENT CENTER	---	1,550
DEFENSE-WIDE		
CARLISLE BARRACKS		
HEALTH CLINIC ADDITION	4,678	4,678
ARMY NATIONAL GUARD		
LATROBE		
READINESS CENTER	---	2,479
ARMY RESERVE		
OAKDALE		
99TH REGIONAL SUPPORT COMMAND (PHASE II)	---	19,512
TOTAL, PENNSYLVANIA	4,678	32,229
RHODE ISLAND		
NAVY		
NEWPORT NAVAL EDUCATION AND TRAINING CENTER		
BOILER PLANT MODIFICATIONS	5,630	5,630
NEWPORT NAVAL UNDERWATER SYSTEMS CENTER		
UNDERSEA WARFARE FACILITY	9,140	9,140
TOTAL, RHODE ISLAND	14,770	14,770
SOUTH CAROLINA		
NAVY		
BEAUFORT MARINE CORPS AIR STATION		
MISSILE MAGAZINES	1,770	1,770
CHARLESTON NAVAL WEAPONS STATION		
ORDNANCE RAILROAD REALIGNMENT	9,737	9,737
PARRIS ISLAND MARINE CORPS RECRUIT DEPOT		
FEMALE RECRUIT BARRACKS	---	8,030
WEAPONS BATTALLION MESSHALL	7,960	7,960
AIR FORCE		
CHARLESTON AFB		
C-17 LIFE SUPPORT FACILITY	4,701	4,701
C-17 SQUADRON OPERATIONS/AIRCRAFT MAINT UNIT	7,639	7,639
C-17 SQUADRON OPERATIONS/AIRCRAFT MAINT UNIT	6,769	6,769
DINING FACILITY	5,221	5,221
AIR NATIONAL GUARD		
MCENTIRE AIR NATIONAL GUARD STATION (EASTOVER)		
ADD/ALTER AIRCRAFT MAINTENANCE COMPLEX	---	9,000
ARMY NATIONAL GUARD		
SPARTANBURG		
READINESS CENTER	---	5,260
TOTAL, SOUTH CAROLINA	43,797	66,087
SOUTH DAKOTA		
AIR FORCE		
ELLSWORTH AFB		
ADD/ALTER SQUADRON OPERATIONS FACILITY	---	6,500

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
AIR NATIONAL GUARD		
JOE FOSS FIELD (SIOUX FALLS)		
VEHICLE MAINTENANCE AND AIRCRAFT SUPPORT EQUIPMENT COMPLEX	---	5,200
TOTAL, SOUTH DAKOTA	---	11,700
TENNESSEE		
AIR FORCE		
ARNOLD AFB		
TEST FACILITIES COOLING TOWER	---	11,600
AIR NATIONAL GUARD		
MCGHEE-TYSON AIR NATIONAL GUARD BASE (KNOXVILLE)		
RELOCATE AIRCRAFT PARKING APRON (PHASE I)	---	10,000
TOTAL, TENNESSEE	---	21,600
TEXAS		
ARMY		
FORT BLISS		
TACTICAL VEHICLE OVERPASS	---	4,100
FORT HOOD		
RAILHEAD FACILITY (PHASE I)	17,500	17,500
FORT SAM HOUSTON		
WHOLE BARRACKS COMPLEX RENEWAL	21,800	21,800
DINING FACILITY	---	5,500
NAVY		
INGLESIDE NAVAL STATION		
BACHELOR ENLISTED QUARTERS (PHASE IV)	---	12,200
AIR FORCE		
DYESS AFB		
B-1B MUNITIONS MAINTENANCE FACILITY	---	3,350
B-1B SUPPORT EQUIPMENT SHOP ADDITION	---	1,400
LACKLAND AFB		
DORMITORY	6,800	6,800
OPERATIONS FACILITY	8,130	8,130
LAUGHLIN AFB		
CONSOLIDATED BASE OPERATIONS FACILITY	---	3,815
CONTROL TOWER	---	3,500
RANDOLPH AFB		
BASE OPERATIONS FACILITY	3,166	3,166
GOODFELLOW AFB		
STUDENT DORMITORY	---	7,300
DEFENSE-WIDE		
FORT HOOD		
BLOOD DONOR CENTER	3,100	3,100
PRIMARY CARE CLINIC	11,000	11,000
NAVY RESERVE		
GALVESTON		
MARINE RESERVE TRAINING CENTER	4,090	4,090
TOTAL, TEXAS	75,586	116,751
UTAH		
ARMY		
TOOELE ARMY DEPOT		
AMMUNITION CONTAINERIZATION COMPLEX	3,900	3,900
AIR FORCE		
HILL AFB		
WAR READINESS ASSET WAREHOUSE	---	2,600
ARMY RESERVE		
SALT LAKE CITY		
US ARMY RESERVE CENTER/ORGANIZATIONAL MAINTENANCE SHOP/DIRECT SUPPORT - GENERAL SUPPORT/EQUIPMENT CONCENTRATION SITE	13,200	---
US ARMY RESERVE CENTER/ORGANIZATIONAL MAINTENANCE SHOP (PHASE II)	---	5,076
AIR FORCE RESERVE		
HILL AFB		
MUNITIONS HANDLING AND STORAGE FACILITY	---	1,900
TOTAL, UTAH	17,100	13,476

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
VERMONT		
AIR NATIONAL GUARD		
BURLINGTON INTERNATIONAL AIRPORT		
BASE SUPPLY COMPLEX	---	5,500
VIRGINIA		
ARMY		
CHARLOTTESVILLE		
NATIONAL GROUND INTELLIGENCE CENTER FACILITY	46,200	46,200
FORT EUSTIS		
PHYSICAL FITNESS CENTER	---	4,650
WHOLE BARRACKS COMPLEX RENEWAL	36,531	36,531
FORT MYER		
BARRACKS RENOVATION	---	6,200
NAVY		
DAHLGREN NAVAL SURFACE WARFARE CENTER		
WARFARE DEFENSES TECHNICAL FACILITY	---	10,550
WEAPONS SYSTEM DEVELOPMENT LABORATORY ADDITION	5,130	5,130
DAM NECK TACTICAL TRAINING GROUP (ATLANTIC)		
TRAINING BUILDING ADDITION	2,430	2,430
NORFOLK FLEET INDUSTRIAL SUPPLY CENTER		
FIRE STATION	1,770	1,770
NORFOLK FLEET TRAINING CENTER		
ENGINEERING TRAINING FAC ADDITION AND RENOVATION	5,700	5,700
NORFOLK NAVAL STATION		
BERTHING PIER (PHASE I)	32,030	32,030
NORFOLK NAVAL SHIPYARD (PORTSMOUTH)		
DREDGING	6,180	6,180
OCEANA NAVAL AIR STATION		
FITNESS CENTER	---	6,400
DEFENSE-WIDE		
CHEATHAM ANNEX		
FLEET HOSPITAL SUPPORT OFFICE - OPERATIONAL WAREHOUSE	9,400	9,400
FLEET HOSPITAL SUPPORT OFFICE - ADMINISTRATIVE OFFICE	1,900	1,900
DEFENSE SUPPLY CENTER (RICHMOND)		
CONVERT WAREHOUSE TO ADMINISTRATIVE SPACE	10,500	10,500
PORTSMOUTH NAVAL HOSPITAL		
HOSPITAL REPLACEMENT (PHASE X)	17,954	17,954
ARMY NATIONAL GUARD		
POWHATAN		
READINESS CENTER	2,435	2,435
ARMY RESERVE		
FORT BELVOIR		
US ARMY RESERVE CENTER/ORGANIZATIONAL MAINTENANCE SHOP/AREA MAINTENANCE SUPPORT ACTIVITY	10,314	10,314
FORT EUSTIS		
AVIATION SUPPORT FACILITY	11,618	11,618
NAVY RESERVE		
NORFOLK NAVAL AIR RESERVE CENTER		
HANGAR ALTERATIONS	1,660	1,660
TOTAL, VIRGINIA	201,752	229,552
WASHINGTON		
ARMY		
FORT LEWIS		
CENTRAL VEHICLE WASH FACILITY	4,650	4,650
CLOSE COMBAT TACTICAL TRAINER BUILDING	7,600	7,600
CONSOLIDATED FUEL FACILITY	3,950	3,950
TANK TRAIL EROSION MITIGATION (YAKIMA)	2,000	2,000
NAVY		
BREMERTON STRATEGIC WEAPONS FACILITY (PACIFIC)		
SECURITY FACILITY UPGRADES	2,750	2,750
PUGET SOUND NAVAL SHIPYARD (BREMERTON)		
COMMUNITY SUPPORT FACILITY	---	4,300
AIR FORCE		
FAIRCHILD AFB		
CONVERT NOSEDOCK TO WASHRACK FACILITY	---	3,700
KC-135 SQUADRON OPERATIONS/AIRCRAFT MAINT UNIT	7,620	7,620
SURVIVAL ACADEMIC TRAINING SUPPORT CENTER	---	3,900
MCCHORD AFB		
C-17 ADD/ALTER AIRCRAFT MAINTENANCE SHOP	2,321	2,321
C-17 ADD/ALTER SIMULATOR FACILITY	1,823	1,823

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
C-17 ADD/ALTER AEROSPACE GROUND EQUIPMENT MAINTENANCE FACILITY	2,110	2,110
C-17 ALTER COMPOSITE SHOP	1,630	1,630
C-17 ALTER MAINTENANCE HANGARS	6,427	6,427
C-17 FLIGHTLINE SUPPORT FACILITY	4,029	4,029
C-17 LIFE SUPPORT EQUIPMENT FACILITY	4,413	4,413
C-17 RAMP/HYDRANT FUELS SYSTEM	18,025	18,025
C-17 REPAIR BASE ROADS	2,224	2,224
C-17 SHORTFIELD ASSAULT STRIP	2,321	2,321
C-17 SQUADRON OPERATIONS/AIRCRAFT MAINTENANCE UNIT	6,524	6,524
DEFENSE-WIDE		
BANGOR NAVAL SUBMARINE BASE		
DISEASE VECTOR ECOLOGY AND CONTROL CENTER	5,700	5,700
BREMERTON NAVAL HOSPITAL		
ADD/ALTER HOSPITAL	28,000	28,000
MCCHORD AFB		
CLINIC/WAR READINESS MATERIAL WAREHSE REPLACEMENT	20,000	20,000
AIR FORCE RESERVE		
MCCHORD AFB		
CONSOLIDATED MEDICAL TRAINING FACILITY	---	3,400
ARMY RESERVE		
FORT LAWTON (SEATTLE)		
US ARMY RESERVE CENTER	---	10,713
TOTAL, WASHINGTON	134,117	160,130
WEST VIRGINIA		
ARMY NATIONAL GUARD		
CAMP DAWSON (KINGWOOD)		
READINESS CENTER	4,465	---
REGIONAL TRAINING INSTITUTE	---	13,595
WISCONSIN		
AIR NATIONAL GUARD		
VOLK FIELD (CAMP DOUGLAS)		
UPGRADE RUNWAY AND TAXIWAY	9,600	9,600
ARMY RESERVE		
FORT MCCOY		
CRASH RESCUE STATION	1,850	1,850
MACHINE GUN RANGE	2,032	2,032
TOTAL, WISCONSIN	13,482	13,482
WYOMING		
ARMY NATIONAL GUARD		
CAMP GUERNSEY		
COMBINED SUPPORT MAINTENANCE SHOP	---	13,891
CONUS CLASSIFIED		
ARMY		
CLASSIFIED LOCATIONS		
CLASSIFIED PROJECT	4,600	4,600
BELGIUM		
ARMY		
BELGIUM		
CHILD DEVELOPMENT CENTER	6,300	6,300
GERMANY		
ARMY		
CONN BARRACKS (SCHWEINFURT)		
WHOLE BARRACKS COMPLEX RENEWAL	18,000	18,000
KITZINGEN FAMILY HOUSING (WUERZBURG)		
CHILD DEVELOPMENT CENTER	4,250	4,250
AIR FORCE		
SPANGDAHLEM AB		
CONSOLIDATED AIR CONTROL SQUADRON OPERATIONS FAC	4,466	---
DORMITORY	9,501	9,501
TOTAL, GERMANY	36,217	31,751
GREECE		
NAVY		
SOUDA BAY CRETE NAVAL SUPPORT ACTIVITY		
BACHELOR ENLISTED QUARTERS	5,260	5,260

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
GUAM		
NAVY		
NAVAL ACTIVITIES (GUAM)		
SPECIAL WARFARE UNIT FACILITY	5,500	5,500
WATERFRONT CONSOLIDATION FACILITIES	4,810	4,810
DEFENSE-WIDE		
NAVAL ACTIVITIES (GUAM)		
ELEMENTARY SCHOOL ADDITION AND RENOVATION	8,600	8,600
HIGH SCHOOL ADDITION AND CONVERSION	4,500	4,500
TOTAL, GUAM	23,410	23,410
ITALY		
NAVY		
NAPLES NAVAL SUPPORT ACTIVITY		
PUBLIC WORKS FACILITY (CAPODICHINO)	18,270	18,270
DEFENSE-WIDE		
SIGONELLA NAVAL AIR STATION		
FLIGHT LINE DISPENSARY	5,300	5,300
TOTAL, ITALY	23,570	23,570
KOREA		
ARMY		
CAMP CASEY		
WHOLE BARRACKS COMPLEX RENEWAL	13,400	13,400
PHYSICAL FITNESS CENTER	---	8,000
CAMP CASTLE		
WHOLE BARRACKS COMPLEX RENEWAL	18,226	18,226
CAMP HUMPHREYS		
WHOLE BARRACKS COMPLEX RENEWAL	8,500	8,500
CAMP STANLEY		
WHOLE BARRACKS COMPLEX RENEWAL	5,800	5,800
AIR FORCE		
KUNSAN AB		
DORMITORY	5,958	5,958
OSAN AB		
DORMITORY	7,496	7,496
TOTAL, KOREA	59,380	67,380
KWAJALEIN		
ARMY		
KWAJALEIN ATOLL		
POWER PLANT (ROI NAMUR ISLAND) (PHASE I)	12,600	12,600
DEFENSE-WIDE		
MISSILE RANGE		
MULTI PURPOSE MISSILE TEST FACILITIES	4,600	---
TOTAL, KWAJALEIN	17,200	12,600
PORTUGAL		
DEFENSE-WIDE		
LAJES FIELD (AZORES)		
FUEL PUMPHOUSE AND TANKS	7,700	7,700
PUERTO RICO		
DEFENSE-WIDE		
FORT BUCHANAN		
ELEMENTARY SCHOOL	8,805	8,805
ROOSEVELT ROADS NAVAL STATION		
OPERATIONS FACILITY	9,600	9,600
TOTAL, PUERTO RICO	18,405	18,405
TURKEY		
AIR FORCE		
INCIRLIK AB		
CENTRAL SECURITY CONTROL FACILITY	2,949	2,949
UNITED KINGDOM		
NAVY		
ST MAWGAN JOINT MARITIME COMMUNICATION CENTER		
EDUATION CENTER ADDITION	2,010	2,010

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
AIR FORCE		
RAF LAKENHEATH		
DORMITORIES (2)	15,838	15,838
RAF MILDENHALL		
DORMITORY	10,926	10,926
KC-135 SQUADRON OPERATIONS/AIRCRAFT MAINT UNIT	14,034	14,034
DEFENSE-WIDE		
RAF LAKENHEATH		
HOSPITAL ANNEX REPLACEMENT	10,800	10,800
TOTAL, UNITED KINGDOM	53,608	53,608
NATO		
NATO SECURITY INVESTMENT PROGRAM	185,000	155,000
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-1,000
TOTAL, NATO	185,000	154,000
WORLDWIDE UNSPECIFIED		
ARMY		
UNSPECIFIED WORLDWIDE LOCATIONS		
HOST NATION SUPPORT	20,450	20,450
PLANNING AND DESIGN	41,819	43,819
UNSPECIFIED MINOR CONSTRUCTION	10,000	12,500
GENERAL REDUCTION	---	-6,000
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-2,000
NAVY		
UNSPECIFIED WORLDWIDE LOCATIONS		
PLANNING AND DESIGN	58,346	60,846
UNSPECIFIED MINOR CONSTRUCTION	8,900	9,900
GENERAL REDUCTION	---	-5,000
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-1,000
AIR FORCE		
UNSPECIFIED WORLDWIDE LOCATIONS		
UNSPECIFIED MINOR CONSTRUCTION	7,135	8,135
PLANNING AND DESIGN	35,592	38,092
GENERAL REDUCTION	---	-11,000
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-1,000
DEFENSE-WIDE		
UNSPECIFIED WORLDWIDE LOCATIONS		
ENERGY CONSERVATION INVESTMENT PROGRAM	46,950	46,950
CONTINGENCY CONSTRUCTION	9,390	4,890
GENERAL REDUCTION	---	-12,000
GENERAL REDUCTION - CHEMICAL DEMILITARIZATION	---	-50,500
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-1,300
PLANNING AND DESIGN		
SPECIAL OPERATIONS COMMAND	1,450	4,150
DEF THREAT REDUCTION/TREATY COMPLIANCE AGENCY	100	100
BALLISTIC MISSILE DEFENSE ORGANIZATION	12,561	10,000
DOD DEPENDENT SCHOOLS	---	1,000
DEFENSE LEVEL ACTIVITIES	2,200	2,200
DEFENSE MEDICAL SUPPORT ACTIVITY	8,555	8,555
SUBTOTAL, PLANNING AND DESIGN	24,866	26,005
UNSPECIFIED MINOR CONSTRUCTION		
SPECIAL OPERATIONS COMMAND	4,200	1,500
DEFENSE FINANCE AND ACCOUNTING SERVICE	1,500	1,500
DEF THREAT REDUCTION/TREATY COMPLIANCE AGENCY	900	900
JOINT CHIEFS OF STAFF	3,595	3,595
DOD DEPENDENT SCHOOLS	999	999
DEFENSE MEDICAL SUPPORT ACTIVITY	1,900	1,900
DEFENSE MANPOWER AND PERSONNEL CENTER	15,000	15,000
DEFENSE LEVEL ACTIVITIES	3,000	3,000
SUBTOTAL, UNSPECIFIED MINOR CONSTRUCTION	31,094	28,394
DEPARTMENT OF DEFENSE MILITARY UNACCOMPANIED HOUSING IMPROVEMENT FUND		
RESCISSION (FISCAL YEAR 1997, P.L. 104-196)	---	-5,000
ARMY NATIONAL GUARD		
UNSPECIFIED WORLDWIDE LOCATIONS		
PLANNING AND DESIGN	4,548	9,048

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
UNSPECIFIED MINOR CONSTRUCTION	546	5,046
GENERAL REDUCTION	---	-2,000
AIR NATIONAL GUARD		
UNSPECIFIED WORLDWIDE LOCATIONS		
PLANNING AND DESIGN	8,549	8,549
UNSPECIFIED MINOR CONSTRUCTION	3,462	7,502
GENERAL REDUCTION	---	-4,000
ARMY RESERVE		
UNSPECIFIED WORLDWIDE LOCATIONS		
PLANNING AND DESIGN	7,368	7,368
NAVY RESERVE		
UNSPECIFIED WORLDWIDE LOCATIONS		
PLANNING AND DESIGN	1,974	2,974
UNSPECIFIED MINOR CONSTRUCTION	877	877
AIR FORCE RESERVE		
UNSPECIFIED WORLDWIDE LOCATIONS		
PLANNING AND DESIGN	2,432	2,432
UNSPECIFIED MINOR CONSTRUCTION	2,903	2,903
TOTAL, WORLDWIDE UNSPECIFIED	327,201	245,880
WORLDWIDE VARIOUS		
DEFENSE-WIDE		
VARIOUS LOCATIONS		
CONFORMING STORAGE FACILITIES	1,300	1,300
FAMILY HOUSING, ARMY		
ALABAMA		
REDSTONE ARSENAL (118 UNITS)	14,000	14,000
HAWAII		
SCHOFIELD BARRACKS (64 UNITS)	14,700	14,700
NORTH CAROLINA		
FORT BRAGG (170 UNITS)	19,800	19,800
TEXAS		
FORT HOOD (154 UNITS)	21,600	21,600
VIRGINIA		
FORT LEE (80 UNITS)	---	13,000
CONSTRUCTION IMPROVEMENTS	28,629	48,479
PLANNING AND DESIGN	6,350	6,350
GENERAL REDUCTION	-1,639	-2,639
SUBTOTAL, CONSTRUCTION	103,440	135,290
OPERATION AND MAINTENANCE		
INTEREST PAYMENTS	3	3
LEASING	202,155	202,155
MISCELLANEOUS ACCOUNT	415	415
MAINTENANCE OF REAL PROPERTY	467,914	467,914
UTILITIES ACCOUNT	250,407	250,407
SERVICES ACCOUNT	52,222	52,222
MANAGEMENT ACCOUNT	87,125	80,089
FURNISHINGS ACCOUNT	44,492	44,492
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-3,000
SUBTOTAL, OPERATION AND MAINTENANCE	1,104,733	1,094,697
TOTAL, FAMILY HOUSING, ARMY	1,208,173	1,229,987
FAMILY HOUSING, NAVY AND MARINE CORPS		
CALIFORNIA		
LEMOORE NAVAL AIR STATION (162 UNITS)	30,379	30,379
HAWAII		
PEARL HARBOR PUBLIC WORKS CENTER (150 UNITS)	29,125	29,125
CONSTRUCTION IMPROVEMENTS	211,991	227,791
PLANNING AND DESIGN	15,618	15,618
GENERAL REDUCTION	-6,323	-6,323

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-1,000
SUBTOTAL, CONSTRUCTION	280,790	295,590
OPERATION AND MAINTENANCE		
MAINTENANCE OF REAL PROPERTY	414,967	414,967
LEASING	135,079	135,079
MISCELLANEOUS ACCOUNT	293	293
MANAGEMENT ACCOUNT	82,331	82,331
FURNISHINGS ACCOUNT	33,199	33,199
UTILITIES ACCOUNT	184,519	184,519
SERVICES ACCOUNT	64,829	64,829
MORTGAGE INSURANCE PREMIUMS	76	76
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-3,000
SUBTOTAL, OPERATION AND MAINTENANCE	915,293	912,293
TOTAL, FAMILY HOUSING, NAVY AND MARINE CORPS	1,196,083	1,207,883
FAMILY HOUSING, AIR FORCE		
ALABAMA		
MAXWELL AFB (143 UNITS)	16,300	16,300
ALASKA		
EIELSON AFB (46 UNITS)	12,932	12,932
CALIFORNIA		
EDWARDS AFB (48 UNITS)	12,580	12,580
VANDENBERG AFB (95 UNITS)	18,499	18,499
DELAWARE		
DOVER AFB (55 UNITS)	8,998	8,998
FLORIDA		
MACDILL AFB (48 UNITS)	7,609	7,609
PATRICK AFB (46 UNITS)	9,692	9,692
TYNDALL AFB (122 UNITS)	14,500	14,500
MISSISSIPPI		
KEESLER AFB (52 UNITS)	---	6,800
COLUMBUS AFB (52 UNITS)	---	6,800
MONTANA		
MALMSTROM AFB (50 UNITS)	---	10,000
NEBRASKA		
OFFUTT AFB (HOUSING MAINTENANCE FACILITY)	900	900
OFFUTT AFB (HOUSING OFFICE)	870	870
OFFUTT AFB (90 UNITS)	12,212	12,212
NEVADA		
NELLIS AFB (28 UNITS)	---	5,000
NEW MEXICO		
KIRTLAND AFB (37 UNITS)	6,400	6,400
OHIO		
WRIGHT-PATTERSON AFB (40 UNITS)	5,600	5,600
TEXAS		
DYESS AFB (64 UNITS)	9,415	9,415
SHEPPARD AFB (65 UNITS)	---	7,000
WASHINGTON		
FAIRCHILD AFB (HOUSING OFFICE/MAINTENANCE FACILITY)	1,692	1,692
FAIRCHILD AFB (14 UNITS)	2,300	2,300
CONSTRUCTION IMPROVEMENTS	81,778	104,108
PLANNING AND DESIGN	11,342	11,342
GENERAL REDUCTION	-7,584	-9,584
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-1,000
SUBTOTAL, CONSTRUCTION	226,035	280,965
OPERATION AND MAINTENANCE		
MORTGAGE INSURANCE PREMIUMS	32	32
MAINTENANCE OF REAL PROPERTY	388,659	388,659
MISCELLANEOUS ACCOUNT	5,240	5,240
LEASING	118,071	118,071
FURNISHINGS ACCOUNT	37,218	36,427
UTILITIES ACCOUNT	152,214	152,214
SERVICES ACCOUNT	36,066	35,849

MILITARY CONSTRUCTION (IN THOUSANDS OF DOLLARS)

INSTALLATION & PROJECT	BUDGET REQUEST	CONFERENCE AGREEMENT
MANAGEMENT ACCOUNT	52,495	48,712
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-2,000
SUBTOTAL, OPERATION AND MAINTENANCE	789,995	783,204
TOTAL, FAMILY HOUSING, AIR FORCE	1,016,030	1,064,169
FAMILY HOUSING, DEFENSE-WIDE		
CONSTRUCTION IMPROVEMENTS (NSA) (MENWITH HILL, UNITED KINGDOM) (27 UNITS)	50	50
CONSTRUCTION IMPROVEMENTS (DLA) (RICHMOND, VA CARPORTS AND SHELTERS; LATHROP, CA FENCING)	295	295
SUBTOTAL, CONSTRUCTION	345	345
OPERATION AND MAINTENANCE		
FURNISHINGS ACCOUNT (NSA)	126	126
FURNISHINGS ACCOUNT (DIA)	2,153	2,153
FURNISHINGS ACCOUNT (DLA)	125	125
MANAGEMENT ACCOUNT (NSA)	70	70
MANAGEMENT ACCOUNT (DLA)	244	244
MISCELLANEOUS ACCOUNT (NSA)	735	735
SERVICES ACCOUNT (NSA)	355	355
SERVICES ACCOUNT (DLA)	51	51
UTILITIES ACCOUNT (NSA)	450	450
UTILITIES ACCOUNT (DLA)	424	424
LEASING (NSA)	12,292	12,292
LEASING (DIA)	18,847	18,847
MAINTENANCE OF REAL PROPERTY (NSA)	496	496
MAINTENANCE OF REAL PROPERTY (DLA)	531	531
SUBTOTAL, OPERATION AND MAINTENANCE	36,899	36,899
TOTAL, FAMILY HOUSING, DEFENSE-WIDE	37,244	37,244
DEPARTMENT OF DEFENSE FAMILY HOUSING IMPROVEMENT FUND		
DEPARTMENT OF DEFENSE FAMILY HOUSING IMPROVEMENT FUND	7,000	2,000
HOMEOWNERS ASSISTANCE FUND		
HOMEOWNERS ASSISTANCE FUND	12,800	---
BASE REALIGNMENT AND CLOSURE ACCOUNT, PART III		
BASE REALIGNMENT AND CLOSURE ACCOUNT, PART III	433,464	429,164
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-2,000
SUBTOTAL	433,464	427,164
BASE REALIGNMENT AND CLOSURE ACCOUNT, PART IV		
BASE REALIGNMENT AND CLOSURE ACCOUNT, PART IV	1,297,240	1,268,438
REVISED ECONOMIC ASSUMPTIONS (MID-SESSION REVIEW)	---	-3,000
INFLATION SAVINGS PREVIOUSLY WITHHELD	---	-26,000
UNREPORTED PROCEEDS	---	-35,700
SUBTOTAL	1,297,240	1,203,738
TOTAL, BASE REALIGNMENT AND CLOSURE	1,730,704	1,630,902
GENERAL PROVISIONS		
SECTION 125 (FAMILY HOUSING, PAINE FIELD, EVERETT, WA)	6,000	6,000
GRAND TOTAL	7,784,074	8,449,742

CONFERENCE TOTAL—WITH COMPARISONS

The total new budget (obligational) authority for the fiscal year 1999 recommended by the Committee of Conference, with comparisons to the fiscal year 1998 amount, the 1999 budget estimates, and the House and Senate bills for 1999 follow:

New budget (obligational) authority, fiscal year 1998.	$9,208,468,000
Budget estimates of new (obligational) authority, fiscal year 1999	7,784,074,000
House bill, fiscal year 1999	8,234,074,000
Senate bill, fiscal year 1999	8,480,574,000
Conference agreement, fiscal year 1999	8,449,742,000
Conference agreement compared with:	
New budget (obligational) authority, fiscal year 1998	−758,726,000
Budget estimates of new (obligational) authority, fiscal year 1999	+665,668,000
House bill, fiscal year 1999	+215,668,000
Senate bill, fiscal year 1999	−30,832,000

RON PACKARD,
JOHN EDWARD PORTER,
DAVID L. HOBSON,
ROGER F. WICKER,
JACK KINGSTON,
MIKE PARKER,
TODD TIAHRT,
ZACH WAMP,
BOB LIVINGSTON,
W.G. (BILL) HEFNER,
JOHN W. OLVER,
CHET EDWARDS,
BUD CRAMER,
NORMAN DICKS,
DAVID OBEY,
Managers on the Part of the House.

CONRAD BURNS,
KAY BAILEY HUTCHISON,
LAUCH FAIRCLOTH,
LARRY E. CRAIG,
TED STEVENS,
PATTY MURRAY,
HARRY REID,
DANIEL K. INOUYE,
ROBERT C. BYRD,
Managers on the Part of the Senate.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. YATES (at the request of Mr. GEPHARDT) for today, on account of illness in the family.

Mr. FORD (at the request of Mr. GEPHARDT) for today, on account of personal business.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. FILNER) to revise and extend their remarks and include extraneous material:)

Mr. CONYERS, for 5 minutes, today.

Mr. ENGEL, for 5 minutes, today.

Ms. NORTON, for 5 minutes, today.

Ms. SLAUGHTER, for 5 minutes, today.

Mr. FALEOMAVAEGA, for 5 minutes, today.

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

Mr. LAMPSON, for 5 minutes, today.

(The following Members (at the request of Mr. COLLINS) to revise and extend their remarks and include extraneous material:)

Mr. GUTKNECHT, for 5 minutes, today.

Mr. BEREUTER, for 5 minutes, today.

Mr. COLLINS, for 5 minutes, today.

EXTENSION OF REMARKS

By unanimous consent, permission to revise and extend remarks was granted to:

Mr. OBERSTAR, and to include extraneous material, notwithstanding the fact it exceeds two pages and is estimated by the Public Printer to cost $1,508.

(The following Members (at the request of Mr. FILNER) and to include extraneous material:)

Mr. KIND.

Mr. BARRETT of Wisconsin.

Mr. MARKEY.

Mr. HALL of Ohio.

Mr. POSHARD.

Mr. COSTELLO.

Mr. HAMILTON.

Mr. ROEMER.

Ms. NORTON.

Mrs. MEEK of Florida.

Mr. LIPINSKI.

Mr. CONYERS.

Mr. FORD.

Mr. SANDERS.

Ms. ESHOO.

(The following Members (at the request of Mr. COLLINS) and to include extraneous material:)

Mr. SMITH of Michigan.

Mr. SHAW.

Mr. GILMAN.

Mr. RADANOVICH.

ADJOURNMENT

Mr. SERRANO. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 4 o'clock and 38 minutes p.m.), under its previous order, the House adjourned until Monday, July 27, 1998, at 10:30 a.m., for morning hour debates.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

10269. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Pyripoxyfen (2-[1-methyl-2- (4-phenoxyp enoxy)ethoxy]pyridine; Pesticide Tolerance [OPP–300666; FRL–5794–6] (RIN: 2070–AB78) received June 29, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

10270. A communication from the President of the United States, transmitting his request to make available appropriations of $100,000,000 in budget authority for the Department of Health and Human Services' Low Income Home Energy Assistance Program, pursuant to Public Law 105—78; (H. Doc. No. 105—289); to the Committee on Appropriations and ordered to be printed.

10271. A letter from the Assistant Secretary of the Army (Research, Development and Acquisition), Department of Army, transmitting notification of munitions disposal, pursuant to 50 U.S.C. 1512(4); to the Committee on National Security.

10272. A letter from the Assistant Secretary, Health Affairs, Department of Defense, transmitting a report on the Sharing Agreement Authorized Under Section 743 of the FY98 Defense Authorization Act Between The Secretary of the Air Force and Gerald Champion Memorial Hospital, pursuant to Public Law 105—85; to the Committee on National Security.

10273. A letter from the Director, Office of Rulemaking Coordination, Department of Energy, transmitting the Department's final rule—Security And Control Of Nuclear Explosives And Nuclear Weapons—received July 7, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on National Security.

10274. A letter from the Acting Director, Office of Management and Budget, transmitting an account for contributions to defray costs of U.S.operations in Southwest Asia; to the Committee on National Security.

10275. A letter from the Secretary of Defense, transmitting a report to Congress entitled ''Medical Tracking System for Members Deployed Overseas,'' pursuant to Pun. L. 105—85; to the Committee on National Security.

10276. A letter from the Acting Director of Communications and Legislative Affairs, Equal Employment Opportunity Commission, transmitting the Department's final rule—Waiver of Rights and Claims Under the Age Discrimination Act (ADEA) [29 CFR Part 1625] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Education and the Workforce.

10277. A letter from the Secretary of Labor, transmitting a report entitled ''Minimum Wage and Overtime Hours Report''; to the Committee on Education and the Workforce.

10278. A letter from the Secretary of Energy, transmitting the Department's report entitled, ''Summary of Expenditures of Rebates from the Low-Level Radioactive Waste Surcharge Escrow Account for Calendar Year 1997,'' pursuant to 42 U.S.C. 2120e(d)(2)(E)(ii)(II); to the Committee on Commerce.

10279. A letter from the Director, Office of Rulemaking Coordination, Department of Energy, transmitting the Department's final rule—Worker Protection Management For DOE Federal And Contractor Employees—received July 7, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10280. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—National Priorities List for Uncontrolled Hazardous Waste Sites [FRL–6130–9] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10281. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Walla Walla and Pullman, Washington, and Hermiston, Oregon) [MM Docket No. 97–246; RM–9205; RM–9250] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10282. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—

Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Shenandoah, Virginia) [MM Docket No. 98–30; RM–9228] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10283. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Canton, Normal and Heyworth, Illinois) [MM Docket No. 96–225; RM–8894; RM–9004] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10284. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Federal-State Joint Board on Universal Service [CC Docket No. 96–45] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10285. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Amendment of the Commission's Rules Concerning Maritime Communications [PR Docket No. 92–257; RM–7956; RM–8031; RM–8352] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10286. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Point Arena, California) [MM Docket No. 97–236; RM–9186] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10287. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Horseshoe Beach and Otter Creek, Florida) [MM Docket No. 97–239; RM–9195; RM–9237] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10288. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations, (Salmon, Idaho) [MM Docket No. 98–51; RM–9241] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10289. A letter from the AMD—Performance Evaluation and Records Management, Federal Communications Commission, transmitting the Commission's final rule—Amendment of Section 73.202(b), Table of Allotments, FM Broadcast Stations (Gurdon, Arkansas) [MM Docket No. 98–40] received July 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10290. A letter from the Acting Secretary, Federal Trade Commission, transmitting the Commission's final rule—Amended Enforcement Policy Concerning Clear and Conspicuous Disclosure in Foreign Language Advertising and Sales Materials—received June 29, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10291. A letter from the Secretary of Health and Human Services, transmitting the fifteenth annual report to Congress of the Orphan Products Board (OPB), pursuant to 42 U.S.C. 236(e); to the Committee on Commerce.

10292. A letter from the Secretary, Securities and Exchange Commission, transmitting the Commission's final rule—Exemption for Investment Advisers Operating in Multiple States; Revisions to Rules Implementing Amendment s to the Investment Advisers Act of 1940; Investment Advisers with Principal Offices and Places of Business in Colorado or Iowa [Release No. IA–1733, File No. S7–28–97] (RIN: 3235–AH22) received July 20, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

10293. A letter from the Secretary of Defense, transmitting second half FY 1997 semi-annual report on Program Activities to Facilitate Weapons Destruction and Nonproliferation in the Former Soviet Union, pursuant to 22 U.S.C. 5956; to the Committee on International Relations.

10294. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–386, ''Sex Offender Registration Temporary Amendment Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10295. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–383, ''School Transit Subsidy Act of 1978 Amendment Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10296. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–385, ''Abatement of Controlled Dangerous Substance Nuisances Temporary Amendment Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10297. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. ACT 12–393, ''Quick Payment Temporary Amendment Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10298. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–405 ''Windshield Wipers and Headlamp Regulation Amendment Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10299. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–404 ''Closing of a Public Alley in Square 185, S.O. 97–106, Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10300. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–384, ''Bishop Aimilianos Laloussis Park Designation Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10301. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–407, ''Closing of 8th, L, and M Streets, N.W., and the Closing of Public Alleys in Squares 400, 401, 402, 426, 425, and 424, S.O. 96–90, Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10302. A letter from the Chairman, Council of the District of Columbia, transmitting a copy of D.C. Act 12–402 ''Washington Convention Center Authority Financing Amendment Act of 1998'' received July 21, 1998, pursuant to D.C. Code section 1—233(c)(1); to the Committee on Government Reform and Oversight.

10303. A letter from the Director, Personnel and Family Readiness Division, Department of the Navy, transmitting the annual report of the Retirement Plan for Civilian Employees of the United States Marine Corps Morale, Welfare and Recreation Support Activity, and Miscellaneous Nonappropriated Fund Instrumentalities, pursuant to 31 U.S.C. 9503(a)(1)(B); to the Committee on Government Reform and Oversight.

10304. A letter from the Acting Assistant General Counsel for Regulations, Department of Education, transmitting the Department's final rule—Administration of grants and agreements with institutions of higher education, hospitals, and other non-profit organizations; and Uniform administrative requirements for grants and cooperative agreements to State and local governments [34 CFR Parts 74 and 80] received July 2, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Government Reform and Oversight.

10305. A letter from the Acting Director, Office of Management and Budget, transmitting a copy of the report, ''Agency Compliance with Title II of the Unfunded Mandates Reform Act of 1995,'' pursuant to 2 U.S.C. 1538; to the Committee on Government Reform and Oversight.

10306. A letter from the Chairman, U.S. Merit Systems Protection Board, transmitting a report entitled ''Federal Supervisors and Strategic Human Resources Management''; to the Committee on Government Reform and Oversight.

10307. A letter from the Secretary of Health and Human Services, transmitting a report on the Indian Lands Open Dump Cleanup Act of 1997; to the Committee on Resources.

10308. A letter from the Acting Secretary, Federal Trade Commission, transmitting the Commission's final rule—Organization, General Procedures, Rules of Practice for Adjudicative Proceedings [16 CFR Parts 0, 1, and 3] received July 2, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on the Judiciary.

10309. A letter from the Attorney, National Council on Radiation Protection and Measurements, transmitting the 1997 annual report of independent auditors who have audited the records of the National Council on Radiation Protection and Measurements, pursuant to Public Law 88—376, section 14(b) (78 Stat. 323); to the Committee on the Judiciary.

10310. A letter from the Executive Director, National Mining Hall of Fame and Museum, transmitting the Museum's 1997 audited financial statement and a copy of Form 990 which was filed with the Internal Revenue Service, pursuant to 36 U.S.C. 4111; to the Committee on the Judiciary.

10311. A letter from the Chief Counsel, Bureau of the Public Debt, transmitting the Department's final rule—Regulations Governing Book-Entry Treasury BONDS, Notes, and Bills; Determination Regarding State Statutes; Georgia, Florida and Connecticut [Department of the Treasury Circular, Public Debt Series, No. 2–86] received July 2, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

10312. A letter from the Secretary of Health and Human Services, transmitting the Department's final rule—Child Support Enforcement Program Quarterly Wage and Unemployment Compensations Claims Reporting to the National Directory of New Hires (RIN: 0970–AB67) received June 31, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Ways and Means.

10313. A letter from the Secretary of Energy, transmitting a draft of proposed legislation to provide for a more competitive electric power industry, and for other purposes; jointly to the Committees on Commerce and the Judiciary.

10314. A letter from the Secretary of Health and Human Services, transmitting

the Department's ''Major'' final rule—Medicare Program; Medicare Coverage of and Payment for Bone Mass Measurements [HCFA–3004–IFC] (RIN: 0938–AI89) received June 23, 1998, pursuant to 5 U.S.C. 801(a)(1)(A); jointly to the Committees on Commerce and Ways and Means.

10315. A letter from the Administrator, Agency for International Development, transmitting a quarterly update report on development assistance program allocations updated as of March 31, 1998, pursuant to 22 U.S.C. 2413(a); jointly to the Committees on International Relations and Appropriations.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk of printing and reference to the proper calendar, as follows:

Mr. SMITH of Texas: Committee on the Judiciary. S. 1304. An act for the relief of Belinda McGregor (Rept. 105–646).

Mr. PACKARD: Committee of Conference. Conference report on H.R. 4059. A bill making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 1999, and for other purposes (Rept. 105–647). Ordered to be printed.

Mr. WOLF: Committee on Appropriations. H.R. 4328. A bill making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 1999, and for other purposes (Rept. 105–648). Referred to the Committee of the Whole House on the State of the Union.

Mr. GOODLING: Committee on Education and the Workforce. H.R. 3254. A bill to amend the Individuals with Disabilities Education Act to clarify the requirements relating to reducing or withholding payments to States under that Act; with an amendment (Rept. 105–649). Referred to the Committee of the Whole House on the State of the Union.

REPORTS OF COMMITTEES ON PRIVATE BILLS AND RESOLUTIONS

Under Clause 2 of rule XIII reports of committees were delivered to the Clerk of printing and reference to the proper calendar, as follows:

Mr. SMITH of Texas: Committee on the Judiciary. H.R. 379. A bill for the relief of Larry Errol Pieterse (Rept. 105–644. Referred to the Committee of the Whole House.

Mr. SMITH of Texas: Committee on the Judiciary. H.R. 2744. A bill for the relief of Chong Ho Kwak, (Rept. 105–645). Referred to the Committee of the Whole House.

PUBLIC BILLS AND RESOLUTIONS

Under clause 5 of rule X and clause 4 of rule XXII, public bills and resolutions were introduced and severally referred, as follows:

By Mr. SMITH of Oregon:

H.R. 4326. A bill to transfer administrative jurisdiction over certain Federal lands located within or adjacent to the Rogue River National Forest and to clarify the authority of the Bureau of Land Management to sell and exchange other Federal lands in Oregon; to the Committee on Resources.

By Mr. SAXTON (for himself, Mr. HUNTER, Mr. GINGRICH, Mr. ARMEY, Mr. SPENCE, Mr. LIVINGSTON, Mr. WELDON of Pennsylvania, and Mrs. BONO):

H.R. 4327. A bill to direct the President to commence an emergency program to build and field as quickly as possible a theater missile defense system capable of defending against the type of ballistic missile that was flight tested by Iran on July 21, 1998; to the Committee on National Security.

By Mr. WOLF:

H.R. 4328. A bill making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 1999, and for other purposes.

By Mr. CASTLE:

H.R. 4329. A bill to require the design of the obverse side of the $1 coin to depict the Statue of Liberty; to the Committee on Banking and Financial Services.

By Mr. COLLINS (for himself and Mr. TANNER):

H.R. 4330. A bill to amend the Internal Revenue Code of 1986 to allow capital gains treatment and an exception from the uniform capitalization rules for timber which is more than 4 years old when harvested; to the Committee on Ways and Means.

By Mr. HILL:

H.R. 4331. A bill to provide for the establishment of an interpretive center and museum at Fort Peck Dam, Montana, and to provide further protection for significant fossil remains in the vicinity of Fort Peck Dam; to the Committee on Transportation and Infrastructure.

By Mr. HULSHOF (for himself, Mr. MCCRERY, Mr. JEFFERSON, Mr. COLLINS, Mr. WELLER, Mr. CRANE, Mr. KLECZKA, Mr. BUNNING of Kentucky, Mr. SAM JOHNSON, Ms. DUNN of Washington, Mr. NUSSLE, Mr. CHRISTENSEN, Mr. WATKINS, Mr. BAKER, Mr. BACHUS, Mr. SESSIONS, Mrs. NORTHUP, and Ms. GRANGER):

H.R. 4332. A bill to amend the Internal Revenue Code of 1986 to repeal the 4.3-cent motor fuel excise taxes on railroads and inland waterway transportation which remain in the general fund of the Treasury; to the Committee on Ways and Means.

By Mrs. MALONEY of New York:

H.R. 4333. 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 require that group and individual health insurance coverage and group health plans provide coverage of annual mammograms and annual prostate cancer screening tests following the model established under the Medicare Program; to the Committee on Commerce, and in addition to the Committees on Education and the Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. YOUNG of Alaska:

H.R. 4334. A bill to prohibit the construction of new facilities and structures within the boundaries of the George Washington Memorial Parkway along the Potomac River in Virginia between the Francis Scott Key Bridge and the Theodore Roosevelt Memorial Bridge; to the Committee on Resources.

By Mr. YOUNG of Alaska (for himself, Mr. HERGER, Mr. POMBO, Mr. NETHERCUTT, Mrs. CHENOWETH, Mr. SMITH of Oregon, and Mr. CRAPO):

H.R. 4335. A bill to transfer to the Secretary of the Interior the functions of the Secretary of Commerce and the National Marine Fisheries Service under the Endangered Species Act of 1973; to the Committee on Resources.

By Mr. BARR of Georgia:

H. Con. Res. 308. Concurrent resolution expressing the sense of the Congress with respect to the failure of Attorney General Janet Reno to seek application for an independent counsel to investigate a number of matters relating to the financing of campaigns in the 1996 Federal election, including the conduct of President Clinton and Vice President Gore; to the Committee on the Judiciary.

By Mr. PAYNE (for himself, Mr. BERMAN, Mr. GILMAN, Mr. SMITH of New Jersey, Mr. MENENDEZ, Mr. LANTOS, and Mr. HASTINGS of Florida):

H. Con. Res. 309. Concurrent resolution condemning the forced abduction of Ugandan children and their use as soldiers; to the Committee on International Relations.

ADDITIONAL SPONSORS

Under clause 4 of rule XXII, sponsors were added to public bills and resolutions as follows:

H.R. 59: Mr. WHITFIELD.
H.R. 303: Ms. DELAURO.
H.R. 997: Mr. KOLBE.
H.R. 1126: Mr. SANDLIN, Mr. CRANE, and Ms. DUNN of Washington.
H.R. 1283: Ms. VELAZQUEZ.
H.R. 1289: Ms. KAPTUR.
H.R. 1382: Ms. KAPTUR and Mr. KING of New York.
H.R. 1401: Mr. SANDERS.
H.R. 1450: Mr. STOKES.
H.R. 1773: Mr. WAMP.
H.R. 1995: Mr. FRANKS of New Jersey.
H.R. 2023: Mr. ROTHMAN.
H.R. 2409: Mr. KAPTUR and Mr. SOUDER.
H.R. 2456: Mrs. WILSON.
H.R. 2602: Mr. LANTOS.
H.R. 2635: Ms. VELAZQUEZ and Mr. UPTON.
H.R. 2754: Mr. SHERMAN and Ms. CHRISTIAN-GREEN.
H.R. 2951: Mr. HAYWORTH.
H.R. 3068: Ms. LEE.
H.R. 3081: Mrs. CLAYTON and Mr. MALONEY of Connecticut.
H.R. 3215: Mrs. THURMAN.
H.R. 3248: Mr. ENSIGN and Mr. COLLINS.
H.R. 3254: Mr. CAMPBELL, Mrs. BONO, Mr. ROYCE, and Mr. THOMAS.
H.R. 3290: Mrs. BONO.
H.R. 3320: Mr. FORBES, Mr. BISHOP, Ms. MCKINNEY, and Mr. ADAM SMITH of Washington.
H.R. 3400: Mr. SHERMAN and Ms. CHRISTIAN-GREEN.
H.R. 3445: Mr. FALEOMAVAEGA.
H.R. 3567: Mr. METCALF.
H.R. 3572: Mr. LAMPSON.
H.R. 3610: Mr. GORDON and Mr. DEAL of Georgia.
H.R. 3629: Mr. SOUDER.
H.R. 3681: Mr. BACHUS.
H.R. 3734: Mr. PICKERING.
H.R. 3780: Mr. LEWIS of Georgia, Mr. ENSIGN, Mr. CALVERT, and Mr. CRANE.
H.R. 3783: Mr. BUYER, Ms. FURSE, Mr. FOLEY, and Mr. CHRISTENSEN.
H.R. 3876: Mr. THOMPSON, Mr. GORDON, Mr. CARDIN, Mr. EVANS, Ms. MCKINNEY, Mr. LAMPSON, Mr. NADLER, and Mr. SHERMAN.
H.R. 3918: Mr. SERRANO, Mr. SCHUMER, and Mr. NADLER.
H.R. 3992: Mr. WELLER, Mr. BUNNING of Kentucky, Mr. GOODE, Mr. SESSIONS, Mr. TALENT, and Mr. BONILLA.
H.R. 3995: Mr. FRANK of Massachusetts, Mr. VENTO, and Ms. ROYBAL-ALLARD.
H.R. 4009: Mr. BOSWELL, Mr. CRAMER, Mr. BONIOR, Ms. FURSE, Mrs. CAPPS, and Ms. MCCARTHY of Missouri.
H.R. 4025: Mrs. THURMAN.
H.R. 4028: Mr. TAYLOR of Mississippi, Mr. FILNER, and Ms. KAPTUR.
H.R. 4031: Mr. RUSH, Mr. WAXMAN, and Ms. FURSE.
H.R. 4071: Mr. OBERSTAR, Mr. STRICKLAND, and Mr. ADERHOLT.

H.R. 4078: Mr. MCGOVERN, Mr. ABERCROMBIE, and Mr. FORD.

H.R. 4095: Mr. BONIOR, Mr. FALEOMAVAEGA, Mr. MENENDEZ, and Mr. BEREUTER.

H.R. 4121: Ms. LOFGREN, Mr. ENGLISH of Pennsylvania, Mrs. THURMAN, Mr. GREENWOOD, and Ms. SANCHEZ.

H.R. 4134: Mr. BALDACCI.

H.R. 4167: Mr. CHRISTENSEN.

H.R. 4188: Mr. BILIRAKIS.

H.R. 4204: Mr. MCCOLLUM, Mr. NUSSLE, and Mr. BLUNT.

H.R. 4206: Mr. DINGELL, Ms. ROYBAL-ALLARD, Mr. TOWNS, Mr. SCHUMER, Mr. MARKEY, Ms. MCKINNEY, Mrs. MORELLA, Mr. PALLONE, Mr. PAYNE, and Mr. MATSUI.

H.R. 4209: Mr. ENGEL.

H.R. 4211: Mr. EHLERS, Mr. HASTINGS of Florida, and Mr. ENGLISH of Pennsylvania.

H.R. 4213: Mr. FOLEY and Mr. RILEY.

H.R. 4224: Mr. LEWIS of Georgia, Mr. BAESLER, and Mr. BONIOR.

H.R. 4233: Mr. SABO, Mr. STARK, Mrs. CLAYTON, Ms. FURSE, Mrs. TAUSCHER, and Mr. FILNER.

H.R. 4250: Mr. BLUNT, Mr. KNOLLENBERG, and Mr. HILL.

H.R. 4258: Mr. CANNON and Mr. BURR of North Carolina.

H.R. 4265: Mr. NORWOOD, Mr. EDWARDS, Mr. HILL, Ms. GRANGER, and Mr. INGLIS of South Carolina.

H.R. 4275: Mr. ROGERS, Mr. HOUGHTON, Mrs. EMERSON, Mr. HINCHEY, Mr. WATTS of Oklahoma, Mr. NEY, Mr. CLYBURN, Mr. RAHALL, Mr. PETERSON of Minnesota, Mr. BALDACCI, Ms. DELAURO, Mr. WISE, Mr. MCGOVERN, Mr. SANDLIN, Mr. LAMPSON, Mr. BOSWELL, Mr. LIPINSKI, Mr. BORSKI, Mr. HOLDEN, Ms. NORTON, Mr. WALSH, Mr. BOUCHER, Mr. BUNNING of Kentucky, Mr. ADERHOLT, Mr. BOEHLERT, and Mr. WICKER.

H.R. 4281: Mr. GOODE.

H. Con. Res. 122: Mr. ABERCROMBIE, Mr. ENGEL, Mr. FORBES, Mr. HINCHEY, Ms. ROS-LEHTINEN, Mr. SPRATT, Mr. WAXMAN, and Mr. YATES.

H. Con. Res. 148: Mr. FRANKS of New Jersey.

H. Con. Res. 184: Mr. MCGOVERN.

H. Con. Res. 185: Mr. UNDERWOOD, Mr. MARKEY, Mr. HOYER, Mr. OLVER, Mrs. MALONEY of New York, Mr. SABO, Mr. PITTS, and Mr. LAMPSON.

H. Con. Res. 203: Mr. PETRI.

H. Con. Res. 239: Ms. KILPATRICK.

H. Con. Res. 299: Mr. STUMP, Mr. CAMPBELL, and Mr. HASTINGS of Washington.

H. Con. Res. 303: Mr. HINCHEY.

H. Con. Res. 304: Mr. CARDIN, Mrs. KELLY, Mr. MILLER of California, and Mr. BONIOR.

PETITIONS, ETC.

Under clause 1 of rule XXII, petitions and papers were laid on the clerk's desk and referred as follows:

69. The SPEAKER presented a petition of Peter Strzelczyk, M.D., citizen of Katowise, Poland, relative to a demand for damages for the estate of his wife, Ewa Strzelczyk, resulting from the Cavalese, Italy tragedy; to the Committee on the Judiciary.

70. Also, a petition of Peter Strzelczyk, M.D., citizen of Katowise, Poland, relative to a demand for damages for the estate of his son, Filip Strzelczyk, resulting from the Cavalese, Italy tragedy; to the Committee on the Judiciary.

DISCHARGE PETITIONS

Under clause 3 of rule XXVII, the following discharge petition was filed:

Petition 7. July 20, 1998, by Mr. GANSKE on House Resolution 486, was signed by the following Members: Greg Ganske, John D. Dingell, Michael R. McNulty, John W. Olver, Sherrod Brown, Bob Filner, Alcee L. Hastings, Eddie Bernice Johnson, Lois Capps, Elijah E. Cummings, Jesse L. Jackson, Jr., Gregory W. Meeks, Barney Frank, Karen McCarthy, Lynn C. Woolsey, Anna G. Eshoo, Frank Mascara, David E. Skaggs, Ron Kind, Maurice D. Hinchey, Barbara Lee, Elizabeth Furse, Eva M. Clayton, Carrie P. Meek, Bill Pascrell, Jr., Max Sandlin, Chet Edwards, Nydia M. Velazquez, Robert E. Wise, Jr., Barbara B. Kennelly, Nick Lampson, Lloyd Doggett, Ruben Hinojosa, Steve R. Rothman, Dale E. Kildee, Jane Harman, Earl Blumenauer, Robert A. Borski, Thomas C. Sawyer, John F. Tierney, James P. McGovern, Robert A. Weygand, Bart Stupak, Lynn N. Rivers, Patsy T. Mink, Scotty Baesler, Albertr Russell Wynn, Thomas J. Manton, Sidney R. Yates, Zoe Lofgren, Rosa L. DeLauro, Jim Turner, Ellen O. Tauscher, Loretta Sanchez, Vic Snyder, Marion Berry, Sanford D. Bishop, Jr., Karen L. Thurman, Debbie Stabenow, Jay W. Johnson, Howard L. Berman, Cynthia A. McKinney, Gene Green, Ken Bentsen, Darlene Hooley, Sheila Jackson-Lee, Steny H. Hoyer, Bart Gordon, John J. LaFalce, David E. Price, Jim Davis, Danny K. Davis, Robert E. Andrews, Jose E. Serrano, Brad Sherman, Melvin L. Watt, Julia Carson, Martin Olav Sabo, David E. Bonior, Ciro D. Rodriguez, Esteban Edward Torres, Vic Fazio, Bruce F. Vento, John M. Spratt, Jr., Diana DeGette, Charles E. Schumer, Calvin M. Dooley, Carolyn McCarthy, James E. Clyburn, Robert Menendez, Edward J. Markey, Thomas H. Allen, Nita M. Lowey, James P. Moran, Ron Klink, Jim McDermott, Jerrold Nadler, Bob Clement, Paul McHale, Robert E. (Bud) Cramer, Jr., Corrine Brown, George Miller, Sam Farr, Michael F. Doyle, Robert A. Brady, Xavier Becerra, Nick J. Rahall II, Norman D. Dicks, Frank Pallone, Jr., Gerald D. Kleczka, Sander M. Levin, Neil Abercrombie, Dennis J. Kucinich, George E. Brown, Jr., Leonard L. Boswell, Tom Lantos, Peter Deutsch, Jerry F. Costello, Maxine Waters, Nancy Pelosi, Chaka Fattah, Louise McIntosh Slaughter, John Elias Baldacci, Thomas M. Barrett, Carolyn C. Kilpatrick, Henry A. Waxman, William D. Delahunt, Patrick J. Kennedy, Robert Wexler, Paul E. Kanjorski, Tony P. Hall, Marcy Kaptur, John Conyers, Jr., Joseph P. Kennedy II, Eliot L. Engel, Sam Gejdenson, David R. Obey, Fortney Pete Stark, Lane Evans, Earl Pomeroy, Tim Holden, Ralph M. Hall, James H. Maloney, Bobby L. Rush, James A. Barcia, Ike Skelton, Peter A. DeFazio, Bernard Sanders, Luis V. Gutierrez, Robert T. Matsui, Donald M. Payne, Benjamin L. Cardin, Major R. Owens, Bill Luther, William J. Coyne, Silvestre Reyes, Carolyn B. Maloney, Ted Strickland, Charles W. Stenholm, Martin T. Meehan, W. G. (Bill) Hefner, William O. Lipinski, Richard A. Gephardt, Lucille Roybal-Allard, Glenn Poshard, John Lewis, Earl F. Hilliard, Martin Frost, Gary L. Ackerman, Edolphus Towns, Bennie G. Thompson, Juanita Millender-McDonald, Adam Smith, Rod R. Blagojevich, Charles B. Rangel, Solomon Ortiz, Lee H. Hamilton, Robert C. Scott, Louis Stokes, Christopher John, William J. Jefferson, John S. Tanner, Ed Pastor, Mike McIntyre, William (Bill) Clay, Rick Boucher, Julian C. Dixon, David Minge, Allen Boyd, and Collin C. Peterson.

DISCHARGE PETITIONS—ADDITIONS OR DELETIONS

The following Members added their names to the following discharge petitions:

Petition 1 by Mr. YATES on House Resolution 141: Earl Pomeroy and Frank Mascara.

Petition 6 by Mr. OBEY on House Resolution 473: Lee H. Hamilton, Ike Skelton, Neil Abercrombie and Darlene Hooley.

AMENDMENTS

Under clause 6 of rule XXIII, proposed amendments were submitted as follows:

H.R. 2183

OFFERED BY: MR. SALMON

(To the Amendments Offered By: Mr. Hutchinson)

AMENDMENT NO. 173: Add at the end the following new title:

TITLE ____—POSTING NAMES OF CERTAIN AIR FORCE ONE PASSENGERS ON INTERNET

SEC. ___01. REQUIREMENT THAT NAMES OF PASSENGERS ON AIR FORCE ONE AND AIR FORCE TWO BE MADE AVAILABLE THROUGH THE INTERNET.

(a) IN GENERAL.—The President shall make available through the Internet the name of any non-Government person who is a passenger on an aircraft designated as Air Force One or Air Force Two not later than 30 days after the date that the person is a passenger on such aircraft.

(b) EXCEPTION.—Subsection (a) shall not apply in a case in which the President determines that compliance with such subsection would be contrary to the national security interests of the United States. In any such case, not later than 30 days after the date that the person whose name will not be made available through the Internet was a passenger on the aircraft, the President shall submit to the chairman and ranking member of the Permanent Select Committee on Intelligence of the House of Representatives and of the Select Committee on Intelligence of the Senate—

(1) the name of the person; and

(2) the justification for not making such name available through the Internet.

(c) DEFINITION OF PERSON.—As used in this Act, the term ''non-Government person'' means a person who is not an officer or employee of the United States, a member of the Armed Forces, or a Member of Congress.

H.R. 4194

OFFERED BY: MR. COBURN

AMENDMENT NO. 33: At the end of the bill, insert after the last section (preceding the short title) the following new sections:

SEC. . The amounts otherwise provided by this Act are revised by reducing the amount made available under the heading ''DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT—FEDERAL HOUSING ADMINISTRATION—FHA—MUTUAL MORTGAGE INSURANCE PROGRAM ACCOUNT'' for non-overhead administrative expenses necessary to carry out the Mutual Mortgage Insurance guarantee and direct loan program, and increasing the amount made available for ''DEPARTMENT OF VETERANS AFFAIRS—VETERANS HEALTH ADMINISTRATION—MEDICAL CARE'', by $199,999,999.

SEC. . The amounts otherwise provided by this Act are revised by reducing the amount made available under the heading ''DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT—FEDERAL HOUSING ADMINISTRATION—FHA—GENERAL AND SPECIAL RISK PROGRAM ACCOUNT'' for non-overhead administrative expenses necessary to carry out the guaranteed and direct loan programs, and increasing the amount made available for ''DEPARTMENT OF VETERANS AFFAIRS—VETERANS HEALTH ADMINISTRATION—MEDICAL CARE'', by $103,999,999.

H.R. 4274

OFFERED BY: MR. DUNCAN

AMENDMENT NO. 1: Page 2, line 19, after ''$150,572,000'' insert ''(decreased by $61,402,000)''.

H.R. 4276

OFFERED BY: MR. KOLBE

AMENDMENT NO. 19: At the end of the bill, insert after the last section (preceding the short title) the following:

TITLE —ADDITIONAL GENERAL PROVISIONS

SEC. . None of the funds made available in this or any other Act may be used to implement, administer, or enforce Executive Order 13083 (titled ''Federalism'' and dated May 14, 1998).

H.R. 4276

OFFERED BY: MR. KOLBE

AMENDMENT NO. 20: At the end of the bill, insert after the last section (preceding the short title) the following:

TITLE —ADDITIONAL GENERAL PROVISIONS

SEC. . None of the funds made available in this Act may be used to implement, administer, or enforce Executive Order 13083 (titled ''Federalism'' and dated May 14, 1998).

H.R. 4276

OFFERED BY: MR. SANDERS

AMENDMENT NO. 21: Page 101, line 21, insert ''(increased by $4,000,000)'' after the dollar amount.

Page 102, line 3, insert ''(increased by $4,000,000)'' after the dollar amount.

Page 100, line 13 insert ''(decreased by $4,000,000)'' after the dollar amount.

H.R. 4276

OFFERED BY: MR. SANDERS

AMENDMENT NO. 22: Page 101, line 21 insert ''(increased by $4,000,000)'' after the dollar amount.

Page 102, line 3 insert ''(increased by $4,000,000)'' after the dollar amount.

Page 40, line 8 insert ''(decreased by $4,000,000)'' after the dollar amount.