"(1) IN GENERAL.—The reasonable costs of the electric reliability organization, and the reasonable costs of each affiliated regional reliability entity that are related to implementation or enforcement of organization standards or other requirements contained in a delegation agreement approved under subsection (h), shall be assessed by the electric reliability organization and each affiliated regional reliability entity, respectively, taking into account the relationship of costs to each region and based on an allocation that is attributable to each region to ensure an equitable sharing of the costs among all electric energy consumers.

(2) RULES.—The Commission shall provide by rule the procedures for costs and allocations under paragraph (1) in accordance with the standards in this subsection and section 443(f).

(3) A M NITION OF ANTITRUST LAWS.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, the following activities are rebuttably presumed to be in compliance with the antitrust laws of the United States:

(A) Activities undertaken by the electric reliability organization under this section or affiliated regional reliability entities operating under a delegation agreement under subsection (h).

(B) Activities of a member of the electric reliability organizations or affiliated regional reliability entity in pursuit of the objectives of the electric reliability organization or affiliated regional reliability entity under this section undertaken in good faith under the rules of the organization of the electric reliability organization or affiliated regional reliability entity.

(2) AVAILABILITY OF DEFENSES.—In a civil action brought by any person or entity against the electric reliability organization or affiliated regional reliability entity alleging a violation of an antitrust law based on an activity under this Act, the defenses of primary jurisdiction and immunity from suit and other affirmative defenses shall be available to the extent applicable.

(3) REGIONAL ADVISORY ROLE.—

"(1) ESTABLISHMENT OF REGIONAL ADVISORY BODY.—The Commission shall establish a regional advisory body on the petition of the Governors of at least two-thirds of the States within a region that have more than one-half of their electrical loads served within the region.

(2) MEMBERSHIP.—A regional advisory body—

(A) shall be composed of 1 member from each State in the region, appointed by the Governor of the State; and

(B) shall include representatives of agencies, States, and Provinces outside the United States, on execution of an appropriate international agreement described in subsection (f).

(3) FUNCTIONS.—A regional advisory body may provide advice to the electric reliability organization, an affiliated regional reliability entity, or the Commission regarding—

(A) the governance of an affiliated regional reliability entity existing or proposed within a region;

(B) whether a standard proposed to apply within the region is just, reasonable, not unduly discriminatory or preferential, and in the public interest;

(C) whether fees proposed to be assessed within the region are—

(i) just, reasonable, not unduly discriminatory or preferential, and in the public interest; and

(ii) consistent with the requirements of subsection (i).

(4) DEFERENCE.—In a case in which a regional advisory body encompasses an entire interconnection, the Commission may give deference to advice provided by the regional advisory body under paragraph (3).

(5) APPLICABILITY OF SECTION.—This section does not apply outside the 48 contiguous States.

(6) REHEARINGS; COURT REVIEW OF ORDERS.—

"(1) The electric reliability organization shall have authority to develop, implement, and enforce compliance with standards for which the reliable operation of only the bulk-power system.

"(2) This section does not provide the electric reliability organization, or other affected party, the Commission with the authority to set and enforce compliance with standards for adequacy or safety of electric facilities or services.

(7) Nothing in this section shall be construed to preempt any authority of any State to take action to ensure the safety, adequacy, and reliability of electric service within that State, as long as such action is not inconsistent with any organization standard.

(8) Not later than 90 days after the application of the electric reliability organizations or affiliated region reliability entity in pursuit of the objectives of the electric reliability organization or affiliated regional reliability entity under this section undertaken in good faith under the rules of the organization of the electric reliability organization or affiliated regional reliability entity.

(9) Enforcement.—

(a) P ATERN LAWS.—

"(1) GENERAL PENALTY.—Section 316(c) of the Federal Power Act (16 U.S.C. 825c(c)) is amended—

(A) by striking "subsection" and inserting "section"; and

(B) by striking "or 214" and inserting "214 or 215".

"(2) CERTAIN PROVISIONS.—Section 316A of the Federal Power Act (16 U.S.C. 825–1) is amended by striking "or 214" each place it appears and inserting "214, or 215".

THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS, 2001

On June 30, 2000, the Senate amended and passed H.R. 4577, as follows:

Resolved, That the bill from the House of Representatives (H.R. 4577) entitled "An Act making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2001, and for other purposes," do pass with the following amendment:

Strike out all after the enacting clause and insert:

DIVISION A—DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES

That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2001, and for other purposes, namely:

TITLE I—DEPARTMENT OF LABOR

EMPLOYMENT AND TRAINING ADMINISTRATION

TRAINING AND EMPLOYMENT SERVICES

For necessary expenses of the Workforce Investment Act, including the purchase and hire of passenger motor vehicles, the construction, alteration, and repair of buildings and other facilities, and the purchase of real property for training centers as authorized by the Workforce Investment Act and the Standards Act of 1994; $2,990,141,000 plus reimbursements, of which $1,718,851,000 is available for obligation for the period July 1, 2001 through December 31, 2001, and of which $1,271,290,000 is available for obligation for the period April 1, 2001 through June 30, 2002, including $1,000,000,000 to carry out chapter 4 of the Workforce Investment Act and $250,000,000 to carry out section 1169 of such Act; and of which $29,275,000 is available for the period July 1, 2001 through June 30, 2004 for necessary expenses of construction and rehabilitation, and acquisition of Job Corps centers: Provided, That $9,000,000 shall be for carrying out section 172 of the Workforce Investment Act, and $3,500,000 shall be for carrying out section 171(d) of such Act; Provided further, That no funds from any other appropriation shall be used to provide meal services at or for Job Corps centers: Provided further, That funds provided to carry out section 171(d) of such Act may be used for demonstration projects that provide assistance to new entrants in the workforce and incumbent workers who need additional funding provided by this Act to carry out projects under section 171(d) of the Workforce Investment Act of 1998 that are identified in the Conference Agreement, shall not be subject to the requirements of section 171(b)(2)(B) of such Act, the requirements of section 171(c)(4)(D) of such Act, or the joint fund-provisions of sections 171(b)(2)(A) and 171(c)(4)(A)(i) of such Act: Provided further, That funding appropriated herein for Dislocated Worker Employment and Training Activities under section 132(a)(2)(A) of the Workforce Investment Act of 1998 may be used for Dislocated Worker Projects under section 171(d) of the Act without regard to the 10 percent limitation contained in section 171(d) of the Act.

For necessary expenses of the Workforce Investment Act, including the purchase and hire of passenger motor vehicles, the construction, alteration, and repair of buildings and other facilities, and the purchase of real property for training centers as authorized by the Workforce Investment Act; $2,463,000,000 plus reimbursements, of which $2,363,000,000 is available for obligation for the period October 1, 2001 through June 30, 2002, and of which $100,000,000 is available for the period October 1, 2001 through June 30, 2004, for necessary expenses of construction, rehabilitation, and acquisition of Job Corps centers.

COMMUNITY SERVICE EMPLOYMENT FOR OLDER AMERICANS

To carry out the activities for national grants or contracts with public agencies and public or private nonprofit organizations under paragraphs (1)(A) of section 595(a) or title V of the Older Americans Act of 1965, as amended, or to carry out older worker activities as subsequently authorized, $343,356,000.

To carry out the activities for grants to States under paragraph (3) of section 595(a) or title V of the Older Americans Act of 1965, as amended, or to carry out older worker activities as subsequently authorized, $49,644,000.

FEDERAL UNEMPLOYMENT BENEFITS AND JOB Placement AID

For payments during the current fiscal year of trade adjustment benefit payments and allowances under part I; and for training, allowances for job search and relocation, and related State administrative expenses under part II, subchapters B and D, chapter 2, title II of the Trade Act of 1974, as amended, $406,550,000, together with such amounts as may be necessary to be charged to the unemployment appropriation for payments for any period subsequent to September 15 of the current year.
STATE UNEMPLOYMENT INSURANCE AND EMPLOYMENT SERVICE OPERATIONS

For authorized administrative expenses, $13,452,000, together with not to exceed $1,085,000, which may be used for amortization payments to States which have independent retirement plans in their State employment service agencies prior to 1983, and are expended from the Unemployment Security Administration account in the Unemployment Trust Fund including the cost of administering section 31 of the Internal Revenue Code, as amended, section 7(d) of the Wagner-Peyser Act, as amended, the Trade Act of 1974, as amended, the Immigration Act of 1990, and the Immigration and Nationality Act (as amended), as may be necessary to (1) make such expenditures, including financial assistance authorized by section 104 of Public Law 96–364, within limits of funds available for such purposes to and expended by the Corporation, and in accord with law, and to make such contracts and commitments without regard to fiscal year limitations as provided by section 104 of the Government Corporation Control Act, as amended (31 U.S.C. 9104), as may be necessary in carrying out the program through September 30, 2001, for such Corporation, provided, That not to exceed $1,652,000 shall be available for administrative expenses of the Corporation: Provided further, That expenses of such Corporation in connection with the termination of pension plans, post-retirement management, and investment of trust assets, and for benefits administration services shall be considered as non-administrative expenses for the purposes aforesaid, and excluded from the above limitation.

EMPLOYMENT STANDARDS ADMINISTRATION

For necessary expenses for the Employment Standards Administration, including reimbursement of State, Federal, and local agencies and their employees for inspection services rendered, $350,779,000, together with $1,985,000 which may be expended for the Special Benefits Protection Unit, and for administrative expenses of the Corporation: Provided further, That of those funds transferred to this account by the Secretary, who is not the employer at the time of injury, for portions of the salary of a reemployed, disabled beneficiary: Provided further, That the Secretary may require that any person filing a notice of injury or a claim for benefits under chapter 81 of title 5, United States Code, or 33 U.S.C. 901 et seq., provide part of such identifying information (including Social Security account number) as such regulations may prescribe.

BLACK LUNG DISABILITY TRUST FUND

For the payment of compensation, benefits, and expenses (except administrative expenses) authorized under plans approved by the Secretary determined to be the cost of administration for employees of such fair share entities through September 30, 2001: Provided further, That of those funds transferred to this account from the fair share entities to pay the cost of administering the Black Lung Disability Trust Fund, to remain available until expended, for payment of all benefits authorized by section 9501(d)(1)(A), (B), (D), and (E) and (F) of the Internal Revenue Code of 1986, as amended, and for processing claims under title III of the Black Lung Disability Trust Fund Act, to remain available until expended, for payment of all benefits authorized by section 9501(d)(1)(A), (B), (D), and (E) and (F) of the Internal Revenue Code of 1986, as amended, and for processing claims under title III of the Black Lung Disability Trust Fund Act.

SALARIES AND EXPENSES

For necessary expenses for administrative expenses of the Corporation: Provided further, That expenses of such Corporation in connection with the termination of pension plans, post-retirement management, and investment of trust assets, and for benefits administration services shall be considered as non-administrative expenses for the purposes aforesaid, and excluded from the above limitation.

ADVANCES TO THE UNEMPLOYMENT TRUST FUND, AND OTHER FUNDS

For repayable advances to the Unemployment Trust Fund as authorized by sections 905(d) and 1203 of the Social Security Act, as amended, and to the Black Lung Disability Trust Fund as authorized by section 9501(c)(1) of the Internal Revenue Code of 1945, as amended; and for non-repayable advances to the Unemployment Trust Fund as authorized by section 8509 of title 5, United States Code, and to the “Federal unemployment benefits and allowances” account, to remain available until September 30, 2002, $435,000,000.

In addition, for making repayable advances to the Black Lung Disability Trust Fund in the current fiscal year after September 15, 2001, for costs incurred by the Black Lung Disability Trust Fund in the current fiscal year, such sums as may be necessary.

PROGRAM ADMINISTRATION

For expenses of administering employment and training programs, $107,591,000, including $6,431,000 to support up to 75 full-time equivalent staff of the Veterans Administration, $35,000,000 for Federal appointments lasting no more than 1 year, to administer welfare-to-work grants, to-
course tuition fees, otherwise authorized by law to be collected, and may utilize such sums for occupational safety and health training and education grants: Provided, That of the amount appropriated in heading three thereof, not to exceed $750,000 may be collected for training materials, otherwise authorized by law to be collected, to be available for mine safety and health training and education activities, not notwithstanding 31 U.S.C. 3302; and, in addition, the Administration may retain up to $1,000,000 from fees collected for the approval and certification of mine rescue organizations, and for research and exploitations for use in mines, and may utilize such funds for such activities; the Secretary is authorized to accept land, buildings, equipment, and other community property from public or private sources and to prosecute projects in cooperation with other agencies, Federal, State, or private; the Mine Safety and Health Administration is authorized to utilize such funds for education and training in the mining community through cooperative programs with States, industry, and safety associations; and any funds available to the department may be used, with the approval of the Secretary, to provide for the costs of mine rescue and survival operations in the event of a major disaster.

BUREAU OF LABOR STATISTICS

FOR NECESSARY EXPENSES FOR THE BUREAU OF LABOR STATISTICS, INCLUDING ADVANCES OR REIMBURSEMENTS TO STATE, FEDERAL, AND LOCAL AGENCIES AND THEIR EMPLOYEES FOR SERVICES RENDERED, $7,300,000 (

DEPARTMENTAL MANAGEMENT

FOR NECESSARY EXPENSES FOR DEPARTMENTAL MANAGEMENT, INCLUDING THE HIRE OF THREE SEDES, AND INCLUDING THE MANAGEMENT OR OPERATION, THROUGH CONTRACTS, GRANTS OR OTHER ARRANGEMENTS, OF ANY TEMPORARY FEDERAL OR MULTIFEDERAL FOREIGN TECHNICAL ASSISTANCE, OF WHICH THE FUNDS DESIGNATED TO CARRY OUT BILATERAL ASSISTANCE UNDER THE INTERNATIONAL LABOR CHILD LABOR INITIATIVES SHALL BE AVAILABLE FOR OBLIGATION THROUGH SEPTEMBER 30, 2002, $30,000,000 FOR THE ACQUISITION OF DEPARTMENTAL INFORMATION TECHNOLOGY, ARCHITECTURE, INFRASTRUCTURE, EQUIPMENT, SOFTWARE AND RELATED ITEMS, TO BE COLLECTED BY THE DEPARTMENT'S CHIEF INFORMATION OFFICER IN ACCORDANCE WITH THE DEPARTMENT'S CAPITAL INVESTMENT MANAGEMENT SYSTEM AND FEDERAL RULES OF PROCEDURE, PROVIDED, THAT NO FUNDS MADE AVAILABLE BY THIS ACT MAY BE USED BY THE SECRETARY OF LABOR TO PARTICIPATE IN A REVIEW IN ANY UNITED STATES COURT OF APPEALS OF ANY DECISION MADE BY THE BENEFITS REVIEW BOARD UNDER SECTION 21 OF THE LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT (33 U.S.C. 921) WHERE SUCH PARTICIPATION IS PREVENTED BY THE UNITED STATES SUPREME COURT IN DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS VS. NEVADA NEWSPAPER BUILDING, 115 S. CT. 1278 (1955), NOTWITHSTANDING ANY PROVISIONS CONTAINED IN RULE 15 OF THE FEDERAL RULES OF APPELLATE PROCEDURE.

VETERANS EMPLOYMENT AND TRAINING


OFFICE OF INSPECTOR GENERAL

FOR SALARIES AND EXPENSES OF THE OFFICE OF INSPECTOR GENERAL IN CARREER POSITIONS, AS AUTHORIZED BY THE INSPECTOR GENERAL ACT OF 1978, AS AMENDED, $50,015,000, TOGETHER WITH NOT TO EXCEED $4,770,000, WHICH MAY BE EXPENDED FROM THE EMPLOYMENT SECURITY ADMINISTRATION ACCOUNT IN THE UNEMPLOYMENT TRUST FUND, $10,000,000 WHICH SHALL BE AVAILABLE FOR OBLIGATION FOR THE PERIOD JULY 1, 2001, THROUGH JUNE 30, 2002, FOR OCCUPATIONAL EMPLOYMENT STATISTICS.

TRANSFER OF FUNDS

FOR NECESSARY EXPENSES FOR THE OFFICE OF DISABILITY EMPLOYMENT POLICY, (AS ENACTED INTO LAW BY SECTION 1003(a)(4) OF THE JOBS AND HUMAN RESOURCES SECURITY ACT OF 2000 (AS ENACTED INTO LAW BY SECTION 1000(a)(4) OF PUBLIC LAW 106-113) IS AMENDED BY STRIKING “3 YEARS” AND INSERTING “5 YEARS”.

GENERATION SERVICES

FOR NECESSARY EXPENSES FOR THE DEPARTMENT OF LABOR, WHICH MAY BE EXPENDED FROM THE UNEMPLOYMENT TRUST FUND.

For salaries and expenses of the Office of Inspector General in connection with the provisions of 29 U.S.C. 9a, pertaining to the approval of the Secretary, to provide for the payment of expenses of obtaining a review in the United States courts of appeals: Provided further, That these appropriations shall not be applicable to the review of any former decision under the Social Security Act (42 U.S.C. 4101 et seq.) provided that, the beneficiaries of any such decision shall be available for obligation by the Secretary of Labor an office of disability employment policy through cooperative programs with States, industry, and safety associations; and any funds available to the department may be used, with the approval of the Secretary, to provide for the costs of mine rescue and survival operations in the event of a major disaster.

BUREAU OF LABOR STATISTICS

SALARIES AND EXPENSES

FOR NECESSARY EXPENSES FOR THE BUREAU OF LABOR STATISTICS, INCLUDING ADVANCES OR REIMBURSEMENTS TO STATE, FEDERAL, AND LOCAL AGENCIES AND THEIR EMPLOYEES FOR SERVICES RENDERED, $7,300,000 ($369,327,000, together with not to exceed $7,257,000, which may be expended from the Employment Security Administration account in the Unemployment Trust Fund; and $10,000,000 which shall be available for obligation for the period July 1, 2001, through June 30, 2002, for Occupational Employment Statistics.

DEPARTMENTAL MANAGEMENT

SALARIES AND EXPENSES

FOR NECESSARY EXPENSES FOR DEPARTMENTAL MANAGEMENT, INCLUDING THE HIRE OF THREE SEDES, AND INCLUDING THE MANAGEMENT OR OPERATION, THROUGH CONTRACTS, GRANTS OR OTHER ARRANGEMENTS, OF ANY TEMPORARY FEDERAL OR MULTIFEDERAL FOREIGN TECHNICAL ASSISTANCE, OF WHICH THE FUNDS DESIGNATED TO CARRY OUT BILATERAL ASSISTANCE UNDER THE INTERNATIONAL LABOR CHILD LABOR INITIATIVES SHALL BE AVAILABLE FOR OBLIGATION THROUGH SEPTEMBER 30, 2002, $30,000,000 FOR THE ACQUISITION OF DEPARTMENTAL INFORMATION TECHNOLOGY, ARCHITECTURE, INFRASTRUCTURE, EQUIPMENT, SOFTWARE AND RELATED ITEMS, TO BE COLLECTED BY THE DEPARTMENT'S CHIEF INFORMATION OFFICER IN ACCORDANCE WITH THE DEPARTMENT'S CAPITAL INVESTMENT MANAGEMENT SYSTEM AND FEDERAL RULES OF APPELLATE PROCEDURE, PROVIDED, THAT NO FUNDS MADE AVAILABLE BY THIS ACT MAY BE USED BY THE SECRETARY OF LABOR TO PARTICIPATE IN A REVIEW IN ANY UNITED STATES COURT OF APPEALS OF ANY DECISION MADE BY THE BENEFITS REVIEW BOARD UNDER SECTION 21 OF THE LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT (33 U.S.C. 921) WHERE SUCH PARTICIPATION IS PREVENTED BY THE UNITED STATES SUPREME COURT IN DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS VS. NEVADA NEWSPAPER BUILDING, 115 S. CT. 1278 (1955), NOTWITHSTANDING ANY PROVISIONS CONTAINED IN RULE 15 OF THE FEDERAL RULES OF APPELLATE PROCEDURE.

SEC. 101. none of the funds appropriated in this title for the Job Corps shall be used to pay the compensation of an individual, either as direct costs or any proration as an indirect cost, at a rate in excess of Executive Level II.

SEC. 102. NOT TO EXCEED 1 PERCENT OF ANY DISCRETIONARY FUNDS (Pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended) WHICH ARE APPROPRIATED FOR THE CURRENT FISCAL YEAR FOR THE DEPARTMENT OF LABOR IN THIS ACT MAY BE TRANSFERRED BETWEEN APPROPRIATIONS, BUT NO SUCH APPROPRIATION SHALL BE INCREASED BY MORE THAN 3 PERCENT BY ANY SUCH TRANSFER.

General provisions

SEC. 103. EXTENDED DEADLINE FOR EXPENDITURE OF FUNDS: Section 7(b)(5) of the Social Security Act (42 U.S.C. 602(a)(5)(C)(vi)) (as amended by section 806(b) of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2000 (as enacted into law by section 1000(a)(4) of Public Law 106-113) is amended by striking “3 years” and inserting “5 years”.

b) CONFORMING AMENDMENTS.—The Social Security Act (as amended by section 806(b) of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2000 (as enacted into law by section 1000(a)(4) of Public Law 106-113) is further amended as follows:

(1) Section 403(a)(5)(E) (42 U.S.C. 602(a)(5)(E)) is amended by striking “subparagraph (I)” and inserting “subparagraph (H)”.

(2) Subclause (I) of each of subparagraphs (A)(iv) and (B)(v) of section 603(a)(5) (42 U.S.C. 602(a)(5)(A)(iv) and (B)(v)) is amended—

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(A) in item (aa)—
(i) by striking ‘‘(I)’’ and inserting ‘‘(H)’’; and
(ii) by striking ‘‘(G)’’ and ‘‘(H)’’ and inserting ‘‘(G)’’;
and
(B) in item (bb), by striking ‘‘(F)’’ and inserting
‘‘(E)’’.

(3) Section 403(a)(5)(B)(e) (42 U.S.C. 603(a)(5)(B)(e)) is redesignated in the preceding subclause (I) by striking ‘‘(D)’’ and inserting ‘‘(H)’’.

(4) Subparagraphs (E), (F), and (G)(i) of section 403(a)(5)(B)(v) (42 U.S.C. 603(a)(5)(B)(v)) as redesignated by subsection (a) of this section, are each amended by striking ‘‘(D)’’ and inserting ‘‘(H)’’.


(c) FUNDING AMENDMENT.—Section 403(a)(5)(H)(i) of such Act (42 U.S.C. 603(a)(5)(H)(i)) as redesignated by subsection (a) of this section and as amended by section 806(b) of the Departments of Labor, Health and Human Services, and Education, and the Native Hawaiian Health Act of 1988, as amended by striking ‘‘$1,450,000,000’’ and inserting ‘‘$1,000,000,000’’.

(d) EFFECTIVE DATE.—The amendments made by this Act may be used by the Occupational Safety and Health Administration to promulgate, issue, adopt, administer, or enforce any proposed, temporary, or final standard on ergonomics.

TITLE II—DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICES ADMINISTRATION

HEALTH RESOURCES AND SERVICES

For carrying out titles II, III, VII, VIII, X, XII, XIX, and XXVI of the Public Health Service Act, and the Federal Medical Care Improvement Act of 1988, as amended, $4,572,424,000, of which $150,000 shall remain available until expended for interest subsidies on loan guarantees made pursuant to the Medicare rural hospital flexibility grants program under section 1820 of such Act, and of which $4,000,000 shall be provided to the Rural Health Outreach Office of the Health Resources and Services Administration for the awarding of grants to community partnerships in rural areas for the purchase of automated external defibrillators and the training of individuals in basic cardiac life support: Provided, That the Division of Occupational Health will utilize personal services contracting to employ professional management/administrative and occupational health professionals: Provided further, That of the funds made available under this heading, $250,000 shall be available until expended for facilities renovations at the Gillis W. Long Hansen’s Disease Center: Provided further, That in addition to fees authorized by section 427(b) of the Health Care Quality Improvement Act of 1986, fees shall be collected for the full disclosure of information under the Act sufficient to cover the costs of operating the National Practitioner Data Bank, and shall remain available until expended to carry out that Act: Provided further, That fees collected for the full disclosure of information under the Act to prevent health care fraud and abuse data collection program, authorized by section 221 of the Health Insurance Portability and Accountability Act of 1996, shall be sufficient to recover the full costs of operating the Program, and shall remain available to carry out that Act until expended: Provided further, That of the funds made available under this heading, $253,932,000 shall be available for carrying out the provisions of Public Law 104–73: Provided further, That none of the funds made available under this heading shall be available from amounts available under section 241 of the Public Health Service Act: Provided further, That none of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used to advocate or promote gun control: Provided further, That the Director may request that the Secretary of the Treasury, under the Act to the Public Law 101–502, section 3, dated November 3, 1990, to activities the Director may so designate: Provided further, That the Congress is to be notified promptly of any such transfer: Provided further, That not to exceed $10,000,000 may be available for making grants under section 1509 of the Public Health Service Act to not more than 15 States: Provided further, That notwithstanding any other provision of law, a single contract or related contracts for development and construction of facilities may be employed with the exceptively interest of the future of the project: Provided further, That the solicitation and contract shall contain the clause ‘‘availability of funds’’ found at 48 CPR 52.223-18: Provided further, That amounts provided to said projects shall be available under this heading for the National Program of Cancer Registries, an additional $5,000,000 shall be made available for such program and specified emphasis is made on the following grants: Each such grant shall be given to States with the highest number of the leading causes of cancer mortality: Provided further, That amounts made available under this Act for administrative and related expenses of the Centers for Disease Control and Prevention shall be reduced by $5,000,000: Provided further, That the funds made available under this heading, and which collectively include the full scope of the National Program of Cancer Registries, shall be used to carry out children’s asthma programs and grants authorized by section 317A of the Public Health Service Act may be made available for programs operated in accordance with a strategy (developed and implemented by the Director for the Centers for Disease Control and Prevention) to identify and target resources for childhood lead poisoning prevention to high-risk populations, including ensuring that any individual or entity of a single contract under this Act for the administrative and related expenses of the Centers for Disease Control and Prevention shall receive a grant under that section to carry out activities relating to childhood lead poisoning prevention, and may use a portion of the grant funds awarded for the purpose of funding screening assessments and referrals at sites of operation of the Early Head Start programs under the Head Start Act.

NATIONAL INSTITUTES OF HEALTH

NATIONAL CANCER INSTITUTE

For carrying out section 301 and title IV of the Public Health Service Act with respect to cancer, $3,804,884,000.

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

For carrying out section 301 and title IV of the Public Health Service Act with respect to cardiovascular, lung, and blood diseases, and blood and blood product supplies, $3,009,923,000.

NATIONAL INSTITUTE OF DENTAL AND CRANIOFACIAL RESEARCH

For carrying out section 301 and title IV of the Public Health Service Act with respect to dental research, $3,181,106,000.

NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES

For carrying out section 301 and title IV of the Public Health Service Act with respect to diabetes and digestive and kidney diseases, $1,189,425,000.
For carrying out sections 301 and 311 and title IV of the Public Health Service Act with respect to children’s health and human development, $303,541,000.

For carrying out sections 301 and 311 and title IV of the Public Health Service Act with respect to allergy and infectious diseases, $1,177,928,000.

For carrying out sections 301 and 311 and title IV of the Public Health Service Act with respect to mental health, $2,730,757,000, of which $15,000,000 shall remain available until expended.

For carrying out sections 301 and 311 and title IV of the Public Health Service Act with respect to the neuroscience research center, $48,900,000, to remain available until expended, of which $47,300,000 shall be for the neuroscience research center.

For carrying out the responsibilities of the Office of the Director, National Institutes of Health, $322,165,000, of which $18,271,000 shall be transferred from title II of the Public Health Service Act. Provided further, That funding shall be available for the purchase of not to exceed 20 passenger motor vehicles for replacement only. Provided further, That the Director may determine the total amount made available in this or any other Act to all National Institutes of Health appropriation activities the Director may so designate. Provided further, That no such appropriation shall be decreased by more than 1 percent by any such transfers and that the Congress is promptly notified of the transfer.

For making payments to States or in the case of section 217(g) and 1844 of the Social Security Act, $93,586,251,000, to remain available until expended.

For making payments to States under title XIX of the Social Security Act for the last quarter of fiscal year 2001 for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

For making payments to States under title XIX of the Social Security Act for the last quarter of fiscal year 2001 under section 1902 of the Social Security Act, $47,300,000, to be transferred from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds for fiscal year 2002, $302,547,170, to remain available until expended.

For making payments to States under title XIX of the Social Security Act, $7,189,500,000, to be transferred from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, for fiscal year 2002, $302,547,170, to remain available until expended.

For carrying out the purposes of this appropriation: Provided further, That no such appropriation shall be decreased by more than 1 percent by any such transfers and that the Congress is promptly notified of the transfer. Provided further, That, notwithstanding any other provision of law, a single contract or related contracts for the development and construction of the National Neuroscience Research Center may be employed which collectively include the full scope of the project. Provided further, That the solicitation of offers for the contract or contracts shall include a clause "availability of funds" found at 40 CFR 52.232-18.

For carrying out the purposes of this appropriation: Provided further, That all funds derived in accordance with 31 U.S.C. 7071 from organizations established under title XIII of the Public Health Service Act shall be available for carrying out the purposes of this appropriation. Provided further, That, $18,000,000 appropriated under this heading for the managed care system redesign shall remain available until expended. Provided further, That the Secretary of Health and Human Services is directed to collect fees in fiscal year 2001 from Medicare-Choice organizations to support through the Medicare-Aided Program for the redesign of the managed care system $200,000,000 of which $78,000,000 shall be for the Office of AIDS Research: Provided, That the amount made available pursuant to section 295(b) of the Public Health Service Act shall not exceed $269,943,000.

For carrying out the purposes of this appropriation: Provided further, That the amount made available pursuant to section 295(b) of the Public Health Service Act shall not exceed $269,943,000.

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For carrying out the purposes of this appropriation: Provided further, That the amount made available pursuant to section 295(b) of the Public Health Service Act shall not exceed $269,943,000.
For making payments under title XXVI of the Omnibus Reconciliation Act of 1981, $200,000,000: Provided, That these funds are hereby determined to be Congress-required emergency requirements pursuant to section 251(b)(2)(A) of the Balanced Budget and Emergency Deficit Control Act of 1985. Provided further, That these funds shall be made available only after submission to the Congress of a formal budget request by the President that includes designation of the entire amount of the request as an emergency requirement as defined in such Act.

For making payments for refugee and entrant assistance activities authorized by title IV of the Immigration and Nationality Act and section 301 of the Refugee Assistance Act of 1980 (Public Law 96–422), $418,321,000, to remain available until September 30, 2003.

For carrying out section 3 of the Torture Victims Relief Act of 1998 (Public Law 105–229), $3,265,000.

PAYMENTS TO STATES FOR CHILD SUPPORT ENFORCEMENT AND FAMILY SUPPORT PROGRAMS

For making payments to States or other non-Federal entities under titles I, IV–D, X, XI, XIV, and XVI of the Social Security Act and the Act of July 5, 1960 (24 U.S.C. ch. 9), $2,473,880,000, to remain available until expended; purposes for the first quarter of fiscal year 2002, $1,000,000,000, to remain available until expended.

For making payments to each State for carrying out the program of Aid to Families with Dependent Children under title IV–A of the Social Security Act before the effective date of the program of Temporary Assistance to Needy Families (TANF) with respect to such State, such sums as may be necessary: Provided, That the sum of the amounts available to a State with respect to expenditures under such title IV–A in fiscal year 2000 for such purposes shall not exceed for purposes for the first quarter of fiscal year 2002, $1,000,000,000, to remain available until expended.

For making payments to each State for carrying out the program of grants to States for the Community Services Block Grant Act, section 473A of the Social Security Act, and title IV of Public Law 105–265; and for necessary administrative expenses to carry out such Acts and titles I, IV, X, XI, XIV, XVI, and XX of the Social Security Act, the Act of July 5, 1960 (24 U.S.C. ch. 9), the Omnibus Budget Reconciliation Act of 1981, title IV of the Community Health and Human Services Act, section 501 of the Refugee Education Assistance Act of 1980, section 251(b) of title IV of the Social Security Act, and section 473A of title IV of the Social Security Act, and title IV of Public Law 105–265, and for necessary administrative expenses to carry out such Acts and titles I, IV, X, XI, XIV, XVI, and XX of the Social Security Act, $4,868,100,000.

SOCIAL SERVICES BLOCK GRANT

For making grants to States pursuant to section 2002 of the Social Security Act, $600,000,000: Provided, That notwithstanding section 2003(c) of such Act, funds allocated and amounts specified for allocation under such section for fiscal year 2001 shall be $600,000,000.

CHILDREN AND FAMILIES SERVICES PROGRAMS

For carrying out, except as otherwise provided, the Runaway and Homeless Youth Act, the Developmental Disabilities Assistance and Bill of Rights Act, the Child Abuse Prevention and Treatment Act, the Native American Programs Act of 1974, title II of Public Law 95–266 (adoption opportunities), the Adoption Assistance and Child Welfare Act of 1980 (Public Law 105–89), the Abandoned Infants Assistance Act of 1988, part B(I) of title IV and sections 413, 429A, 4110, and 1119 of the Social Security Act; for making payments under the Community Services Block Grant Act, section 473A of the Social Security Act, and title IV of Public Law 105–265; and for necessary administrative expenses to carry out such Acts and titles I, IV, X, XI, XIV, XVI, and XX of the Social Security Act, the Act of July 5, 1960 (24 U.S.C. ch. 9), the Omnibus Budget Reconciliation Act of 1981, title IV of the Community Health and Human Services Act, section 501 of the Refugee Education Assistance Act of 1980, section 251(b) of title IV of the Social Security Act, and section 473A of title IV of the Social Security Act, $4,868,100,000.

PROMOTING SAFE AND STABLE FAMILIES


For making payments under the Community Services Block Grant Act, and of which $5,000,000 shall be made available to provide grants for early childhood learning for young children, of which $5,528,000, to remain available until September 30, 2002, shall be for grants to States for adoption incentive payments, as authorized by section 473A of title IV of the Social Security Act (42 U.S.C. 670–679); of which $134,074,000, to remain available until expended, shall be for administrative expenses to carry out the Community Services Block Grant Act; and of which $966,676,000 shall be for making payments under the Community Services Block Grant Act; and of which $8,267,000,000 shall be for making payments under the Head Start Act, of which $1,400,000,000 shall become available October 1, 2001, and remain available until September 30, 2002: Provided, That to the extent Community Services Block Grant funds are distributed as grant funds by a State to an eligible entity as provided under this Act, and such entity has been designated under such Act as a lead entity, such entity shall remain with such entity for carryover into the next fiscal year for expenditure for such purposes; and for making payments under this Act, $954,619,000, of which $5,000,000 shall be used by the Secretary to carry out the provisions of section 201(g)(4) of such Act.

For making payments to States or other non-Federal entities under titles I, III, VII, and XX of the Public Health Service Act, and the United States-Mexico Border Health Commission Act, $206,766,000, together with $5,651,000, to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Hospital Insurance Trust Fund and the Supplemental Medical Insurance Trust Fund; Provided further, That any grants made pursuant to this Act for making payments under title XX of the Public Health Service Act, $10,569,000 shall be for activities specified under section 2003(b)(2), of which $9,132,000 shall be for purposes of expanding services under the Social Security Act, for the first quarter of fiscal year 2000 under section 201(c) of title XX of the Social Security Act, as amended, without any limitation as to the use of such funds.

OFFICE OF INSPECTOR GENERAL


OFFICE FOR CIVIL RIGHTS

For expenses necessary for the Office for Civil Rights, $20,742,000, together with not to exceed $3,314,000, to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Hospital Insurance Trust Fund and the Supplemental Medical Insurance Trust Fund; Provided, That an additional $2,500,000 shall be made available for the Office for Civil Rights: Provided further, That any expenses made available under this title shall be specifically set aside for programs for persons with disabilities.

RETRIEVAL AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

For retirement pay and medical benefits of Public Health Service Commissioned Officers as authorized by law, for payments under the Retired Servicemen’s Family Protection Plan and Survivor Benefit Plan, for medical care of dependents, for veterans, and for the Dependants’ Medical Care Act (10 U.S.C. ch. 55), and for payments pursuant to section 229(b) of
the Social Security Act (42 U.S.C. 429(b)), such amounts as may be required during the current fiscal year.

**PUBLIC HEALTH AND SOCIAL SERVICES**

**EMERGENCY FUND**

For public health and social services, $264,600,000.

**GENERAL PROVISIONS**

SEC. 201. Funds appropriated in this title shall be available for not to exceed $37,000 for official representation and reception expenses when specifically approved by the Secretary.

SEC. 202. The Secretary shall make available through assignment not more than 60 employees of the Public Health Service to assist in child survival and health programs through and with funds provided by the Agency for International Development, the United Nations International Children’s Emergency Fund or the World Health Organization.

SEC. 203. None of the funds appropriated under this Act may be used to implement section 399L(b) of the Public Health Service Act or section 1903 of the National Institutes of Health Revitalization Act of 1993, Public Law 103-43.

SEC. 204. None of the funds appropriated in this Act for the National Institutes of Health and the Public Health Service Mental Health Services Administration shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II.

SEC. 205. Notwithstanding section 241(a) of the Public Health Service Act, such portion as the Secretary shall determine, but not more than 1.5 percent, of any amounts appropriated for programs authorized under the PHS Act shall be made available for the evaluation (directly or by grants or contracts) of the implementation and effectiveness of such programs.

**TRANSFER OF FUNDS**

SEC. 206. Not to exceed 1 percent of any discretionary funds (pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99–177), to the extent such funds, in accordance with subsection (b), to enhance the timing of the State obligation of the applicable amount for a State shall not exceed the applicable amount for a State as of September 30, 1998.)

SEC. 207. The Director of the National Institutes of Health, jointly with the Director of the Office of AIDS Research, may make awards and contracts to that extent such funds, in accordance with the applicable amount for a State as of September 30, 1998.)

SEC. 208. Of the amounts made available in this Act for the National Institutes of Health, the amount for research related to the human immunodeficiency virus, as jointly determined by the Director of the Public Health Service, the Director of the Office of AIDS Research, shall be made available to the “Office of AIDS Research” account. The Director of the Office of AIDS Research shall transfer such funds to the National Institutes of Health.

SEC. 209. None of the funds appropriated in this Act may be used to reimburse costs of providing medical care for services provided in connection with services provided by the Secretary of the Treasury or any other Federal or local government agency.

**SEC. 211.** (a) **MENTAL HEALTH.**—Section 191(b) of the Public Health Service Act (42 U.S.C. 740a-7) is amended to read as follows:

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(b) **MINIMUM ALLOCATIONS FOR STATES.**—
Each State’s allotment for fiscal year 2001 for programs under this subpart shall not be less than such State’s allotment for such programs for fiscal year 2000.
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SEC. 212. The Secretary, in carrying out the provisions of this Act, shall make available to the “Office of the Public Health Service” the amount for research related to the human immunodeficiency virus, as jointly determined by the Office of AIDS Research and the Director of the Office of AIDS Research.

SEC. 213. **EXTENSION OF CERTAIN ADDENDUM PROVISIONS.—**The Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1990 (Public Law 101-167) is amended—

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(2) in subsection (e), by striking “October 1, 2000” and inserting “October 1, 2001”; and
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SEC. 214. None of the funds provided in this Act or any other Act making appropriations for fiscal year 2001 may be used to purchase any drug, device, or biological product or for the performance of any service under title X of the Public Health Service Act or in any other Act making appropriations for fiscal year 2000.

SEC. 215. **WITHHOLDING OF SUBSTANCE ABUSE FUNDS.** (a) **IN GENERAL.** Except as provided by paragraph (b), none of the funds appropriated by this Act may be used to withhold substance abuse funds from a State pursuant to section 201(c) of the Public Health Service Act (42 U.S.C. 740a–7).

SEC. 216. Section 403(a)(3) of the Social Security Act (42 U.S.C. 602(a)(3)) is amended to read as follows:

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(2) in subparagraph (B), by inserting at the end “and”;
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SEC. 217. (a) **NOTWITHSTANDING SECTION 210(f)(3) OF THE SOCIAL SECURITY ACT (THE ACT), THE SECRETARY OF HEALTH AND HUMAN SERVICES SHALL**—

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(b) **AMOUNT OF STATE FUNDS.**—The amount of State funds, in accordance with subsection (b), for fiscal year 2001 shall not be less than such State’s allotment for such programs for fiscal year 2000.
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SEC. 218. **SENSE OF THE SENATE ON PREVENTION OF NEEDLESTICK INJURIES.** (a) **FINDINGS.**—The Senate finds that—

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(1) the Centers for Disease Control and Prevention reports that American health care workers report 600,000 to 800,000 needlestick injuries each year;
(2) the occurrence of needlestick injuries is believed to be widely under-reported;
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(3) needlestick and sharps injuries result in at least 1,000 new cases of health care workers with HIV, hepatitis C or hepatitis B every year; (4) more than 80 percent of needlestick injuries can be prevented through the use of safer devices; and (5) the Occupational Safety and Health Administration’s November 1999 Compliance Directive has improved the duty of employers to use safer needle devices to protect their workers. However, millions of State and local government employees are not covered by OSHA’s bloodborne pathogen standards and are not protected against the hazards of needlesticks.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the Secretary should provide technical assistance to persons who request such assistance and to the extent feasible to provide training to employers, employees, and other persons when they are evaluating and selecting needleless systems and sharps with engineered sharps injury protections.

(2) develop a model training curriculum to train employers, employees, and other persons on the evaluation of needleless systems and sharps with engineered sharps injury protections.

(3) establish and maintain a national database on existing needleless systems and sharps with engineered sharps injury protections;

(4) develop a model training curriculum to train employers, employees, and other persons on the evaluation of needleless systems and sharps with engineered sharps injury protections.

(5) provide training on the feasibility of providing technical assistance to persons who request such assistance; and

(6) develop a national system to collect comprehensive data on needlestick injuries to health care workers, including data on mechanisms to analyze and evaluate prevention interventions in relation to needlestick injury occurrence.

(b) In this section:

(1) EMPLOYER.—The term “employer” means each employer having an employee with occupational exposure to human blood or other material potentially containing bloodborne pathogens.

(2) ENGINEERED SHARPS INJURY PROTECTIONS.—The term “engineered sharps injury protections” means—

(A) a physical attribute built into a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, that effectively reduces the risk of an exposure incident by a mechanism such as barrier creation, blunting, encapsulation, withdrawal, sheath, retraction, destruction, or other effective mechanisms; or

(B) a physical attribute built into any other type of needle device, or into a nonneedle sharp, which effectively reduces the risk of an exposure incident.

(3) NEEDLELESS SYSTEM.—The term “needleless system” means a device that does not use needles.

(A) the withdrawal of body fluids after initial venous or arterial access is established;

(B) the administration of medication or fluids; and

(C) any other procedure involving the potential for an exposure incident.

(4) SHARP.—The term “sharp” means any object used or encountered in a health care setting that can be reasonably anticipated to penetrate the skin or any other part of the body, and to result in an exposure incident, including, but not limited to, needle devices, scalpels, lancets, broken glass, broken capillary tubes, exposed ends of dental wires and dental knives, drills, and bone cutters.

(5) SHARPS INJURY.—The term “sharps injury” means any injury caused by a sharp, including cuts, abrasions, or needlesticks.

(c) Amendments made under this Act for the travel, consulting, and printing services for the Department of Labor, the Department of Health and Human Services, and the Department of Education shall be reduced on a pro rata basis by $10,000,000.

SEC. 220. None of the funds made available under this Act shall be available to any entity under the Public Health Service Act after September 1, 2001, unless the Director of the National Institutes of Health has provided to the Committee on Appropriations of the Senate, the Committee on Appropriations, and the Health, Education, Labor, and Pensions a proposal to require a reasonable rate of return on both intramural and extramural research by March 31, 2001.

SEC. 221. (a) STUDY.—The Secretary of Health and Human Services shall conduct a study to examine—

(1) the experiences of hospitals in the United States in obtaining reimbursement for foreign health insurance companies whose enrollees receive medical treatment in the United States;

(2) the identity of the foreign health insurance companies that do not cooperate with or reimburse (in whole or in part) United States health care providers for medical services rendered in the United States to enrollees who are foreign nationals;

(b) REPORT.—Not later than March 31, 2001, the Secretary of Health and Human Services shall prepare an interim report on the Committee on Appropriations, and the Health, Education, Labor, and Pensions of the Senate and the Committee on Appropriations, a report concerning the results of the study conducted under subsection (a), including the recommendations described in paragraph (4) of such subsection.

SEC. 222. NATIONAL INSTITUTE OF CHILD HEALTH AND Human Development. Section 448 of the Public Health Service Act (42 U.S.C. 2850) is amended by inserting “gynecologic health,” after “with respect to”.

SEC. 223. In addition to amounts otherwise appropriated under this title for the Centers for Disease Control and Prevention, $35,500,000, to be utilized to provide grants to States and political subdivisions of States under section 317 of the Public Health Service Act to enable such States and political subdivisions to carry out immunization infrastructure and operations activities.

SEC. 224. None of the funds made available in this Act for infrastructure funding for the Centers for Disease Control and Prevention, not less than 10 percent shall be used for programs with immunization or declination immunization rates or areas that are particularly susceptible to disease outbreaks, and not more than 14 percent shall be used to carry out the incentive bonus programs: Provided, That amounts made available under this Act shall be expended by the National Institutes of Health on a contract for the care of the 288 chimpanzees acquired by the National Institutes of Health from the Coulston Corporation, unless the contractor is accredited by the Association for the Assessment and Accreditation of Laboratory Animal Care International or has a Public Health Services assurance, and has not been charged multiple times with egregious violations of the Animal Welfare Act.

SEC. 225. (a) In addition to amounts made available under the heading “Health Resources and Services Administration-Health Resources and Services for poison prevention and poison control centers”, there shall be made available $30,000,000 to provide assistance for such activities and to stabilize the funding of regional poison control centers as provided for pursuant to the Poison Control Center Enhancement and Awareness Act (Public Law 106– 174).

(b) Amounts made available under this Act for the administrative and related expenses of the Department of Health and Human Services, the Department of Labor, and the Department of Education shall be further reduced on a pro rata basis by $20,000,000.

SEC. 226. SENSE OF THE SENATE REGARDING THE IMPORTANCE OF EMERGENCY MEDICAL SERVICES. (a) FINDINGS.—The Senate finds the following:

(1) Several States have developed and implemented a unique 2-tiered emergency medical services system that effectively provides services to the residents of those States.

(2) These 2-tiered systems include volunteer and for-profit emergency medical technicians who provide basic life support and hospital-based paramedics who provide advanced life support.

(3) These 2-tiered systems have provided universal access for residents of those States to affordable emergency services, while simultaneously controlling the cost of the most advanced care receive such care from the public authorities.

(4) One State’s 2-tiered system currently has an estimated 20,000 emergency medical technicians providing ambulance transportation for basic life support and advanced life support emergency services, over 80 percent of which are handled by centers who are reimbursed under the medicare program under title XVIII of the Social Security Act.

The hospital-based paramedics, also known as mobile intensive care units, are reimbursed under the medicare program when they respond to advanced life support emergencies. The 2-tiered systems save the lives of thousands of residents of those States each year, while saving the medicare program, in some instances, as much as $39,000,000 in reimbursement fees.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that the Health Care Financing Administration enact changes to the emergency medical services fee schedule as a result of the Balanced Budget Act of 1997, including a general overhaul of reimbursement rates and administrative costs, as was intended by the Balanced Budget Act of 1997.

(c) The Health Care Financing Administration is considering implementing emergency medical services reimbursement guidelines that may destabilize the 2-tier system that has developed in these States.

(d) SENSE OF THE SENATE.—It is the sense of the Senate that the Health Care Financing Administration should—

(1) consider the unique nature of 2-tiered emergency medical services delivery systems when implementing new reimbursement guidelines for paramedics and hospitals under the medicare program under title XVIII of the Social Security Act; and

(2) promote innovative emergency medical services systems enacted by States that reduce reimbursement costs to the medicare program while ensuring that all residents receive quick and appropriate emergency care when needed.

SEC. 227. SENSE OF THE SENATE REGARDING IMPACTS OF THE BALANCED BUDGET ACT OF 1997. (a) FINDINGS.—The Senate makes the following findings:

Since its passage in 1997, the Balanced Budget Act of 1997 has drastically cut payments under the medicare program under title XVIII of the Social Security Act in the areas of hospital, physician, and other payments.

(b) AMENDMENTS.—The Senate recommends that Congress consider the following amendments:

(1) State health systems save the lives of thousands of residents of those States each year, while saving the medicare program, in some instances, as much as $39,000,000 in reimbursement fees.

(2) These 2-tiered systems have provided universal access for residents of those States to affordable emergency services, while simultaneously controlling the cost of the most advanced care receive such care from the public authorities.

(3) These 2-tiered systems have provided universal access for residents of those States to affordable emergency services, while simultaneously controlling the cost of the most advanced care receive such care from the public authorities.

(4) These 2-tiered systems have provided universal access for residents of those States to affordable emergency services, while simultaneously controlling the cost of the most advanced care receive such care from the public authorities.
planners surveyed a greater difficulty obtaining home health services for medicare beneficiaries as a result of the Balanced Budget Act of 1997.

(3) In accordance to the Medicare Payment Advisory Commission, rural hospitals were disproportionately affected by the Balanced Budget Act of 1997, dropping an inpatient margin of such hospitals by a percentage points in 1996.

(b) SENSE OF SENATE.—It is the sense of the Senate that Congress and the President should act expeditiously to the adverse impacts of the Balanced Budget Act of 1997 on beneficiaries under the medicare program under title XVIII of the Social Security Act and health care planning in such program.

TITLE III—DEPARTMENT OF EDUCATION

OFFICE OF ELEMENTARY AND SECONDARY EDUCATION

EDUCATION REFORM

For carrying out activities authorized by title IV of the Goals 2000: Educate America Act as in effect prior to September 30, 2000, and sections 3122, 3123, 3136, and 3141, parts B, C, and D of title III, and part I of title X of the Elementary and Secondary Education Act of 1965, $1,434,500,000, of which $40,000,000 shall be for the Goals 2000: Educate America Act, and of which $1,394,500,000 shall be for section 3122, except as otherwise provided in this Act: Provided, That $7,113,403,000 shall be available for basic support payments under section 611(a)(1)(B), $50,000,000 shall be for payments for children with disabilities under section 611(b)(5), $82,000,000, to remain available until expended, shall be available under section 611(c), $35,000,000 shall be for construction under section 617, $47,000,000 shall be for Federal property payments under section 612 and $2,464,452,000 shall become available for obligations under section 607, to be used for competitive grants to local educational agencies that experience a reduction in funding under the program for fiscal year 2001 as a result of the application of the 100 percent hold harmless provisions under the heading "Grants for the Disadvantaged"; Provided further, That the Secretary shall not take into account the hold harmless provisions in this section in calculating reduction in funding under any other program administered by the Secretary in any fiscal year.

IMPACT AID

For carrying out programs of financial assistance to federally affected schools authorized by title VIII of the Elementary and Secondary Education Act of 1965, $130,000,000,000, of which $181,000,000 shall be for basic support payments under section 611(a)(1)(B), $50,000,000 shall be for payments for children with disabilities under section 611(b)(5), $82,000,000, to remain available until expended, shall be available under section 611(c), $35,000,000 shall be for construction under section 617, $47,000,000 shall be for Federal property payments under section 612 and $2,464,452,000 shall become available for obligations under section 607, to be used for competitive grants to local educational agencies that experience a reduction in funding under the program for fiscal year 2001 as a result of the application of the 100 percent hold harmless provisions under the heading "Grants for the Disadvantaged"; Provided further, That the Secretary shall not take into account the hold harmless provisions in this section in calculating reduction in funding under any other program administered by the Secretary in any fiscal year.

For carrying out school improvement activities authorized by titles II, IV, V–A and B, VI, IX, X, and XIII of the Elementary and Secondary Education Act of 1965, and part C of title I of the Elementary and Secondary Education Act of 1965, $91,000,000, which shall be available for education reform projects that provide gender-segregated programs, consistent with applicable law; Provided further, That the amount made available under this heading for activities carried out through the Fund for the Improvement of Education under part A of title X, $19,000,000 shall be made available to enable the Secretary of Education to award grants to develop and implement school dropout prevention programs.

READING EXCELLENCE

For necessary expenses to carry out the Reading Excellence Act, $3,000,000,000, which shall become available on July 1, 2001 and shall remain available through September 30, 2002 and $395,000,000 shall be available on October 1, 2001 and shall remain available through September 30, 2002.

OFFICE OF BILINGUAL EDUCATION AND MINORITY LANGUAGES

BILINGUAL AND IMMIGRANT EDUCATION

For carrying out the Individual with Disabilities Education Act, $7,352,341,000, of which $2,464,452,000 shall become available for obligations under section 311(a)(1)(B) of the Individuals with Disabilities Education Act (20 U.S.C. 1411 et seq.); or for school construction and renovation of facilities, at the sole discretion of the local educational agency; Provided further, That for expenses necessary to carry out section 310(b) of the Elementary and Secondary Education Act of 1965 shall be available for education reform projects that provide gender-segregated programs, consistent with applicable law; Provided further, That the amount made available under this heading for activities carried out through the Fund for the Improvement of Education under part A of title X, $19,000,000 shall be made available to enable the Secretary of Education to award grants to develop and implement school dropout prevention programs.

SPECIAL EDUCATION

For carrying out the Individuals with Disabilities Education Act, $7,352,341,000, of which $2,464,452,000 shall become available for obligations under section 311(a)(1)(B) of the Individuals with Disabilities Education Act (20 U.S.C. 1411 et seq.); or for school construction and renovation of facilities, at the sole discretion of the local educational agency; Provided further, That for expenses necessary to carry out section 310(b) of the Elementary and Secondary Education Act of 1965 shall be available for education reform projects that provide gender-segregated programs, consistent with applicable law; Provided further, That the amount made available under this heading for activities carried out through the Fund for the Improvement of Education under part A of title X, $19,000,000 shall be made available to enable the Secretary of Education to award grants to develop and implement school dropout prevention programs.
For carrying out the Act of March 3, 1879, as amended (20 U.S.C. 101 et seq.), $12,500,000.

NATIONAL INSTITUTE FOR THE DEAF

For the National Technical Institute for the Deaf under titles I and II of the Education of the Deaf Act of 1986 (20 U.S.C. 401 et seq.), $54,366,000, of which $7,176,000 shall be for construction and shall remain available until expended: Provided, That from the total amount available, the Institute may at its discretion use funds for the endowment program as authorized under section 207.

GALLAUDET UNIVERSITY

For the Kendall Demonstration Elementary School, the Model Secondary School for the Deaf, and the partial support of Gallaudet University under titles I and II of the Education of the Deaf Act of 1986 (20 U.S.C. 401 et seq.), $47,650,000: Provided, That from the total amount available, the amounts made available for the Carl D. Perkins Vocational and Technical Education Act, the Adult Education and Family Literacy Act, and title VIII-D of the Higher Education Act of 1965, as amended, and Public Law 102–73, $1,726,600, of which $1,000,000 shall remain available until expended, and of which $929,000,000 shall become available on July 1, 2002, and shall remain available through September 30, 2002, and of which $781,000,000 shall become available on October 1, 2001 and shall remain available through September 30, 2001: Provided further, That not less than $1,475,000,000 shall be used for authorized activities and operations at the National Technical Institute for the Deaf, the Institute shall be entitled to use funds transferred to the National Technical Institute for the Deaf pursuant to section 118(a) of the Act, and any funds transferred to the National Technical Institute for the Deaf shall not be subject to the limitations of section 118(a) of the Act.

OFFICE OF VOCATIONAL AND ADULT EDUCATION

For vocational and adult education, to the extent not otherwise provided for in this Act, for Federal administrative expenses authorized in section 10102, section 10105, and 10601 of title X, and section 931(c)(2) of Public Law 103–227 and section 404H of the Higher Education Act of 1965, as amended, $1,000,000: Provided, That the amount made available for the activities authorized under section 242: Provided further, That $22,000,000, of which $5,000,000 shall be for Youth Offender Grants, of which $5,000,000 shall be used in accordance with section 102–227 of the Act, shall remain available until expended: Provided further, That of the amounts made available for the Perkins Act, the Secretary may reserve up to 0.54 percent for incentive grants under section 503 of the Workforce Investment Act, without regard to section 111(e)(6)(C) of the Perkins Act: Provided further, That of the amounts made available for the Adult Education and Family Literacy Act, the Secretary may reserve up to 0.54 percent for incentive grants under the Workforce Investment Act, without regard to section 211(a)(3) of the Adult Education and Family Literacy Act.

OFFICE OF STUDENT FINANCIAL ASSISTANCE

STUDENT FINANCIAL ASSISTANCE

For carrying out subparts 1, 3 and 4 of part A, part C and part E of title IV of the Higher Education Act of 1965, as amended, $10,624,000,000, of which shall remain available through September 30, 2002.

The maximum Pell Grant for which a student shall be eligible during award year 2001–2002 shall be $5,550: Provided, That the amount made available for Pell Grant awards in such award year, and any funds available from the fiscal year 2000 appropriation for Pell Grant awards, are insufficient to satisfy all awards for which students are eligible, as calculated under section 401(h) of the Act, the amount paid for each such award shall be reduced by either a fixed or variable percentage of the appropriate per capita amount, as determined in accordance with a schedule of reductions established by the Secretary for this purpose.

FEDERAL FAMILY EDUCATION LOAN PROGRAM ACCOUNT

For Federal administrative expenses to carry out guaranteed student loans authorized by title IV, part B of the Higher Education Act of 1965, as amended, $48,000,000.

OFFICE OF POSTSECONDARY EDUCATION

HIGHER EDUCATION

For carrying out, to the extent not otherwise provided for in this Act, for the Office of Postsecondary Education, the Higher Education Act of 1965, as amended, and the Mutual Educational and Cultural Exchange Act of 1961; section 401(g) of the Act, the Secretary determines, prior to publication of the payment schedule for such award year, that the amount which the Secretary determines must be set aside for Pell Grant awards in such award year, and any funds available from the fiscal year 2000 appropriation for Pell Grant awards, are insufficient to satisfy all awards for which students are eligible, as calculated under section 401(h) of the Act, the amount paid for each such award shall be reduced by either a fixed or variable percentage of the appropriate per capita amount, as determined in accordance with a schedule of reductions established by the Secretary for this purpose.

HISTORICALLY BLACK COLLEGE AND UNIVERSITY CAPITAL FINANCING PROGRAM ACCOUNT

The total amount of bonds insured pursuant to section 344 of title III, part D of the Higher Education Act of 1965 shall not exceed $1,000,000,000, and the total amount of the guarantee extended under section 502 of the Congressional Budget Act of 1974, of such bonds shall not exceed $2,000,000.

EDUCATION RESEARCH, STATISTICS, AND IMPROVEMENT

For carrying out activities authorized by the Educational Research, Development, Dissemination, and Improvement Act of 1994, including sections 411 and 412; section 202 of title II, and parts A, B, and K and section 10102, section 10105, section 10601 of title X, and section 10901 of title X, and as amended, $208,000.

HISTORICALLY BLACK COLLEGE AND UNIVERSITY CAPITAL FINANCING PROGRAM ACCOUNT

For Federal administrative expenses authorized by the Educational Research, Development, Dissemination, and Improvement Act of 1994, including sections 411 and 412; section 202 of title II, and parts A, B, and K and section 10102, section 10105, section 10601 of title X, and section 10901 of title X, and as amended, $208,000.

EDUCATION RESEARCH, STATISTICS, AND IMPROVEMENT

For carrying out activities authorized by the Educational Research, Development, Dissemination, and Improvement Act of 1994, including sections 411 and 412; section 202 of title II, and parts A, B, and K and section 10102, section 10105, section 10601 of title X, and section 10901 of title X, and as amended, $208,000.
shall be reduced on a pro rata basis by $10,000,000.

SEC. 307. TECHNOLOGY AND MEDIA SERVICES. Notwithstanding any other provision of this Act—

(1) the total amount appropriated under this title under the heading “OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES” under the heading “SPECIAL EDUCATION” to carry out the Individuals with Disabilities Education Act shall be $33,333,141,000, of which $35,323,900 shall be available for technology and media services;

(2) the total amount appropriated under this title under the heading “DEPARTMENTAL MANAGEMENT” under the heading “PROGRAM ADMINISTRATION” shall be further reduced by $800,000.

SEC. 308. (a) In addition to any amounts appropriated under this title for the Perkins loan cancellation program under section 485 of the Higher Education Act of 1965 (20 U.S.C. 1094e), an additional $15,000,000 is appropriated to carry out such program.

(b) Notwithstanding any other provision of this Act, amounts made available under titles I and II, and this title, for salaries and expenses at the Departments of Labor, Health and Human Services, respectively, shall be further reduced on a pro rata basis by $15,000,000.

SEC. 309. The Comptroller General of the United States shall evaluate the extent to which funds made available under part A of title I of the Elementary and Secondary Education Act of 1965 are allocated to schools and local educational agencies, described in this section does not include the establishment of magnet schools.

SECTION 310. The amount made available under this title to carry out section 428K of the Higher Education Act of 1965 is increased by $5,000,000, which increase shall be used for construction and renovation projects under such section; and the amount made available under this title under the heading “OFFICE OF POST-SECONDARY EDUCATION” under the heading “HIGHER EDUCATION” to carry out part B of title VII of the Higher Education Act of 1965 is decreased by $5,000,000.

TITLE IV—RELATED AGENCIES

ARMED FORCES RETIREMENT HOME

ARMED FORCES RETIREMENT HOME

For expenses necessary for the Armed Forces Retirement Home to operate and maintain the United States Soldiers’ and Airmen’s Home and the United States Naval Home, to be paid from funds available in the Armed Forces Retirement Home Trust Fund, $69,832,000, of which $9,832,000 shall remain available until expended for construction of the physical plants at the United States Soldiers’ and Airmen’s Home and the United States Naval Home: Provided, That, notwithstanding any other provision of this Act, the Director’s jurisdiction.

For expenses necessary for the Corporation for National and Community Service to carry out the provisions of the Domestic Volunteer Service Act of 1973, as amended, $302,504,000: Provided, That none of the funds made available to the Corporation for National and Community Service under this Act shall be used to provide stipends or other monetary incentives to volunteers or volunteer leaders whose incomes exceed 125 percent of the national poverty level.

DOMESTIC VOLUNTEER SERVICE PROGRAMS, OPERATING EXPENSES

For expenses necessary for the Corporation for Public Broadcasting, as authorized by the Communications Act of 1934, an amount which shall be available within limitations specified by that Act, $8,228,000: Provided, That no funds made available to the Corporation for Public Broadcasting by this Act shall be used to pay for receptions, parties, or similar forms of entertainment for Government officials or employees: Provided further, That none of the funds contained in this paragraph shall be available or used to aid or assist any individual or organization from which any person is excluded, or is discriminated against, on the basis of race, color, national origin, religion, or sex; Provided further, That no funds contained in this paragraph shall be used for the purpose of purchasing or leasing any building, structure, or equipment for which $20,000,000, to remain available until expended, shall be for digitalization, pending enactment of authorizing legislation.

FEDERAL MEDIATION AND CONCILIATION SERVICE

SALARIES AND EXPENSES

For expenses necessary for the Federal Mediation and Conciliation Service to carry out the functions vested in it by the Labor Management Relations Act, 1947 (29 U.S.C. 171–189, 182–183), including hire of passenger motor vehicles; for expenses necessary for the Labor-Management Services Act of 1947 (29 U.S.C. 175a): Provided, That none of the funds authorized and appropriated under this title shall be used to carry out such program or activity from which any person is excluded, or is discriminated against, on the basis of race, color, national origin, religion, or sex: Provided further, That none of the funds made available under this heading shall be used for the purpose of purchasing or leasing any building, structure, or equipment for which $3,000,000, to remain available until expended, shall be for digitalization, pending enactment of authorizing legislation.

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

SALARIES AND EXPENSES

FEDERAL PAYMENTS TO THE RAILROAD RETIREMENT ACCOUNTS

For payment to the accounts established in the Treasury for the payment of benefits under the Railroad Retirement Act, interest earned on unegotiated checks, $150,000, to remain available through September 30, 2002, which shall be the maximum amount available for payment pursuant to section 417 of Public Law 95–76.

LIMITATION ON ADMINISTRATION

For necessary expenses for the Railroad Retirement Board for administration of the Railroad Retirement Act and the Railroad Unemployment Insurance Act, $92,500,000, to be derived in such amounts as determined by the Board from the railroad retirement accounts, and from moneys credited to the railroad unemployment insurance administration fund.

LIMITATION ON THE OFFICE OF INSPECTOR GENERAL

For expenses necessary for the Office of Inspector General for audit, investigatory and review activities, as authorized by the Inspector General Act, not more than $5,700,000, to be derived from the railroad retirement accounts and railroad unemployment insurance account: Provided, That none of the funds made available under this paragraph of this Act may be transferred to the Office; used to carry out any such transfer; used to provide any office space, equipment, office supplies, communications, or travel services, or maintenance services, or administrative services for the Office; used to pay any salary, benefit, or award for any personnel of the Office; used to pay any travel expenses of the Office; or used to reimburse the Office for any service provided, or expense incurred, by the Office.

SOCIAL SECURITY ADMINISTRATION

PAYMENTS TO SOCIAL SECURITY TRUST FUNDS

For administrative and maintenance expenses for Old-Age and Survivors Insurance and the Federal Disability Insurance trust funds, as provided under sections 201(m), 228(g), and 1313(b)(2) of the Social Security Act, $20,400,000.

SPECIAL BENEFITS FOR DISABLED COAL MINERS

For carrying out title IV of the Federal Mine Safety and Health Act of 1977, $365,748,000, to remain available until expended.

For making, after July 31 of the current fiscal year, benefit payments to individuals under title IV of the Federal Mine Safety and Health Act of 1977, for the fiscal year 2002, $114,000,000, to remain available until expended.

SUPPLEMENTAL SECURITY INCOME PROGRAM

For carrying out titles XI and XVI of the Social Security Act, section 402 of Public Law 92–603, section 212 of Public Law 93–66, as amended, and section 405 of Public Law 95–216, including payment to the Social Security trust funds for administrative expenses incurred pursuant to section 201(q)(1) of the Social Security Act, $23,053,000,000, to remain available until expended: Provided, That any portion of the funds provided to a State in the current fiscal year and not obligated by the State during that year shall be returned to the Treasury.

From funds provided under the previous paragraph, not less than $100,000,000 shall be available for payment to the Social Security trust funds for administrative expenses for conducting continuing disability reviews.

In addition, $210,000,000, to remain available until September 30, 2002, for payment to the Social Security trust funds for administrative expenses incurred pursuant to section 201(q)(1) of the Social Security Act, $23,053,000,000, to remain available until expended: Provided, That any portion of the funds provided to a State in the current fiscal year and not obligated by the State during that year shall be returned to the Treasury.

For making, after June 15 of the current fiscal year, benefit payments to individuals under title XVI of the Social Security Act, for unanticipated costs incurred for the current fiscal year, such amounts as may be necessary.

For making benefit payments under title XVI of the Social Security Act for the first quarter of fiscal year 2002, $10,470,000,000, to remain available until expended.

LIMITATION ON ADMINISTRATIVE EXPENSES

For necessary expenses, including the hire of two passenger motor vehicles, and not to exceed $10,000 for official reception and representation expenses, not more than $6,469,000,000 may be expended, as authorized by section 201(g)(1) of the Social Security Act, from any one or all of the Social Security trust funds.

That not less than $1,800,000 shall be for the Social Security Advisory Board: Provided further, That unobligated balances at the end of fiscal year 2001 not needed for fiscal year 2001 shall remain available until expended to invest in the Social Security Administration information technology and telecommunications hardware and software infrastructure, including related equipment and non-payroll administrative expenses.

From funds provided under the first paragraph, not less than $221,000,000 shall be available for conducting continuing disability reviews.

In addition, to funding already available under this heading, funds may be used to provide continuing disability reviews for beneficiaries living in the same terms and conditions, $450,000,000, to remain available until September 30, 2002, for continuing disability reviews as authorized by section 103 of Public Law 104–173 and section 102 of Public Law 103–33. The term "continuing disability reviews" means reviews and redeterminations as defined under section 201(q)(1)(A) of the Social Security Act, as amended.

In addition, $91,000,000 to be derived from administration fees in excess of $5.00 per supplementary payment collected pursuant to section 101(d) of the Social Security Act, section 212(b)(3) of Public Law 93–66, which shall remain available until expended: Provided, That the amounts collected pursuant to such section 101(d) or 212(b)(3) in fiscal year 2002 exceed $91,000,000, the amounts shall be available in fiscal year 2002 only to the extent provided in advance in appropriations Acts.

From funds appropriated for this purpose, any unobligated balances at the end of fiscal year 2000 shall be available to continue Federal-State partnerships which will evaluate and promote Medicare+Choice programs targeted to elderly and disabled individuals under titles XVIII and XIX of the Social Security Act.

OFFICE OF INSPECTOR GENERAL

(INCLUDING TRANSFER OF FUNDS)

For expenses necessary for the Office of Inspector General in carrying out the provisions of the Inspector General Act of 1978, as amended, $16,544,000, together with not to exceed $2,500,000, to be transferred and expended as authorized by section 201(g)(1) of the Social Security Act from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund.

In addition, an amount not to exceed 3 percent of the total provided in this appropriation may be transferred and used for administrative expenses”, Social Security Administration, to be merged with this account, to be available for the time and purposes for which these funds are available; Notice of such transfers shall be transmitted promptly to the Committees on Appropriations of the House and Senate.

UNITED STATES INSTITUTE OF PEACE

OPERATING EXPENSES

For necessary expenses of the United States Institute of Peace as authorized in the United States Institute of Peace Act, $12,951,000.
S6368

TITLe V—GENERAL PROVISIONS

SEC. 501. The Secretaries of Labor, Health and Human Services, and Education are authorized to transfer unexpended balances of prior appropriations to accounts corresponding to current appropriations made in this Act, pursuant to the procedures described in section 9.400 through 9.408 of the Federal Mediation and Conciliation Service. Such transfers are for the same purpose, and for the same periods of time, for which they were originally appropriated.

SEC. 502. Any appropriation contained in this Act shall remain available for obligation beyond the current fiscal year unless expressly so provided herein.

SEC. 503. (a) No funds for any appropriation contained in this Act shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the distribution of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress or any State legislature, except in presentation to the Congress or any State legislature itself.

(b) None of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

SEC. 504. The Secretaries of Labor and Education shall make available not to exceed $20,000 and $15,000, respectively, from funds available for salaries and expenses under titles I and III, respectively, for official reception and representation expenses; the Director of the Federal Mediation and Conciliation Service is authorized to make available for official reception and representation expenses not to exceed $1,000 from funds available for “Salaries and expenses, Federal Mediation and Conciliation Service”; and the Chairman of the National Mediation Board is authorized to make available for official reception and representation expenses not to exceed $2,500 from funds available for “Salaries and expenses, National Mediation Board”.

SEC. 505. Notwithstanding any other provision of this Act, no funds appropriated under this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug unless the Secretary of Health and Human Services determines that such programs are effective in preventing the spread of HIV and do not encourage the Secretary of Health and Human Services determines that such programs are effective in preventing the spread of HIV and do not encourage the Secretary of Health and Human Services determines that such programs are effective in preventing the spread of HIV and do not encourage

SEC. 506. (a) PURCHASE OF AMERICAN-MADE EQUIPMENT AND PRODUCTS.—It is the sense of the Congress that, to the greatest extent practicable, products purchased with funds made available in this Act should be American-made.

(b) NOTICE REQUIREMENT.—In providing for distribution of any illegal drug unless the Secretary of Health and Human Services determines that such programs are effective in preventing the spread of HIV and do not encourage the Secretary of Health and Human Services determines that such programs are effective in preventing the spread of HIV and do not encourage

SEC. 507. When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds included in this Act, including but not limited to State and local governments and recipients of Federal funds appropriated to the Federal Mediation and Conciliation Service: (1) the percentage of the total costs of the program or project which will be financed with Federal money; (2) the dollar amount of Federal funds made available under this Act; (3) for the period of time coverage with State funds (other than a State’s or locality’s contribution of Medicaid matching funds).

SEC. 508. (a) None of the funds appropriated under this Act, and none of the funds in any trust fund to which funds are appropriated under this Act, shall be expended for any abortion—

(1) if the pregnancy is the result of an act of rape or incest; or

(2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness caused by physical or mental injury during pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State’s or locality’s contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State’s or locality’s contribution of Medicaid matching funds).

SEC. 509. (a) The limitations established in the preceding section shall not apply to an abortion—

SEC. 510. (a) None of the funds made available in this Act may be used for—

(1) the creation of a human embryo or embryos for research purposes; or

(2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for in the case of fertilized human embryos under 45 CFR 46.208(a)(2) and section 498(b) of the Public Health Service Act (42 U.S.C. 200g(b)).

(b) For purposes of this section, the term “human embryo or embryos” includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

SEC. 511. (a) LIMITATION ON USE OF FUNDS FOR PROMOTION OF LEGALIZATION OF CONTROLLED SUBSTANCES.—None of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or other substance included in schedule 1 of the schedules of controlled substances established under section 201 of the Controlled Substances Act (21 U.S.C. 812).

(b) EXCEPTIONS.—The limitation in subsection (a) shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance or that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

SEC. 512. (a) In general.—Any statement, communication, or report made in this Act shall be prepared and submitted in accordance with section 512 of the Federal Mediation and Conciliation Service.

(b) Exceptions.—The prohibition in subsection (a) shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance or that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

SEC. 513. Except as otherwise specifically provided by law, unexpended balances remaining available at the end of fiscal year 2000 from appropriations made available for salaries and expenses for fiscal year 2000 in this Act shall remain available through December 31, 2001, for such amounts as are necessary to carry out the provisions of this Act, provided, That the House and Senate Committees on Appropriations shall be notified at least 15 days prior to the obligation of such funds.

SEC. 514. None of the funds made available in this Act may be used to promulgate or adopt any final standard under section 1173(b) of the Social Security Act (42 U.S.C. 1320d–2(b)) providing for, or providing for the assignment of, 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 such an identifier.

SEC. 515. Section 410(b) of The Ticket to Work and Work Incentives Improvement Act of 1999 (Public Law 106–170) is amended by striking “2000” both places it appears and inserting “2001”.

SEC. 516. Amounts made available under this Act for the administrative and related expenses for departmental management for the Department of Labor, the Department of Health and Human Services, and the Department of Education shall be reduced on a pro rata basis by $10,000,000.

SEC. 517. (a) None of the funds appropriated under this Act to carry out section 338 of title X of the Public Health Service Act (42 U.S.C. 254h; 300 et seq.), title V of the Social Security Act (42 U.S.C. 701 et seq., 1396 et seq.), or any other provision of law, shall be used for the distribution or provision of postcoital emergency contraception, or the provision of a prescription for postcoital emergency contraception, to an unemancipated minor, on the premises or in the facilities of any elementary school or secondary school.

(b) This section takes effect 1 day after the date of enactment of this Act.

(c) In this section:

(1) the terms “elementary school” and “secondary school” have the meanings given the terms in section 1401 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8001).

(2) The term “unemancipated minor” means an unmarried individual who is 17 years of age or younger and is a dependent, as defined in section 152(a) of the Internal Revenue Code of 1986.

SEC. 518. Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended by adding at the end the following:

“PART G—REQUIREMENT RELATING TO THE RIGHTS OF RESIDENTS OF CERTAIN FACILITIES

SEC. 519. REQUIREMENT RELATING TO THE RIGHTS OF RESIDENTS OF CERTAIN FACILITIES

SEC. 520. IN GENERAL.—A public or private general hospital, nursing facility, intermediate care facility, residential treatment center, or other health care facility, that receives support in any form from any program supported in whole or in part with funds appropriated to any Federal department or agency shall protect and promote the rights of each resident of the facility, including the right to be free from physical or chemical restraints or involuntary seclusions imposed for purposes of discipline or convenience.”
(b) REQUIREMENTS.—Restrains and seclusion may only be imposed on a resident of a facility described in subsection (a) if—

(1) the restraints or seclusion are imposed to ensure the physical safety of the resident, a staff member, or others; and

(2) the restraints or seclusion are imposed only after an examination under subparagraph (A); and

(3) such facility has in place written individualized, evidenced, and validated treatment plans, and provide active treatment measures; and

(4) the restraints or seclusion are to be used (except in emergency circumstances specified by the Secretary) until such an order could reasonably be obtained.

(c) ENFORCEMENT.—A facility to which this paragraph applies, to meet the requirements of this paragraph, must—

(1) submit to the Commission a certification described in subparagraph (B), and

(2) ensure that such facility is in compliance with the requirements described in subparagraph (B),

(d) REQUIREMENTS.—Any facility described in subsection (a) shall require that—

(1) the term 'restraints' means—

(A) any physical restraint that is a mechanical or personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, head freely, or move within the room of the resident; and

(B) a drug or medication that is used as a restraint to control behavior or restrict the resident's freedom of movement that is not a standard treatment for the resident's medical or psychiatric condition.

(2) The term 'seclusion' means any separation of the resident from the general population of the facility that prevents the resident from returning to such population if he or she desires.

SECTION 502. REPORTING REQUIREMENT.

SEC. 502. REQUIREMENT FOR SCHOOLS AND LIBRARIES TO IMPLEMENT FILTERING OR BLOCKING TECHNOLOGY FOR COMPUTERS WITH INTERNET ACCESS AS CONDITION OF UNIVERSAL SERVICE PROGRAM.

(a) Training.—Not later than 1 year after the date of enactment of this part, the Secretary, after consultation with appropriate State and local protection and advocacy organizations, physicians, facility, and other health care professionals and patients, shall promulgate regulations that require facilities to which the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 et seq.) applies, to meet the requirements of subsection (b).

(b) REQUIREMENTS.—The regulations promulgated under subsection (a) shall require that—

(I) facilities described in subsection (a) ensure that there is an adequate number of qualified professional and supportive staff to evaluate patients, written individualized, comprehensive treatment plans, and to provide active treatment measures; and

(II) such facilities complete and accurately notify of deaths, as required under section 502(a).

(II) child pornography; and

(III) material that is obscene; and

(9) TO USE INTERNET ACCESS IN AN APPROPRIATE MANNER.—An Internet service provider or a telecommunications carrier that provides Internet access to any person, or to any entity under subparagraph (B) only for purposes other than as a service to provide telephone services, or as a service to provide video service, shall use Internet access to—

(e) Whereas it is estimated that many cases of sexual abuse in schools are not reported; and

(f) Whereas many of the accused staff quietly resign at their present school district and are then rehired at a new district which has no knowledge of their alleged abuse;

(g) Whereas according to the Child Abuse and Neglect Reporting Act, a school administrator is required to report any allegation of sexual abuse to the appropriate authorities;

(h) Whereas an individual who is falsely accused of sexual misconduct with a student desires appropriate legal and professional protections;

(i) Whereas it is estimated that many cases of sexual abuse in schools are not reported;

(j) Whereas the state of Florida requires that each enrolled child receives such a test either by referral or by performing the test (under contract or otherwise).

SEC. 520. (a) Whereas sexual abuse in schools between a student and a member of the school staff or a student and another student is a cause for concern in America;

(b) Whereas relatively few studies have been conducted on sexual abuse in schools and the extent of this problem is unknown;

(c) Whereas according to the Child Abuse and Neglect Reporting Act, a school administrator is required to report any allegation of sexual abuse to the appropriate authorities;

(d) Whereas an individual who is falsely accused of sexual misconduct with a student desires appropriate legal and professional protections;

(e) Whereas it is estimated that many cases of sexual abuse in schools are not reported;

(f) Whereas many of the accused staff quietly resign at their present school district and are then rehired at a new district which has no knowledge of their alleged abuse;

(g) Whereas according to the Child Abuse and Neglect Reporting Act, a school administrator is required to report any allegation of sexual abuse to the appropriate authorities;

(h) Whereas an individual who is falsely accused of sexual misconduct with a student desires appropriate legal and professional protections;

(i) Whereas it is estimated that many cases of sexual abuse in schools are not reported;

(j) Whereas the state of Florida requires that each enrolled child receives such a test either by referral or by performing the test (under contract or otherwise).

SEC. 520. (a) Whereas sexual abuse in schools between a student and a member of the school staff or a student and another student is a cause for concern in America;

(b) Whereas relatively few studies have been conducted on sexual abuse in schools and the extent of this problem is unknown;

(c) Whereas according to the Child Abuse and Neglect Reporting Act, a school administrator is required to report any allegation of sexual abuse to the appropriate authorities;

(d) Whereas an individual who is falsely accused of sexual misconduct with a student desires appropriate legal and professional protections;

(e) Whereas it is estimated that many cases of sexual abuse in schools are not reported;

(f) Whereas many of the accused staff quietly resign at their present school district and are then rehired at a new district which has no knowledge of their alleged abuse;

(g) Whereas according to the Child Abuse and Neglect Reporting Act, a school administrator is required to report any allegation of sexual abuse to the appropriate authorities;

(h) Whereas an individual who is falsely accused of sexual misconduct with a student desires appropriate legal and professional protections;

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(c) Whereas according to the Child Abuse and Neglect Reporting Act, a school administrator is required to report any allegation of sexual abuse to the appropriate authorities;

(d) Whereas an individual who is falsely accused of sexual misconduct with a student desires appropriate legal and professional protections;

(e) Whereas it is estimated that many cases of sexual abuse in schools are not reported;

(f) Whereas many of the accused staff quietly resign at their present school district and are then rehired at a new district which has no knowledge of their alleged abuse;

(g) Whereas according to the Child Abuse and Neglect Reporting Act, a school administrator is required to report any allegation of sexual abuse to the appropriate authorities;

(h) Whereas an individual who is falsely accused of sexual misconduct with a student desires appropriate legal and professional protections;

(i) Whereas it is estimated that many cases of sexual abuse in schools are not reported;

(j) Whereas the state of Florida requires that each enrolled child receives such a test either by referral or by performing the test (under contract or otherwise).
reimbursement under this subparagraph shall not affect the carrier's treatment of the discount on which such reimbursement was based in accordance with the third sentence of paragraph (1)(B).

(2) CESSATION DATE.

(1) DETERMINATION.—The Commission shall determine the date on which the provision of services at discount rates under paragraph (1)(B) shall cease under this paragraph by reason of the failure of a school to comply with the requirements of this paragraph.

(ii) FAILURE TO COMPLY WITH CERTIFICATION.—The library fails to ensure the use of its computers in accordance with a certification under subparagraph (B) shall reimburse each telecommunications carrier for such services during the period beginning on the date of such certification and ending on the date on which the provision of such services at discount rates under paragraph (1)(B) is determined to cease under subparagraph (F).

(iii) TREATMENT OF REIMBURSEMENT.—The receipt by a telecommunications carrier of any reimbursement under this subparagraph shall not affect the carrier's treatment of the discount on which such reimbursement was based in accordance with the third sentence of paragraph (1)(B).

(F) CESSATION DATE.

(1) DETERMINATION.—The Commission shall determine the date on which the provision of services at discount rates under paragraph (1)(B) shall cease under this paragraph by reason of the failure of a library to comply with the requirements of this paragraph.

(ii) FAILURE TO COMPLY WITH CERTIFICATION.—The library fails to ensure the use of its computers in accordance with a certification under subparagraph (B) shall reimburse each telecommunications carrier for such services during the period beginning on the date of such certification and ending on the date on which the provision of such services at discount rates under paragraph (1)(B) is determined to cease under subparagraph (F).

(2) CESSATION DATE.

(1) DETERMINATION.—The Commission shall determine the date on which the provision of services at discount rates under paragraph (1)(B) shall cease under this paragraph by reason of the failure of a school to comply with the requirements of this paragraph.

(ii) FAILURE TO COMPLY WITH CERTIFICATION.—The library fails to ensure the use of its computers in accordance with a certification under subparagraph (B) shall reimburse each telecommunications carrier for such services during the period beginning on the date of such certification and ending on the date on which the provision of such services at discount rates under paragraph (1)(B) is determined to cease under subparagraph (F).

(iii) TREATMENT OF REIMBURSEMENT.—The receipt by a telecommunications carrier of any reimbursement under this subparagraph shall not affect the carrier's treatment of the discount on which such reimbursement was based in accordance with the third sentence of paragraph (1)(B).
“(D) MINOR.—The term ‘minor’ means any individual who has not attained the age of 17 years.”.

“(E) CONFORMING AMENDMENT.—Paragraph (3) of such section is amended by—

(1) striking paragraph (A) and inserting the following:

“(A) SCHOOLS AND LIBRARIES.—No service may be provided under subsection (b)(1)(B) to any school or library that fails to implement a filter or blocking system that allows the customer to prevent the access of minors to material on the Internet.

(2) applying the requirements of subsection (h)(1)(B) on or after July 1, 2001.’’.

(2) DEADLINE.—Notwithstanding any other provision of law, the requirements prescribed under paragraph (1) shall take effect 120 days after the date of the enactment of this Act.

(3) ADJUSTMENT FOR RATES.—In the case of rates under section 254(h)(1)(B) of the Communications Act of 1934 (47 U.S.C. 254(h)(1)(B)—

(1) shall be available in amounts up to the annual federal universal service support for schools and libraries only for services covered by Federal Communications Commission regulations under section 543 of the Consolidated Appropriations Act for Fiscal Year 2001 for universal service support for telecommunications services, Internet access, Internet services, and Internet connections that assign priority for available funds for the poorest schools and libraries; and

(2) to the extent made available under paragraph (1), may be used for the purchase or acquisition of filtering or blocking products necessary to meet the requirements of section 254(h)(5) and (6) of that Act, but not for the purchase of software or other technology other than what is required to meet those requirements.

(h) EFFECTIVE DATE.—The amendments made by this section shall take effect 120 days after the date of the enactment of this Act.

TITLE VII—UNIVERSAL SERVICE FOR SCHOOLS AND LIBRARIES

SEC. 701. SHORT TITLE. This title may be cited as the “Neighborhood Children’s Internet Protection Act”.

SEC. 702. NO UNIVERSAL SERVICE FOR SCHOOLS OR LIBRARIES THAT FAIL TO IMPLEMENT A FILTERING OR BLOCKING SYSTEM FOR INTERNET ACCESS OR ADOPT INTERNET USE POLICIES. (a) NO UNIVERSAL SERVICE.—

(1) In the case of the Communications Act of 1934 (47 U.S.C. 254) is amended by adding at the end the following:

“(1) IMPLEMENTATION OF INTERNET FILTERING OR BLOCKING SYSTEM OR USE POLICIES.—

“(I) IN GENERAL.—No services may be provided under subsection (h)(1)(B) to any school or library that fails to implement a filter or blocking system that allows the customer to prevent the access of minors to material on the Internet.

“(II) NOT IN APPLICABLE.—This subsection shall not apply with respect to schools and libraries seeking universal service assistance under subsection (h)(1)(B) on or after July 1, 2001.”.

(2) CONFORMING AMENDMENT.—Subsection (h)(1)(B) of such section is amended by striking “All telecommunications” and inserting “Except as provided by subsection (I), all telecommunications.”

(b) STUDY.—Not later than 150 days after the date of the enactment of this Act, the National Telecommunications and Information Administration shall initiate a notice and comment proceeding for purposes of—

(1) evaluating whether or not currently available commercial Internet blocking, filtering, and monitoring software adequately addresses the needs of the educational institutions; and

(2) making recommendations on how to foster the development of products which meet such needs; and

(3) evaluating the development and effectiveness of local Internet use policies that are currently in operation after community input.
SEC. 703. IMPLEMENTING REGULATIONS. Not later than 100 days after the date of the enactment of this Act, the Federal Communications Commission shall adopt rules implementing this title and such regulations as may be necessary to carry out any of the provisions of this Act.

TITLE VIII—SOCIAL SECURITY AND MEDICARE OFF-BUDGET LOCKBOX ACT OF 2000

SEC. 801. SHORT TITLE. This title may be cited as the "Social Security and Medicare Off-Budget Lockbox Act of 2000".

SEC. 802. STRENGTHENING SOCIAL SECURITY POINTS OF ORDER. (a) IN GENERAL.—Section 312 of the Congressional Budget Act of 1974 is amended by inserting "312(g)," after "310(d)(2),".

(b) SUPER MAJORITY REQUIREMENT.—(1) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting "310(d)(2)," after "310(d)(2),".

(2) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting "312(g)," after "312(g),".

(c) MEDICARE FIREWALL.—Section 31(a) of the Congressional Budget Act of 1974 is amended by adding after paragraph (3), the following: "(4) POINTS OF ORDER TO PROTECT SOCIAL SECURITY AND MEDICARE DIAMOND RESERVES.—It shall not be in order in the House of Representatives or the Senate to consider any concurrent resolution on the budget, or amendment, motion, or conference report if that would set forth an on-budget deficit for any fiscal year.

(d) BUDGETARY TREATMENT OF HOSPITAL INSURANCE DIAMOND RESERVES.—Section 312 of the Congressional Budget Act of 1974 is amended by adding after paragraph (3), the following: "(4) POINTS OF ORDER TO PROTECT SOCIAL SECURITY AND MEDICARE DIAMOND RESERVES.—It shall not be in order in the House of Representatives or the Senate to consider any concurrent resolution on the budget, or amendment, motion, or conference report if that would set forth an on-budget deficit for any fiscal year.

SEC. 803. MEDICARE TRUST FUND OFF-BUDGET. (a) IN GENERAL.—(1) EXCLUSION FROM ALL BUDGETS.—Title III of the Congressional Budget Act of 1974 is amended by adding at the end the following: "SEC. 316. (a) EXCLUSION OF MEDICARE TRUST FUND FROM ALL BUDGETS. —Notwithstanding any other provision of law, the receipts and disbursements of the Federal Hospital Insurance Trust Fund shall be counted as budget authority, outlays, receipts, or deficit or surplus for purposes of—

"(1) the budget of the United States Government as submitted by the President;

"(2) the congressional budget; or

"(3) the Balanced Budget and Emergency Deficit Control Act of 1985.

"(b) STRENGTHENING MEDICARE POINT OF ORDER.—It shall not be in order in the House of Representatives or the Senate to consider any concurrent resolution on the budget, or amendment, motion, or conference report if that would increase an on-budget deficit for any fiscal year.

SEC. 804. BUDGET DEFICITS. (a) POINTS OF ORDER TO PREVENT ON-BUDGET DEFICITS.—Section 312 of the Congressional Budget Act of 1974 is amended by adding after paragraph (3), the following: "(4) POINTS OF ORDER TO PREVENT ON-BUDGET DEFICITS.—It shall not be in order in the House of Representatives or the Senate to consider any concurrent resolution on the budget, or conference report thereon or amendment thereto, that would cause or increase an on-budget deficit for any fiscal year.

(b) SUPER MAJORITY REQUIREMENT.—(1) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting "310(d)(2)," after "310(d)(2),".

(2) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting "312(g)," after "312(g),".

(c) BUDGET TOTALS.—Section 301(a) of the Congressional Budget Act of 1974 (2 U.S.C. 632(a)) is amended by inserting after paragraph (7), the following: "(8) For purposes of Senate enactment under this title, revenues and outlays of the Federal Hospital Insurance Trust Fund for each fiscal year covered by the budget resolution.

(d) BUDGET RESOLUTIONS.—Section 301 of the Congressional Budget Act of 1974 (2 U.S.C. 632(i)) is amended by—

(1) striking "SOCIAL SECURITY POINT OF ORDER. —It shall not be in order in the House of Representatives or the Senate to consider any concurrent resolution on the budget, or amendment, motion, or conference report if that would set forth an on-budget deficit for any fiscal year.

(2) POINTS OF ORDER TO PROTECT SOCIAL SECURITY AND MEDICARE DIAMOND RESERVES.—It shall not be in order in the House of Representatives or the Senate to consider any concurrent resolution on the budget, or amendment, motion, or conference report if that would set forth an on-budget deficit for any fiscal year.

SEC. 805. SOCIAL SECURITY AND MEDICARE SURPLUSES.—(1) MEDICARE SURPLUSES OFF-BUDGET.—Notwithstanding any other provision of law, the net surplus of any trust fund for part A of Medicare shall not be counted as a net surplus for purposes of—

"(A) the budget of the United States Government as submitted by the President;

"(B) the congressional budget; or

"(C) the Balanced Budget and Emergency Deficit Control Act of 1985.

"(2) POINTS OF ORDER TO PROTECT SOCIAL SECURITY AND MEDICARE SURPLUSES.—Section 312 of the Congressional Budget Act of 1974 is amended by adding after paragraph (3), the following: "(4) POINTS OF ORDER TO PROTECT SOCIAL SECURITY AND MEDICARE SURPLUSES.—It shall not be in order in the House of Representatives or the Senate to consider any bill, joint resolution, amendment, motion, or conference report if—

"(A) the enactment of that bill or resolution as reported;

"(B) the adoption and enactment of that amendment; or

"(C) the enactment of that bill or resolution in the form recommended in that conference report, would cause or increase an on-budget deficit for any fiscal year.

"(3) SUPER MAJORITY REQUIREMENT.—(A) POINT OF ORDER.—Section 904(c)(1) of the Congressional Budget Act of 1974 is amended by inserting "310(d)(2)," after "310(d)(2),".

(B) WAIVER.—Section 904(d)(2) of the Congressional Budget Act of 1974 is amended by inserting "312(g)," after "312(g),".

(c) PROTECTION OF SOCIAL SECURITY AND MEDICARE SURPLUSES.—(1) IN GENERAL.—Chapter 11 of subtitle H of title 31, United States Code, is amended by adding before section 1101 the following: "§1100. Protection of social security and medicare surpluses. —The budget of the United States Government submitted by the President under this chapter shall not recommend an on-budget deficit for any fiscal year covered by that budget.

(2) CHAPTER ANALYSIS.—The chapter analysis for chapter 11 of title 31, United States Code, is amended by inserting before the item for section 1101 the following:

"1100. Protection of social security and medicare surpluses."
(d) EFFECTIVE DATE.—This section shall take effect upon the date of its enactment and the amendments made by this section shall apply to fiscal year 2001 and subsequent fiscal years.

TITLE IX.—GENETIC INFORMATION AND GENETIC SERVICES

SEC. 901. SHORT TITLE. This title may be cited as the “Genetic Information Nondiscrimination in Health Insurance Act of 2000”.

SEC. 2701. PROHIBITION ON GROUP EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974. (a) PROHIBITION OF HEALTH DISCRIMINATION ON THE BASIS OF GENETIC INFORMATION OR GENETIC SERVICES.—

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

(2) NO DISCRIMINATION IN GROUP PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following:

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

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

(3) CONFORMING AMENDMENTS.—

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

“(B) NO DISCRIMINATION IN PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(b)) is amended by adding at the end the following:

“(B) NO DISCRIMINATION IN PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(b)) is amended by adding at the end the following:

“SEC. 714. Prohibiting premium discrimination against groups on the basis of predictive genetic information.”.

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

“(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

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

(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, that provide items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or the health insurance issuer, offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

(3) LIMITATION ON REQUESTING OR REQUIRING GENETIC SERVICES.—

(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require predictive genetic services, as described in subsection (d), of such predictive genetic information.

(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or the health insurance issuer, offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

(4) LIMITATION ON REQUESTING OR REQUIRING CONSULTATION.—

(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require consultation with the National Committee on Vital and Health Statistics or the National Academy of Sciences.

(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or the health insurance issuer, offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

(5) LIMITATION ON REQUESTING OR REQUIRING INFORMATION.—

(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require information about an individual (including information about a request for or receipt of genetic services).

(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or the health insurance issuer, offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

(6) LIMITATION ON REQUESTING OR REQUIRING INFORMATION ABOUT A REQUEST FOR OR RECEIPT OF GENETIC SERVICES.—

(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require information about a request for or receipt of genetic services.

(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or the health insurance issuer, offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

(c) PROHIBITION ON GROUP MARKET.—

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

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

(d) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, that provide items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or the health insurance issuer, offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

(C) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require predictive genetic services, as described in subsection (d), of such predictive genetic information.

(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or the health insurance issuer, offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.
“(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, that provides genetic services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

(B) NOTWITHSTANDING GENETIC INFORMATION.—

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

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

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

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

(i) information about the sex of an individual;

(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including chelator tests; and

(iii) information about physical exams of the individual.

(C) GENETIC TEST.—The term ‘genetic test’ means diagnostic, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting an autosomal or X-linked undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual in order to detect symptoms, clinical signs, or a diagnosis of disease.

(D) AMENDMENTS TO PHSA RELATING TO THE INDIVIDUAL MARKET.—The first subpart 3 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300g–51 et seq.) (relating to the requirement of enrollment or use of preventive health services) is amended by adding at the end the following:

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

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

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

(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

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

(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—A health insurance issuer offering health insurance coverage in the individual market shall not request or require predictive genetic information concerning an individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

(3) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

(i) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan, or the health insurance issuer offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in subsection (d), of such predictive genetic information.

(ii) CONFIDENTIALITY WITH RESPECT TO GENETIC SERVICES.—

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

(2) PROHIBITION OF HEALTH DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.—

(a) IN GENERAL.—Subchapter B of chapter 100 of title XXVII of the Public Health Service Act (42 U.S.C. 300g–91 et seq.) is amended by adding the following subsection at the end:

“(b) CONFORMING AMENDMENT.—Section 9813 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

“SEC. 9813. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF GENETIC INFORMATION.

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

(1) NO DISCRIMINATION IN GROUP PREMIUMS BASED ON PREDICTIVE GENETIC INFORMATION.—

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

“SEC. 9813. PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF PREDICTIVE GENETIC INFORMATION.

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

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

“SEC. 9802(b).—PROHIBITING PREMIUM DISCRIMINATION AGAINST GROUPS ON THE BASIS OF GENETIC INFORMATION.

A group health plan shall not adjust premium or contribution amounts for a group on the basis of genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).
(d) Collection of Predictive Genetic Information.—

(1) Limitation on Requesting or Requiring Predictive Genetic Information.—Except as provided in paragraph (2), a group health plan shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual, except as specified in subsection (e), of such predictive genetic information.

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

(3) Notice of Confidentiality Practices; Description of Safeguards.—As a part of a request under subparagraph (A), the group health plan shall provide to the individual or dependent a description of the procedures in place to safeguard confidentiality, as described in subsection (e), of such predictive genetic information.

(e) Confidentiality with Respect to Predictive Genetic Information.—

(1) Notice of Confidentiality Practices.—

(A) Preparation of Written Notice.—A group health plan shall post or provide, in writing any appropriate manner, a notice of the confidentiality practices of the plan's confidentiality practices, that shall include—

(i) a description of an individual's rights with respect to predictive genetic information; and

(ii) the procedures established by the plan for the exercise of the individual's rights; and

(B) Right to Obtain a Copy of the Notice.—A group health plan shall provide to the individual or dependent a copy of the notice of the confidentiality practices required under this subsection.

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

(f) Establishment of Safeguards.—A group health plan shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan.

(g) Definitions.—Section 9823(d) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

(6) Family Member.—The term 'family member' means—

(A) the spouse of the individual;

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

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

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

(g) Genetic Services.—The term 'genetic services' means services provided to obtain, assess, or interpret genetic information for diagnostic and therapeutic purposes, and for genetic education and counseling.

(h) Genetic Information.—

(1) In General.—The term 'predictive genetic information' means, in the absence of symptoms, clinical signs, or a diagnosis of the condition related to such information—

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

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

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

(2) Inclusions.—The term 'predictive genetic information' shall not include—

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

(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

(iii) information about physical exams of the individual, clinical signs, or a diagnosis of disease.

(i) Genetic Test.—The term 'genetic test' means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, phenotypes, or karyotypes, for the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual prior to detect symptoms, clinical signs, or a diagnosis of disease.

(j) Effective Date.—As excepted in this section, this section and the amendments made by this section shall apply with respect to group health plans for plan years beginning after 1 year after the date of the enactment of this Act.

Division B—Health Care Access and Protection for Consumers

Sec. 201. Deduction for Health and Long-Term Care Insurance Costs of Individuals Not Participating in Employer-Subsidized Health Plans.

(a) In General.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by adding section 222 as section 223 and by inserting after section 221 the following new section:

Title XXI—Tax-Related Health Care Provisions

Sec. 2101. Deduction for Health and Long-Term Care Insurance Costs of Individuals Not Participating in Employer-Subsidized Health Plans.

(a) In General.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by adding section 222 as section 223 and by inserting after section 221 the following new section:

"SEC. 222. HEALTH AND LONG-TERM CARE INSURANCE AND COVERAGE.

"(a) In General.—In the case of an individual, there shall be allowed as a deduction the amount the applicable percentage of the amount paid during the taxable year for insurance purchased by the taxpayer and the taxpayer's spouse and dependents.

"(b) Applicable Percentage.—

"(1) In General.—For purposes of subsection (a), the applicable percentage shall be determined in accordance with the following table:

For taxable years beginning in calendar year in which

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>2002 and 2003</td>
<td>25</td>
</tr>
<tr>
<td>2004</td>
<td>35</td>
</tr>
<tr>
<td>2005</td>
<td>65</td>
</tr>
<tr>
<td>2006 and 2007</td>
<td>100</td>
</tr>
</tbody>
</table>

"(2) Long-Term Care Insurance for Individuals 60 Years or Older.—In the case of amounts paid for a qualified long-term care insurance policy to any individual over age 60 before the close of the taxable year, the applicable percentage shall be 100.

"(c) Limitation Based on Other Coverage.—

"(1) Coverage Under Certain Subsidized Employer Plans.—

"(A) In General.—Subsection (a) shall not apply to any calendar month for which the taxpayer participates in any health plan maintained by any employer of the taxpayer or of the spouse of the taxpayer if 50 percent or more of the cost of coverage under such plan (determined under section 4980B and without regard to payments made with respect to such coverage described in subsection (a) or (c)) is paid or incurred by the employer.

"(B) Employer Contributions to Cafeteria Plans, Flexible Spending Arrangements, and Medical Savings Accounts.—The term 'employer' as described in such subparagraph if such plan would be so described if all health plans of persons treated as a single employer under subsection (b), (c), (m), or (o) of section 412 were treated as one health plan.

"(2) Separate Application to Health Insurance and Long-Term Care Insurance.—Subparagraphs (A) and (C) shall be applied separately with respect to—

"(i) plans which include primarily coverage for qualified long-term care insurance contracts, and

"(ii) plans which do not include such coverage.

"(d) Coverage Under Certain Federal Programs.—

"(A) In General.—Subsection (a) shall not apply to any amounts paid for coverage under a qualified long-term care insurance contract.

"(B) Exception.—Subparagraph (A)(ii) shall not apply to coverage which is comparable to continuation coverage under section 4980B.

"(c) Coordination of Deduction Limited to Qualified Long-Term Care Insurance Contracts.—In the case of a qualified long-term care insurance contract, only eligible long-term care premiums (as defined in section 223(d)(10)) may be taken into account under subsection (a).

"(d) Deduction Not Available for Payment of Ancillary Coverage Premiums.—Any amount paid as a premium for insurance which provides for—

"(1) coverage for accidents, disability, dental care, vision care, or a specified illness, or

"(2) making payments of a fixed amount per day or other period by reason of being hospitalized, shall not be taken into account under subsection (a).

"(2) Special Rules.—

"(1) Coordination with Deduction for Health Insurance Costs of Self-Employed Individuals.—The amount taken into account by the taxpayer in computing the deduction under section 162(l) shall not be taken into account under this section.

"(2) Coordination with Medical Expense Deduction.—The amount taken into account by the taxpayer in computing the deduction under this section shall not be taken into account under section 213(b).
carry out this section, including regulations requiring employers to report to their employees and the Secretary such information as the Secretary determines to be appropriate.

(b) **DEDUCTION WHETHER OR NOT TAXPAYER ITEMS OTHER DEDUCTIONS.**—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (17) the following new item:

"(18) **HEALTH AND LONG-TERM CARE INSURANCE COSTS.**—The deduction allowed by section 222."

(c) **CLERICAL AMENDMENT.**—The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following new item:

"Sec. 22. Health and long-term care insurance costs.

"Sec. 223. Cross reference."

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 2102. **DEDUCTION FOR 100 PERCENT OF HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.**

(a) **IN GENERAL.**—Paragraph (1) of section 162(l) of the Internal Revenue Code of 1986 is amended to read as follows:

"(1) ALLOWANCE OF DEDUCTION.—In the case of an individual who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to 100 percent of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer and the taxpayer's spouse and dependents.

(b) **CLARIFICATION OF LIMITATIONS ON OTHER COVERAGE.**—The first sentence of section 162(l)(2)(B) of such Code is amended to read as follows:

"(B) **EXCEPTIONS APPLICABLE TO SELF-EMPLOYED INDIVIDUALS.**—The study conducted under section 220(c) of such Code is amended by striking paragraph (2) and inserting the following:

"(2) **CONFORMING AMENDMENTS.**—A Technical and nontaxicability Act of 1996 on the provision and fin-

SEC. 2103. **LONG-TERM CARE INSURANCE PER-

SEC. 2104. **ADDITIONAL PERSONAL EXEMPTION FOR TAXPAYER CARING FOR ELDERLY FAMILY MEMBER IN TAXPAYER’S HOME.**

(a) **IN GENERAL.**—Section 151 of the Internal Revenue Code of 1986 (relating to allowance of deductions for personal exemptions) is amended by redesignating the subsections as (e) as subsection (f) and by inserting after subsection (f) the following new subsection:

"(e) **ADDITIONAL EXEMPTION FOR CERTAIN ELDERLY FAMILY MEMBERS RESIDING WITH TAX-

"(1) **IN GENERAL.**—An exemption of the exemption amount for each qualified family member of the taxpayer for purposes of this subsection, the term "qualified family member" means, with respect to any taxable year, any individual—

"(A) who is an ancestor of the taxpayer or of the taxpayer's spouse or who is the spouse of the taxpayer,

"(B) who is a member of the entire taxable year of a household maintained by the taxpayer, and

"(C) who has been certified, before the due date for filing the return of tax for the taxable year (without extensions), by a physician (as defined in section 1601(c)(1) of the Social Security Act) as being an individual with long-term care needs described in paragraph (3) for a period—

"(i) which is at least 180 consecutive days, and

"(ii) of which occurs within the taxable year.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the 3½ month period ending on such due date (or such other period as the Secretary prescribes) a physician (as so defined) has certified that such individual meets such requirements.

(3) **INDIVIDUALS WITH LONG-TERM CARE NEEDS.**—An individual is described in this paragraph if the individual—

"(A) is unable to perform (without substantial assistance from another individual) at least two activities of daily living (as so defined) or to the extent provided in regulations prescribed by the Secretary (in consultation with the Secretary of Health and Human Services), is unable to engage in age appropriate activities.

"(B) requires substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment and is unable to perform, without reminding or cuing assistance, at least one activity of daily living (as so defined) or to the extent provided in regulations prescribed by the Secretary (in consultation with the Secretary of Health and Human Services), is unable to engage in age appropriate activities.

"(C) **SPECIAL RULES.**—Rules similar to the rules of paragraphs (1), (2), (3), (4), and (5) of section 26(f)(5) shall apply for purposes of this subsection.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 2105. **STUDY OF LONG-TERM CARE NEEDS IN THE 21ST CENTURY.**

(a) **IN GENERAL.**—The Secretary of Health and Human Services (referred to in this section as the "Secretary") shall on or after October 1, 2001, provide, in accordance with this section, a study in order to determine—

"(1) future demand for long-term health care services (including institutional and home and community-based services) in the United States in order to meet the needs in the 21st century; and

"(2) long-term options to finance the provision of such services.

(b) **DETAILS.**—The study conducted under subsection (a) shall include the following:

"(1) An identification of the relevant demographic characteristics affecting demand for long-term health care services, at least through the year 2030.

"(2) The viability and capacity of community-based and other long-term health care services under different policy scenarios, including the role of public and non-profit providers.

"(3) How to improve the quality of long-term health care services.

"(4) The integration of long-term health care services for individuals between different classes of health care services (including hospitals, nursing facilities, and home care agencies) and different Federal programs (such as the Medicare and Medicaid programs).

"(5) The role of government and government entities, including long-term care insurance, to meet the need to finance such services.

(6) An examination of the effect of enactment of the Health Insurance Portability and Accountability Act of 1996 on the provision and financing of long-term health care services, including the impact of the other Federal programs (such as the Medicare and Medicaid programs).

"(7) The financial impact of the provision of long-term health care services on caregivers and other family members.

"(8) REPORT AND RECOMMENDATIONS.—(1) **IN GENERAL.**—October 1, 2002, the Secretary shall provide for a report on the study under this section.

"(2) **RECOMMENDATIONS.**—The report under paragraph (1) shall include findings and recommendations regarding each of the following:

(A) The most effective and efficient manner that the Federal Government may use its resources to educate the public on planning for needs for long-term health care services.

(B) The public, private, and joint public-private strategies for meeting identified needs for long-term health care services.

(C) The role of States and local communities in the financing of long-term health care services.

(3) **INCLUSION OF COST ESTIMATES.**—The report under paragraph (1) shall include cost estimates of the most effective and efficient options for which recommendations are made.

"(D) **CONDUCT OF STUDY.**—(1) **USE OF INSTITUTE OF MEDICINE.**—The Secretary of Health and Human Services shall seek to enter into an appropriate arrangement with the Institute of Medicine of the National Academy of Sciences to conduct the study under this section. If such an arrangement cannot be made, the Secretary may provide for the conduct of the study by any other qualified non-governmental entity.

"(2) **CONSULTATION.**—The study should be conducted under this section in consultation with experts from a wide-range of groups from the public and private sectors.

**Subtitle B—Medical Savings Accounts**

SEC. 2111. **EXPANSION OF AVAILABILITY OF MEDICAL SAVINGS ACCOUNTS.**

(a) **REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.**—(1) **IN GENERAL.**—Subdivision (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

"(2) **CONFORMING AMENDMENTS.**—(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

"(B) Section 138 of such Code is amended by striking subsection (I).

"(C) **AVAILABILITY NOT LIMITED TO ACCOUNTS FOR EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS.**—(1) **IN GENERAL.**—Section 220(c)(1)(A) of such Code (relating to eligible individual) is amended to read as follows:

"(A) **IN GENERAL.**—The term "eligible individual" means, with respect to any month, any individual if—

"(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

"(ii) such individual is not, while covered under such health plan, covered under any other health plan, other than a health savings account plan.

"(B) **INCLUSION OF COST ESTIMATES.**—The report under paragraph (1) shall include findings and recommendations regarding each of the following:

(A) The most effective and efficient manner that the Federal Government may use its resources to educate the public on planning for needs for long-term health care services.

(B) The public, private, and joint public-private strategies for meeting identified needs for long-term health care services.

(C) The role of States and local communities in the financing of long-term health care services.

"(3) **INCLUSION OF COST ESTIMATES.**—The report under paragraph (1) shall include cost estimates of the most effective and efficient options for which recommendations are made.

"(D) **CONDUCT OF STUDY.**—(1) **USE OF INSTITUTE OF MEDICINE.**—The Secretary of Health and Human Services shall seek to enter into an appropriate arrangement with the Institute of Medicine of the National Academy of Sciences to conduct the study under this section.

"(2) **CONSULTATION.**—The study should be conducted under this section in consultation with experts from a wide-range of groups from the public and private sectors.
(C) Section 220(b) of such Code is amended by striking paragraph (4) (relating to deduction limited by compensation) and by redesignating paragraphs (5), (6), and (7) as paragraphs (4), (5), and (6), respectively.

(c) INCREASE IN AMOUNT OF ALLOWANCE 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 individual’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) IN GENERAL.—Paragraph (4) of section 220(b) of such Code (as redesignated by subsection (b)(2)(C)) is amended to read as follows:

“(4) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection for any taxable year, but only to the extent such pay or annuity of an employee or annuitant, if coverage is for such employee or annuitant, would (but for this paragraph) apply under this section for that same year with respect to such employee or annuitant, would cause the total to exceed—

“(i) the limitation under paragraph (1) of section 220(b) of the Internal Revenue Code of 1986 (as amended without regard to paragraph (3) thereof) which is applicable to such employee or annuitant for the calendar year in which such period commences; or

“(ii) the amount which, when added to previous contributions made for such period, would cause the total to exceed—

“(A) the limitation under paragraph (1) of section 220(b) of the Internal Revenue Code of 1986 (as amended without regard to paragraph (3) thereof) which is applicable to such employee or annuitant for the calendar year in which the taxable year begins or January 1 of the last calendar year in which the account holder is covered under a high deductible health plan; or

“(B) the amount of the biweekly Government contribution for the contract year involved as defined by paragraph (2), exceeds the amount which, when added to contributions made for such period, would cause the total to exceed—

“(i) the limitation under paragraph (1) of section 220(b) of the Internal Revenue Code of 1986 (as amended without regard to paragraph (3) thereof) which is applicable to such employee or annuitant for the calendar year in which the taxable year begins or the remainder of a year; or

“(ii) such lower amount 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; and

“(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 beginning on the last day of such 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 (as determined without regard to paragraph (2) thereof).

SEC. 2112. AMENDMENTS TO TITLE 5, UNITED STATES CODE, RELATING TO MEDICAL SAVINGS ACCOUNTS AND HIGH DEDUCTIBLE HEALTH PLANS UNDER FEHBP.

(a) MEDICAL SAVINGS ACCOUNTS.—

(1) CONTRIBUTIONS.—Title 5, United States Code, is amended by—

(i) redesignating section 8906a as section 8906c and by inserting after section 8906c the following:

*S8906a. 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 this section for that same year with respect to such employee or annuitant, to a medical savings account of an employee or annuitant.

(b) Notwithstanding any other provision of this section, the maximum Government contribution for the month in which such taxable year begins or January 1 of the calendar year in which the taxable year begins or January 1 of the last calendar year in which the account holder is covered under a high deductible health plan.

(2) IN GENERAL.—Subsection (f) of section 8906c of such Code is amended by striking “75 percent of”.

(b) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection for any taxable year, but only to the extent such pay or annuity of an employee or annuitant, if coverage is for such employee or annuitant, would (but for this paragraph) apply under this section for that same year with respect to such employee or annuitant, would cause the total to exceed—

“(i) the limitation under paragraph (1) of section 220(b) of the Internal Revenue Code of 1986 (as amended without regard to paragraph (3) thereof) which is applicable to such employee or annuitant for the calendar year in which such period commences; or

“(ii) the amount which, when added to previous contributions made for such period, would cause the total to exceed—

“(A) the limitation under paragraph (1) of section 220(b) of the Internal Revenue Code of 1986 (as amended without regard to paragraph (3) thereof) which is applicable to such employee or annuitant for the calendar year in which the taxable year begins or January 1 of the last calendar year in which the account holder is covered under a high deductible health plan.

(2) TREATMENT OF NETWORK-BASED MANAGED CARE PLANS.—Section 220(c)(2)(B) of such Code (relating to the reduction of the amount in subsection (c)(2)(A) which is applicable to such employee or annuitant to a medical savings account of such employee or annuitant under this section) is amended by including in the total at least the amount in subsection (c)(2)(A) which is applicable to such employee or annuitant to a medical savings account of such employee or annuitant under this section.

(3) 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 beginning on the last day of such 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 (as determined without regard to paragraph (2) thereof).

(c) A Government contribution under this section—

(1) shall be made at the same time that, and in 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 appropriated 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 (or supporting information) necessary to identify any medical savings account to which contributions under this section are required 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).

*S8906b. 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) Nothing in subsection (a), no withholding under this section may be made from the pay or annuity of an employee or annuitant for any period.
(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.

(d) AUTHORITY TO CONTRACT FOR HIGH DEDUCTIBLE HEALTH PLANS, ETC.—

(1) CONTRACTS 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 this subsection, offers a health benefits plan under this chapter.

“(p)(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 this subsection, offer a health benefits plan under this chapter.

(2) COMPUTATION OF GOVERNMENT CONTRIBUTIONS TO PLANS UNDER CHAPTER 89 IS NOT AFFECTED BY HIGH DEDUCTIBLE HEALTH PLANS.—Paragraph (2) of section 8906(a) of title 5, United States Code, is amended by striking “subsection (2)(A)” and inserting “subsection (2)(A)” and adding at the end the following:

“(B) Notwithstanding any other provision of this section, the subscription charges for, and the contributions to, high deductible health plans shall be disregarded for purposes of determining any weighted average under paragraph (1).”

(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)(3).

“(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 the requirements of 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.

(f) CONFORMING AMENDMENTS.—

(A) Section 8903a of title 5, United States Code, is amended by redesignating subsections (d) as subsection (c) 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(d)(4)(A).”.

(B) Section 8904(d) of title 5, United States Code, is amended by striking "8904(a)(2)" and inserting "8904(a)(1)".

(g) REFERENCES.—Section 8903 of title 5, United States Code, is amended by adding after paragraph (4) of subsection (d) the following:

“(5) HIGH DEDUCTIBLE HEALTH PLANS.—Similar regulations prescribed with respect to any plan under section 8902(a)(3).”.

(h) ALLOWANCE OF CARRYOVERS OF UNUSED BENEFITS TO LATER TAXABLE YEARS.—

(1) IN GENERAL.—For purposes of this title—

“(A) notwithstanding any other provision of this chapter, offer a health benefits plan under this chapter.

“(B) any other arrangement shall not fail to be treated as a cafeteria plan or flexible spending, or similar arrangement, and

“(C) the plan or arrangement any nontaxable benefit which is unused as of the close of a taxable year may be carried forward to 1 or more succeeding taxable years.

(2) LIMITATION.—Paragraph (1) shall not apply to amounts carried from a plan to the extent such amounts exceed $500 (applied on an annual basis).

(i) ALLOCATION OF ROLLOVER.—

(A) IN GENERAL.—In the case of any unused benefit described in paragraph (1) that consists of amounts in a health flexible spending account or a dependent care flexible spending account, the plan or arrangement shall provide that a participant may elect, in lieu of such carryover, to have such amounts distributed to the participant.

(B) AMOUNTS NOT INCLUDED IN INCOME.—Any distribution under subparagraph (A) shall not be included in gross income by reason of this section or any other provision of this chapter.
for the taxable year from which the unused amount would otherwise be carried.

"(c) TREATMENT OF ROLLOVER.—Any amount rolled over under subparagraph (B) shall be treated as a rollover rollover under section 220, 401(k), 403(b), or 457, whichever is applicable, and shall be taken into account in applying any limitation (or participation requirement) on employer- or employee-contribution under such section or any other provision of this chapter for the taxable year of the rollover.

"(4) COST-OF-LIVING ADJUSTMENT.—In the case of a rollover occurring in a calendar year after 2002, the amount under paragraph (2) shall be adjusted at the same time and in the same manner as under section 415(d)(2).

"(5) APPLICABILITY.—This subsection shall apply to taxable years beginning after December 31, 2001.

"(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

SEC. 2123. REDUCTION IN TAX ON VACCINES.

"(a) IN GENERAL.—Paragraph (1) of section 431(b) of the Internal Revenue Code of 1986 (relating to amount of tax) is amended by striking "3.5 cents" and inserting "15 cents.

"(b) TRANSFERS.—(1) DEPARTMENT OF THE TREASURY.—The Secretary of the Treasury shall annually estimate the impact that the enactment of this division has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

(2) TRANSFER OF FUNDS.—If, under paragraph (1), the Secretary of the Treasury estimates that the enactment of this division has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer an amount equal to the quarterly distribution from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of such division.

SEC. 2123. CUSTOMS USER FEES.

Paragraph (1) of section 8203(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 2803(b)), is amended by striking "2001" and inserting "2010".

SEC. 2123. ESTABLISHMENT OF MEDICARE ADMINISTRATION COST REPORTS.

"(a) IMPOSITION OF FEE.—Notwithstanding any other provision of law and subject to subsection (b), the Secretary of Health and Human Services shall establish (in the form of a separate fee or reduction of payment otherwise made under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)) an administrative fee of $2 for the submission of a claim described in subsection (b).

"(b) CLAIMS SUBJECT TO FEE.—A claim described in this subsection is a claim that—

(1) is submitted by an individual or entity for items or services which payment is sought under title XVIII of the Social Security Act; and

(2) either—

(A) duplicates, in whole or in part, another claim submitted by the same individual or entity; or

(B) is a claim that cannot be processed and must, in accordance with the Secretary of Health and Human Services' instructions, be returned by the fiscal intermediary or carrier to the individual or entity for completion.

"(c) TREATMENT OF FEES FOR PURPOSES OF COST REPORTS.—Any entity may not include a fee assessed pursuant to this section as an allowable item on a cost report submitted under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or title XIX of such Act (42 U.S.C. 1396 et seq.).

"(d) EFFECTIVE DATE.—The provisions of this section apply to claims submitted on or after January 1, 2002.

SEC. 2134. ESTABLISHMENT OF MEDICARE ADMINISTRATION COST REPORTS FOR SUBMISSION OF DUPLICATE AND UNPROCESSABLE CLAIMS.

"(a) IMPOSITION OF FEE.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall establish (in the form of a separate fee or reduction of payment otherwise made under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.)) an administrative fee of $2 for the submission of a claim described in subsection (b).

"(b) CLAIMS SUBJECT TO FEE.—A claim described in this subsection is a claim that—

(1) is submitted by an individual or entity for items or services which payment is sought under title XVIII of the Social Security Act; and

(2) either—

(A) duplicates, in whole or in part, another claim submitted by the same individual or entity; or

(B) is a claim that cannot be processed and must, in accordance with the Secretary of Health and Human Services' instructions, be returned by the fiscal intermediary or carrier to the individual or entity for completion.

"(c) TREATMENT OF FEES FOR PURPOSES OF COST REPORTS.—Any entity may not include a fee assessed pursuant to this section as an allowable item on a cost report submitted under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or title XIX of such Act (42 U.S.C. 1396 et seq.).

"(d) EFFECTIVE DATE.—The provisions of this section apply to claims submitted on or after January 1, 2002.

SEC. 2201. PATIENT RIGHT TO MEDICAL ADVICE AND CARE.

"(a) IN GENERAL.—The Secretary shall annually estimate the impact that the enactment of this division has on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401).

"(b) TRANSFERS.—If, under paragraph (1), the Secretary of the Treasury estimates that the enactment of this division has a negative impact on the income and balances of the trust funds established under section 201 of the Social Security Act (42 U.S.C. 401), the Secretary shall transfer an amount equal to the quarterly distribution from the general revenues of the Federal Government an amount sufficient so as to ensure that the income and balances of such trust funds are not reduced as a result of the enactment of such division.

SEC. 721. ACCESS TO EMERGENCY MEDICAL CARE.

"(a) COVERAGE OF EMERGENCY SERVICES.—If a group health plan (other than a fully insured group health plan) provides coverage for any benefits consisting of emergency medical care, except for items or services specifically excluded from coverage, the plan shall, without regard to prior authorization or provider participation, provide coverage for emergency medical care to stabilize an emergency medical condition following an emergency medical screening examination (if determined necessary and appropriate for additional emergency medical care to stabilize an emergency medical condition) to a participant or beneficiary after the participant or beneficiary has been furnished to transport an individual who has an emergency medical condition to a treating facility for receipt of emergency medical care if—

(1) the emergency medical condition is medically necessary and appropriate and related to the emergency medical condition involved; and

(2) the timely provision of the items or services is medically necessary and appropriate.

"(b) RESPONSIBILITY OF PARTICIPANT.—With respect to items or services provided by a nonparticipating provider under this section, the participant or beneficiary shall not be responsible for amounts that exceed the amounts (including co-insurance, co-payments, deductibles or any other form of cost-sharing) that would be incurred if the care was provided by a participating health care provider with prior authorization.

SEC. 2211. INFORMATION AND PROVIDER RIGHTS.

"(a) IN GENERAL.—Nothing in this section shall be construed to prohibit a group health plan from negotiating reimbursement rates with a nonparticipating provider under this section.

"(b) RESPONSIBILITY OF PROVIDER.—The provider of a group health plan that does not provide reimbursement to a nonparticipating provider under this section shall cease accruing upon the earlier of—

(1) the transfer or discharge of the participant or beneficiary; or

(2) the completion of other arrangements made by the plan and the nonparticipating provider.

"(c) RESPONSIBILITY OF PARTICIPANT.—With respect to items or services provided by a nonparticipating provider under this section, the participant or beneficiary shall not be responsible for amounts that exceed the amounts (including co-insurance, co-payments, deductibles or any other form of cost-sharing) that would be incurred if the care was provided by a participating health care provider with prior authorization.

"(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require a provider to participate in a group health plan, except for items or services provided by a nonparticipating provider under this section.

"(e) DEFINITIONS.—In this section:

(1) EMERGENCY AMBULANCE SERVICES.—The term ‘emergency ambulance services’ means, with respect to a participant or beneficiary under a group health plan (other than a fully insured group health plan) and an otherwise covered service, an emergency ambulance furnished to transport an individual who has an emergency medical condition to a treating facility for receipt of emergency medical care if—

(1) the individual furnishes to transport an individual who has an emergency medical condition to a treating facility for receipt of emergency medical care if—

(a) is covered under the group health plan (other than a fully insured group health plan) involved; and

(b) a prudent layperson who possesses an average knowledge of health and medicine, would reasonably expect the absence of such transport to result in placing the health of the participant
emergency medical condition. Such term is defined in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395d(e)(3)) as an emergency medical condition.

(2) EMERGENCY MEDICAL CONDITION.—The term ‘emergency medical care’ means, with respect to a participant or beneficiary under a group health plan, coverage of such other times as the plan offers the participant or beneficiary to designate a physician who specializes in obstetrics and gynecology as the primary care provider.

(3) APPLICATION OF SECTION.—A group health plan described in subsection (a) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under paragraph (1), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(4) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

(a) to require the coverage under a group health plan (other than a fully insured group health plan) from requiring an authorization in order to obtain obstetrical or gynecological care from a health care professional other than a physician if the provision of obstetrical or gynecological care by such professional is permitted by the group health plan and consistent with State licensure, credentialing, and scope of practice laws and regulations; or

(b) to require that a group health plan (other than a fully insured group health plan) from designating a health care professional other than a physician as a primary care provider for the child if such designation is permitted by the plan and the treatment by such professional is consistent with State licensure, credentialing, and scope of practice laws.

SEC. 725. TIMELY ACCESS TO SPECIALISTS.

(a) TIMELY ACCESS.—If a group health plan (other than a fully insured group health plan) shall ensure that participants and beneficiaries receive timely coverage for access to specialists who are appropriate to the medical condition of the participant or beneficiary, when such specialty care is a covered benefit under the plan.

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

(c) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

(a) to require any group health plan (other than a fully insured group health plan) to provide coverage of any service that is covered by a participating provider if such provider participates in the network, the provisions of subparagraph (C) of clause (i), such specialty care is a covered benefit under the plan.

(b) to require the group health plan to pay any amount that is otherwise payable by the plan.

(c) to require the group health plan to take any action required by this section.

(d) to require any group health plan (other than a fully insured group health plan) to provide coverage of any service that is otherwise payable by the plan.

(e) to require any group health plan (other than a fully insured group health plan) to provide coverage of any service that is otherwise payable by the plan.

(f) to require any group health plan (other than a fully insured group health plan) to provide coverage of any service that is otherwise payable by the plan.

(g) to require any group health plan (other than a fully insured group health plan) to provide coverage of any service that is otherwise payable by the plan.

SEC. 726. ACCESS TO PEDIATRIC CARE.

(a) PEDICATRIC CARE.—If a group health plan (other than a fully insured group health plan) requires or provides for a participant or beneficiary to designate a participating pediatric care provider for the child, such designation shall be permitted by the plan and the treatment by such professional is consistent with State licensure, credentialing, and scope of practice laws.

(b) POINT-OF-SERVICE COVERAGE DEFINED.—In this section, the term ‘point-of-service coverage’ means, with respect to benefits covered under a group health plan (other than a fully insured group health plan), coverage of such benefits when provided by a nonparticipating health care professional.
such specialist may authorize such referrals, procedures, tests, and other medical services with respect to such condition, or coordinate the care for such condition, subject to the terms of a treatment plan agreed to in subsection (c) with respect to the condition.

"(B) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term ‘ongoing special condition’ means:

"(i) is life-threatening, degenerative, or disabling; and

"(ii) requires specialized medical care over a prolonged period of time.

"(C) TREATMENT PLANS.—

"(1) IN GENERAL.—Nothing in this section shall prohibit a group health plan (other than a fully insured group health plan) from requiring that specialty care be provided pursuant to a treatment plan so long as the treatment plan:

"(A) developed by the specialist, in consultation with the case manager or primary care provider, and the participant or beneficiary,

"(B) approved by the plan in a timely manner if the plan requires such approval; and

"(C) in accordance with the applicable quality assurance and utilization review standards of the plan.

"(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan from requiring that the plan provide the provider regular updates on the specialty care provided, as well as all other necessary medical information.

"(D) SPECIALIST DEFINED.—For purposes of this section, the term ‘specialist’ means, with respect to the medical condition of the participant or beneficiary, a health care professional, facility, or center (such as a center of excellence) that has adequate expertise (including age-appropriate expertise) through appropriate training and experience.

"(E) RIGHT TO EXTERNAL REVIEW.—Pursuant to the requirements of section 503B, a participant or beneficiary shall have the right to an independent external review if the denial of an item or service or condition that is required to be covered under this section is eligible for such review.

"SEC. 726. CONTINUITY OF CARE.

"(a) TERMINATION OF PROVIDER.—If a contract between a group health plan (other than a fully insured group health plan) and a treating health care provider is terminated (as defined in paragraph (1) of subsection (d)), the group health plan shall provide the plan with regular updates on the specialty care provided, as well as all other necessary medical information related to the treatment of the terminal illness.

"(b) TERMINAL CONDITION DEFINED.—For purposes of this section, a patient’s right to continuity of care under this section shall be construed as requiring a group health plan and in relation to a participating provider to:

"(1) to provide for failure to meet applicable quality or fraud.

"(i) frequent monitoring over a prolonged period of time and requires substantial ongoing specialist care across a variety of domains of care.

"(2) TERMINAL ILLNESS.—If a participant or beneficiary was determined to be terminally ill (as determined under section 1861(d)(3)(A) of the Social Security Act) at the time of a provider’s termination of participation;

"(B) the provider was treating the terminal illness before the date of the termination under this subsection shall extend for the remainder of the individual’s life for care directly related to the terminal illness.

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

"(1) The treating health care provider agrees to accept reimbursement from the plan and individual involved (with respect to cost-sharing) at the rates applicable according to the provider’s participation status for any service provided under this section after the date of the termination of the contract with the group health plan and not to impose cost-sharing with respect to the individual in an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in this section had not been terminated.

"(2) The treating health care provider agrees to adhere to the quality assurance standards of the plan for payment under paragraph (1) and to provide the plan with regular updates on the specialty care provided as required by the plan.

"(3) The treating health care provider agrees to provide the plan with regular updates on the specialty care provided as required by the plan.

"(d) RULES OF CONSTRUCTION.—Nothing in this section shall be construed to:

--require the coverage of benefits which would not have been covered if the provider involved remained a participating provider; or
--with respect to the termination of a contract under section (a) of a group health plan from requiring that the health care provider—

--notify participants or beneficiaries of their rights under this section; or
--provide the plan with the name of each participant or beneficiary who the provider believes is eligible for transitional care under this section.

"(e) DEFINITIONS.—In this section:

"(1) CONTRACT.—The term ‘contract’ means a plan or group health plan that provides covered benefits with respect to prescription drugs, and limits such coverage to drugs included in a formulary, the plan shall:

--ensure the participation of physicians and pharmacists in developing and reviewing such formulary; and

--in accordance with the applicable quality assurance and utilization review standards of the plan, provide for exceptions from the formulary limitation when a non-formulary alternative is medically necessary and appropriate.

--right to external review.—Pursuant to the requirements of section 503B, a participant or beneficiary shall have the right to an independent external review if the denial of an item or service or condition that is required to be covered under this section is eligible for such review.
SEC. 729. SELF-PAYMENT FOR BEHAVIORAL HEALTH CARE SERVICES.

(a) In general.—A group health plan (other than a fully insured group health plan) may not—

(1) prohibit or otherwise discourage a participant or beneficiary from self-paying for behavioral health care services once the plan has defined coverage for such services; or

(2) terminate a health care provider because such provider permits participants or beneficiaries to self-pay for behavioral health care services—

(A) that are not otherwise covered under the plan; or

(B) for which the group health plan provides limited coverage, to the extent that the group health plan denies coverage of the services.

(b) Rule of construction.—Nothing in subsection (a) shall be construed as prohibiting a group health plan from terminating a contract with a health care provider for failure to meet applicable quality standards or for fraud.

SEC. 730. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CANCER CLINICAL TRIALS.

(a) Coverage.—

(1) in general.—If a group health plan (other than a fully insured group health plan) provides coverage to a qualified individual (as defined in this section) for items and services furnished in connection with participation in a clinical trial referred to in subsection (b)(2),

(A) may not deny the individual participation in such trial;

(B) subject to subsections (b), (c), and (d) 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 participant’s or beneficiary’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 presenting a plan from requiring that a qualified individual participate in the trial through such a participating provider or that the plan 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 and who meets the following conditions:

(D)(A) the individual has been diagnosed with cancer 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 medical advancement for the individual.

(2) either—

(A) the referring physician is a 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 or beneficiary 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 (other than a fully insured group health plan) 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 to be paid for by the sponsors of an approved clinical trial.

(2) factors.—In establishing routine patient costs associated with clinical trial participation—

(A) that are not otherwise covered under the plan, the Secretary shall, in accordance with this paragraph, establish standards relating to the coverage of routine patient costs for individuals participating in clinical trials that group health plans must meet under this section.

(B) the factors—

(i) quality of patient care;

(ii) reasonable costs versus costs associated with the conduct of clinical trials, including unanticipated patient care costs as a result of participation in clinical trials; and

(iii) previous and on-going studies relating to patient care costs associated with participation in clinical trials.

(C) appointment and meetings of negotiated rulemaking committee.—

(i) publication of notice.—Not later than November 15, 2000, the Secretary shall publish notice of the establishment of a negotiated rulemaking committee under section 564(a) of title 5, United States Code, to develop the standards described in subparagraph (A), which shall include—

(I) the proposed scope of the committee;

(II) the interests that may be impacted by the standards;

(iii) a list of the proposed membership of the committee;

(iv) the proposed meeting schedule of the committee;

(v) a solicitation for public comment on the committee; and

(vi) the procedures under which an individual may apply for membership on the committee.

(ii) comment period.—Notwithstanding section 564(c) of title 5, United States Code, the Secretary shall provide for a period, beginning on the date on which the notice is published under clause (i) and ending on November 30, 2000, for the submission of public comments on the committee under this subparagraph.

(iii) appointment of committee.—Not later than December 30, 2000, the Secretary shall appoint a needle rulemaking committee under this subparagraph.

(iv) facilitator.—Not later than January 10, 2001, the negotiated rulemaking committee shall elect a facilitator under section 566(c) of title 5, United States Code, to carry out the activities described in subsection (d) of such section.

(v) meetings.—During the period beginning on the date on which the facilitator is nominated under clause (iv) and ending on March 30, 2001, the negotiated rulemaking committee shall meet to develop the standards described in subparagraph (A).

(D) preliminary committee report.—

(i) in general.—The report to the Secretary shall be under subparagraph (C) and shall report to the Secretary, by not later than March 30, 2001, regarding the committee’s progress on reaching consensus with respect to the rulemaking proceedings and whether such consensus is likely to occur before the target date described in subsection (F).

(ii) publication and public comment.—If the committee reports under clause (i) that the committee has failed to make significant progress towards such consensus by the target date described in subsection (F), the Secretary shall terminate such process and provide for the publication in the Federal Register, by not later than June 30, 2001, of a rule under this paragraph through such other methods as the Secretary may provide.

(E) final committee report and publication or rule by Secretary.—

(i) in general.—If the rulemaking committee is not terminated under subparagraph (D)(ii), the such rulemaking committee shall submit to the Secretary, by not later than May 30, 2001, a report containing a proposed rule.

(ii) publication of rule.—If the Secretary receives a report under clause (i), the Secretary shall provide for the publication in the Federal Register, by not later than June 30, 2001, of the proposed rule.

(F) target date for publication of rule.—As part of the notice under subparagraph (C)(i), and for purposes of this paragraph, the ‘target date for publication’ (referred to in section 564(a)(5) of title 5, United States Code) shall be June 30, 2001.

(G) effective date.—The provisions of this paragraph shall apply to group health plans (other than a fully insured group health plan) for plan years beginning on or after January 1, 2002.

(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 would normally pay for comparable services under subparagraph (A).

(D) approved clinical trial defined.—

(A) in general.—For purposes of this section, ‘approved clinical trial’ means a cancer clinical research study or cancer clinical investigation approved or 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) The Food and Drug Administration.

(D) Either of the following if the conditions described in paragraph (B) are met:

(i) The Department of Veterans Affairs.

(ii) The Department of Defense.

(ii) 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 coverage with respect to clinical trials.

(F) plan satisfaction of certain requirements; responsibilities of fiduciaries.—

(1) in general.—For purposes of this section, insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the issuer shall be treated as meeting the requirements of this section with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the plan sponsor or its representatives not to have established and implemented the required standards 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 because of a failure of the plan sponsor or its representatives to have established and implemented such standards.

(2) construction.—Nothing in this section shall be construed to modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.
“(A) any incremental cost to group health plans resulting from the provisions of this section;

(b) a projection of expenditures to such plans attributable to provisions of this section; and

“(C) any impact on premiums resulting from this section.

(B) RIGHT TO EXTERNAL REVIEW.—Pursuant to the requirements of section 503B, a participant or beneficiary shall have the right to an independent external review if the denial of an item or service that is required to be covered under this section is eligible for such review.

SEC. 730A. PROHIBITION OF DISCRIMINATION AGAINST PROVIDERS BASED ON LICENSURE.

“(a) In General.—A group health plan (other than a fully insured group health plan) shall not discriminate with respect to participation or reimbursement for indeminiﬁcation 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 the provider’s licensure or scope-of-practice law;

“(b) Construction.—Subsection (a) shall not be construed—

“(1) as requiring the coverage under a group health plan of a particular beneﬁt or service or to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan’s participants or beneﬁciaries or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan;

“(2) to avoid any State licensure or scope-of-practice law; or

“(3) as requiring a plan that offers network coverage to include for participation every willing provider who meets the terms and conditions of the plan.

SEC. 730B. GENERALLY APPLICABLE PROVIDER DISCLOSURE REQUIREMENTS.

“In the case of a group health plan that provides coverage under 2 or more coverage options, the requirements of this subpart shall apply separately with respect to each coverage option.”.

(b) RULE WITH RESPECT TO CERTAIN PLANS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, health insurance issuers may offer, and eligible individuals may purchase, high deductible health plans described in section 220(2)(A) of the Internal Revenue Code of 1986. Effective for the 5-year period beginning on the date of the enactment of this Act, such health plans shall not be required to provide payment for any health care items or services that are exempt from the plan’s deductible.

(2) EXISTING STATE LAWS.—A State law relating to participants or beneﬁciaries of health care items and services in effect on the date of enactment of this Act that is preempted under paragraph (1), shall not apply to high deductible health plans after the expiration of the 5-year period described in such paragraph unless the State reenacts such law after such period.

(c) DEFINITION.—Section 731(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191(a)) is amended by adding at the end the following:

“SEC. 731A. INFORMATION ABOUT PLANS AND PROVIDERS.

“SEC. 2211. INFORMATION ABOUT PLANS AND PROVIDERS.

“(a) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

“Subpart C—PATIENT RIGHT TO MEDICAL CARE AND CARE

“Sec. 721. Access to emergency medical care.

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

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

“Sec. 724. Access to mental health care.

“Sec. 725. Timely access to specialists.

“Sec. 726. Continuity of care.

“Sec. 727. Protection of patient-provider conﬁdentiality.

“Sec. 728. Patient’s right to prescription drugs.

“Sec. 729. Self-payment for behavioral health services.

“Sec. 730. Coverage for individuals participating in approved cancer clinical trials.

“Sec. 730A. Prohibition of discrimination against providers based on licensure.

“Sec. 730B. Generally applicable provision.


“Subchapter B of chapter 106 of the Internal Revenue Code of 1986 is amended—

“(1) in the tables of sections, by inserting after the item relating to section 9812 the following new item:

“Sec. 9813. Standard relating to patient’s bill of rights.”;

and

(2) by inserting after section 9812 the following:

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

“A group health plan (other than a fully insured group health plan) shall comply with the requirements of subpart C of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 added by section 2201 of the Patients’ Bill of Rights Plus Act, and such requirements shall be deemed to be incorporated into this section.”

SEC. 2203. ISSUE DATES AND RELATED RULES.

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

(b) LIMITATION ON ENFORCEMENT ACTIONS.—No enforcement action shall be taken, pursuant to the provisions and amendments made by this subtitle, against a group health plan with respect to a violation of a requirement imposed by such amendments before the date of issuance of regulations under this section.

(c) PROVISION OF INFORMATION.—The information to be provided under the amendments made by this subtitle shall be given to participants or beneﬁciaries under this section at the last known address maintained by the plan or issuer with respect to such participants or beneﬁciaries, to the extent the party delegating such responsibility did not cause such noncompliance.

(d) ANY LIMITATION ON ENFORCEMENT ACTIONS.—Any enforcement action shall only be taken against the plan sponsor or the issuer agrees to assume responsibility for compliance with the requirements of this section, in whole or in part, and the party delegating such responsibility is released from liability for compliance with the requirements that are assumed by the other party to the extent the other party did not cause such noncompliance.

SEC. 741H. HEALTH PLAN INFORMATION.

“(a) REQUIREMENT—

“(1) DISCLOSURE.—

“(A) IN GENERAL.—A group health plan, and a health insurance issuer that provides coverage in connection with group health insurance coverage, shall provide for the disclosure of the information described in subsection (b) to participants and beneﬁciaries—

“(i) at the time of the initial enrollment of the participant or beneﬁciary under the plan or coverage;

“(ii) on an annual basis after enrollment—

“(I) in conjunction with the election period of the plan or coverage if the plan or coverage has such an election period; and

“(II) in the case of a plan or coverage that does not have an election period, in conjunction with the beginning of the plan or coverage year; and

“(iii) in the case of any material reduction to the beneﬁts or information described in paragraphs (1) and (2) (and (3) of subsection (b), in the form of a summary notice provided not later than the date on which the reduction takes effect.

“(B) PARTICIPANTS AND BENEFICIARIES.—The disclosure required under subparagraph (A) shall be provided—

“(i) jointly to each participant and beneﬁciary who reside at the same address; or

“(ii) in the case of a beneﬁciary who does not reside at the same address as the participant, separately to the participant and such beneﬁciary.

“(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to prevent a group health plan sponsor and health insurance issuer from entering into an agreement under which either the plan sponsor or the issuer agrees to assume responsibility for compliance with the requirements of this section, in whole or in part, and the party delegating such responsibility is released from liability for compliance with the requirements that are assumed by the other party to the extent the other party did not cause such noncompliance.

SEC. 741I. CONSUMER PROVIDER RELATIONS.

“(a) REQUIREMENT.—The information to be provided under the amendments made by this subtitle shall be given to participants or beneﬁciaries under this section at the last known address maintained by the plan or issuer with respect to such participants or beneﬁciaries, to the extent the party delegating such responsibility did not cause such noncompliance.

“(b) ANY LIMITATION ON ENFORCEMENT ACTIONS.—Any enforcement action shall only be taken against the plan sponsor or the issuer agrees to assume responsibility for compliance with the requirements of this section, in whole or in part, and the party delegating such responsibility is released from liability for compliance with the requirements that are assumed by the other party to the extent the other party did not cause such noncompliance.

“(c) PROVISION OF INFORMATION.—The information to be provided under the amendments made by this subtitle shall be given to participants or beneﬁciaries under this section at the last known address maintained by the plan or issuer with respect to such participants or beneﬁciaries, to the extent the party delegating such responsibility did not cause such noncompliance.

“(d) ANY LIMITATION ON ENFORCEMENT ACTIONS.—Any enforcement action shall only be taken against the plan sponsor or the issuer agrees to assume responsibility for compliance with the requirements of this section, in whole or in part, and the party delegating such responsibility is released from liability for compliance with the requirements that are assumed by the other party to the extent the other party did not cause such noncompliance.

“(e) ANY LIMITATION ON ENFORCEMENT ACTIONS.—Any enforcement action shall only be taken against the plan sponsor or the issuer agrees to assume responsibility for compliance with the requirements of this section, in whole or in part, and the party delegating such responsibility is released from liability for compliance with the requirements that are assumed by the other party to the extent the other party did not cause such noncompliance.
“(5) CHOICE OF PRIMARY CARE PROVIDER.—A description of any requirements and procedures to be used by participants and beneficiaries in selecting, accessing, or changing their primary care provider or designee, or whether such services are provided by a person who is a child of such section applies.

(6) PREAUTHORIZATION REQUIREMENTS.—A description of the requirements and procedures to be used to obtain preauthorization for health services, if such preauthorization is required.

(7) EXPERIMENTAL AND INVESTIGATIONAL TREATMENTS.—A description of the procedures for determining whether a particular item, service, or treatment is considered experimental or investigational, and the circumstances under which such treatments are covered by the plan or issuer.

(8) SPECIALTY CARE.—A description of the requirements and procedures to be used by participants and beneficiaries in accessing specialty care and obtaining referrals to participating and nonparticipating specialists, including the right of beneficiaries to obtain coverage for specialty care under section 725 if such section applies.

(9) CLINICAL TRIALS.—A description the circumstances and conditions under which participation in clinical trials is covered by the plan or issuer, and the right to obtain coverage for approved clinical trials under section 725 if such section applies.

(10) PRESCRIPTION DRUGS.—To the extent the plan or issuer provides coverage for prescription drugs, information whether such coverage is limited to drugs included in a formulary, a description of any provisions and cost-sharing required for obtaining on- and off-formulary medications, a description of the rights of participants and beneficiaries in obtaining access to prescription drugs under section 725 if such section applies, and any educational information that the plan or issuer may provide regarding the appropriate use of emergency services.

(11) CLAIMS AND APPEALS.—A description of the plan or issuer’s rules and procedures pertaining to appeals, a description of the rights of participants and beneficiaries under sections 501, 501A and 501B in obtaining coverage for prescription drugs, and a claim for benefits and appealing coverage decisions internally and externally (including telephone numbers and mailing addresses of the appropriate authority), and a description of any additional legal rights and remedies available under section 502.

(12) ADVANCE DIRECTIVES AND ORGAN DONATION.—A description of procedures for advance directives and organ donation decisions if the plan or issuer maintains such procedures.

(13) INFORMATION ON PLANS AND ISSUERS.—The name, telephone number or numbers of the plan administrator and the issuer to be used by participants and beneficiaries seeking information about plan or coverage benefits, payment, or authorization for services and treatment. The name of the designated decision-maker (or decision-makers) appointed under section 502(n)(2) for paying final determinations under section 503A and approving coverage pursuant to the written determination of an independent medical reviewer under section 503B. Notice of whether the benefits under the plan or issuer are provided under a contract or policy of insurance issued by an issuer, or whether benefits are provided directly by the plan sponsor who bears the insured risk.

(14) TRANSLATION SERVICES.—A summary description of any translation or interpretation services (including the availability of printed information in languages other than English, audio tapes, or information in Braille) that are available for non-English speakers and participants or beneficiaries with communication disabilities and a description of how to access these items or services.

(15) ACCREDITATION INFORMATION.—Any information that the plan or issuer is required to provide by accrediting organizations in the process of accreditation if the plan or issuer is accredited, or any additional quality indicators (such as the results of enrollee satisfaction surveys) that the plan or issuer makes public or makes available to participants and beneficiaries.

(16) DEVELOPMENT OF FUNDING SOURCES.—A description of any rights of participants and beneficiaries that are established by the Patients’ Bill of Rights Plus Act (excluding those described in paragraphs (1) through (15)) if such sections apply. The description required under this paragraph may be combined with the notice required under sections 711(d), 713(b), or 604(a)(1), and with any other notice provision that the Secretary determines may be combined.

(17) AVAILABILITY OF ADDITIONAL INFORMATION.—A statement that the information described in subparagraphs (C) and (D) of section 716(e) is made available by the plan or issuer to participants and beneficiaries.

(18) ACCESSIBILITY.—The information described in subparagraphs (C) and (D) of section 716(e) is made available for non-English speakers and participants and beneficiaries with communication disabilities and a description of how to access these items or services.

(19) INCREASE IN AMOUNT.—The amount referred to in subparagraph (A) shall be increased or decreased, for each calendar year that ends after December 31, 2000, by the same percentage as the percentage by which the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, in September of the preceding calendar year has increased or decreased from the such Index for September of 2000.

(20) CONFORMING AMENDMENTS.—For purposes of this section, a plan or issuer shall have failed to comply with the requirements of this section with respect to a participant or beneficiary if the plan or issuer failed or refused to comply with the requirements of this section within 30 days after the date described in subsection (A).

(21) INFORMATION REQUIRED TO BE USED.—(A) The information required under section 711 shall be used by the Secretary to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under part 1, to reduce duplication with respect to any information that is required to be provided under any such requirements.

(22) CONTACT INFORMATION.—(A) In general.—The Secretary shall issue regulations to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under part 1, to reduce duplication with respect to any information that is required to be provided under any such requirements.

(23) RETROACTIVE EFFECT.—The requirements imposed under part 1, to reduce duplication with respect to any information that is required to be provided under any such requirements.

(24) CONFORMING AMENDMENTS.—(A) In general.—The Secretary shall issue regulations to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under part 1, to reduce duplication with respect to any information that is required to be provided under any such requirements.

(25) SEC. 714. HEALTH PLAN COMPARATIVE INFORMATION.

(26) SEC. 715. COMPLIANCE REQUIREMENTS.

(27) SEC. 716. INFORMATION MAINTAINED.

(28) SEC. 717. REPORTS.

(29) SEC. 718. PENALTIES.

(30) SEC. 719. ENFORCEMENT.

(31) SEC. 720. CONFORMING AMENDMENTS.

(32) SEC. 721. COMPLIANCE REQUIREMENTS.

(33) SEC. 722. INFORMATION MAINTAINED.

(34) SEC. 723. REPORTS.

(35) SEC. 724. PenALTIES.

(36) SEC. 725. ENFORCEMENT.

(37) SEC. 726. CONFORMING AMENDMENTS.

(38) SEC. 727. COMPLIANCE REQUIREMENTS.

(39) SEC. 728. INFORMATION MAINTAINED.

(40) SEC. 729. REPORTS.

(41) SEC. 730. PenALTIES.

(42) SEC. 731. ENFORCEMENT.

(43) SEC. 732. CONFORMING AMENDMENTS.

(44) SEC. 733. COMPLIANCE REQUIREMENTS.

(45) SEC. 734. INFORMATION MAINTAINED.

(46) SEC. 735. REPORTS.

(47) SEC. 736. PenALTIES.

(48) SEC. 737. ENFORCEMENT.
of the report and study conducted under subsection (a).

Subtitle C—Right to Hold Health Plans Accountable

SEC. 2211. AMENDMENTS TO EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) In General.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as added by section 503 (29 U.S.C. 1133) the following:

SEC. 503A. CLAIMS AND INTERNAL APPEALS PROCEDURES FOR GROUP HEALTH PLANS.

“(a) Initial Claim for Benefits Under Group Health Plans.—

(1) Procedures.—

(A) A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall ensure that procedures are in place for—

(i) making a determination on an initial claim for benefits by a participant or beneficiary (or authorized representative) regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involved, including any cost-sharing amount that the participant or beneficiary is required to pay with respect to the initial claim for benefits; and

(ii) notifying a participant or beneficiary (or authorized representative) and the treating health care professional (if any) that a determination on an initial claim for benefits made under the terms and conditions of the plan or coverage, including any cost-sharing amount that the participant or beneficiary may be required to make with respect to such claim for benefits, and of the right of the participant or beneficiary to an internal appeal under subsection (b).

(B) Access to Information.—With respect to an initial claim for benefits, the participant or beneficiary (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information necessary to make a determination relating to the claim, not later than 5 business days after the date on which the claim is filed or to meet the applicable timelines under clauses (ii) and (iii) of paragraph (2)(A).

(C) Oral Requests.—In the case of a claim for benefits, and any request for an expedited or retrospective determination, a participant or beneficiary (or authorized representative) may make an initial claim for benefits orally, but a group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, may require that the participant or beneficiary (or authorized representative) provide written confirmation of such request in a timely manner.

(2) Notice of a Denial of a Claim for Benefits.—Written notice of a denial of a claim for benefits under section (a) under the procedures described in clause (i), a group health plan, shall maintain procedures to ensure that a determination under the procedures described in clause (i) would seriously jeopardize the life or health of the participant or beneficiary. Such determination shall be made within 72 hours after a request is received by the plan or issuer under this clause.

(3) Conduct of Review.—A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall maintain procedures to ensure that a determination under the procedures described in clause (i) would seriously jeopardize the life or health of the participant or beneficiary. Such determination shall be made within 72 hours after a request is received by the plan or issuer under this clause.

(4) Failure to Act.—The failure of a plan or issuer to make a determination on a claim for benefits under subsection (a) within the applicable timeline established for such determination under this subsection shall be treated as a denial of a claim for benefits for purposes of proceeding to external review under this subsection.

(D) Plan Waiver of Internal Review.—A group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall maintain procedures to ensure that a determination under the procedures described in clause (i) would seriously jeopardize the life or health of the participant or beneficiary. Such determination shall be made within 72 hours after a request is received by the plan or issuer under this clause.

(5) Time Limitations.—A denial of a claim for benefits under this subsection shall be conducted by an individual with appropriate expertise who was not directly involved in the initial determination.
claim for benefits that is based on a lack of medical necessity and appropriateness, or based on an experimental or investigational treatment, or requires an evaluation of medical facts, shall be made by a physician with appropriate expertise, including a physician who is not involved in the initial determination.

(4) NOTICE OF DETERMINATION.—

(A) Written notice of a determination made under an internal appeal of a denial of a claim for benefits shall be issued to the participant or beneficiary (or authorized representative) and the treating health care professional not later than 2 business days after the completion of the review (or within 72- or 24-hour period referred to in paragraph (2) if applicable).

(B) FINAL DETERMINATION.—The decision by a plan or issuer under this subsection shall be treated as a final determination if, within the applicable timeline established for such a determination, the failure of a plan or issuer to issue a determination on a claim for benefits under this subsection within the applicable timeline established for such a determination shall be treated as a final determination on an appeal of a denial of a claim for benefits.

(5) OBLIGATIONS PERMITTED IN EXPEDITED OR CONCURRENT CASES.—In the case of an expedited or concurrent external review as provided for under subsection (e), the request may be made orally, but written confirmation of such request shall be made in a timely manner. Such written confirmation shall be treated as a consent for purposes of subparagraph (A) unless the participant or beneficiary involved (or an authorized representative) provides written confirmation of such decision.

(6) EXCEPTION TO FILING FEE REQUIREMENT.—

(I) IN GENERAL.—Payment of a filing fee shall not be required under subparagraph (A)(iv) (where there is a certification (in a form and manner specified in guidelines established by the Secretary) that the participant or beneficiary involved (as defined in such guidelines) and the treating health care professional (if any) that the denial is not subject to independent medical review under section 503A(b)(1)(D).

(II) FEE NOT REQUIRED.—Payment of a filing fee shall not be required under subparagraph (A)(iv) if the plan or issuer waives the internal appeals process under section 503A(b)(1)(D).

(III) REDUNDANCY OF FEE.—The filing fee paid under subparagraph (A)(iv) shall be refunded if the determination under the independent external review is to reverse the denial which is the subject of the review.

(IV) INCREASE IN AMOUNT.—The amount referred to in clause (I) shall be increased or decreased, for each calendar year that ends after December 31, 2001, by the same percentage as the percentage by which the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, for September of the preceding calendar year has increased or decreased from the such Index for September of 2001.

(7) ACCESS TO PLAN OR ISSUER AND HEALTH PROFESSIONAL INFORMATION.—With respect to an independent external review conducted under this section, the participant or beneficiary involved shall be provided with all information concerning the denial of a claim for benefits under this section (determined by the entity, not later than 5 business days after the date on which a request is referred to a qualified external review entity), and if required the independent medical reviewer.

(8) FEE REQUIREMENT.—Payment of a filing fee shall not be required under subparagraph (A)(iv) if (A) the request is submitted by a participant or beneficiary involved (or an authorized representative) and the treating health care professional (if any) that the denial is not subject to independent medical review under section 503A(b)(1)(D).

(B) REQUIREMENTS AND EXCEPTION RELATING TO GENERAL RULE.—

(I) IN GENERAL.—Written notice of a determination under section 503A(b)(1)(D) requires an evaluation of medical facts, shall be treated as a final determination on an appeal of a denial of a claim for benefits under section 503B and shall be served on the participant or beneficiary involved (or an authorized representative) and the treating health care professional (if any). Such written confirmation shall be understood by the average participant.

(II) THE THRESHOLDS DESCRIBED IN SUBPARAGRAPH (A) SHALL NOT APPLY IF THE ENTITY DETERMINES THAT—

(a) The denial is not subject to independent medical review under section 503A(b)(1)(D).

(b) The entity has determined that the claim is not subject to independent medical review.

(9) USE OF APPROPRIATE PERSONNEL.—A qualified external review entity shall use appropriate personnel for each case for the determination, or scope of coverage of items or services involved is not eligible for independent medical review for purposes of sections 503A or 503B.

(B) REQUIREMENTS AND EXCEPTION RELATING TO GENERAL RULE.—

(I) IN GENERAL.—The thresholds described in this subparagraph are that—

(a) The total amount payable under the plan or coverage for the item or service was the result of a significant risk of placing the life, health, or development of the participant or beneficiary in jeopardy if the denial of the claim for benefits is sustained.

(b) NO REFERENCE TO PRIOR DETERMINATIONS.—In making determinations under subparagraph (A), there shall be no reference given to determinations made by the plan or issuer under section 503A or the recommendation of a treating health care professional (if any).

(10) GENERAL TIMELINE FOR DETERMINATION.—

(II) shall include the reasons for the determination.

The entity shall provide notice in accordance with subparagraph (D).

(c) PROCESS FOR MAKING DETERMINATIONS.—

(A) IN GENERAL.—The entity shall provide notice in accordance with subparagraph (D).

(B) REQUIREMENTS AND EXCEPTION RELATING TO GENERAL RULE.—

(I) IN GENERAL.—If the entity under this paragraph does not make a referral to an independent medical reviewer, the entity shall provide notice to the participant or beneficiary (or authorized representative) filing the request, and the treating health care professional (if any) that the denial is not subject to independent medical review.

(ii) E XCEPTION TO FILING FEE REQUIREMENT.—

(A) IN GENERAL.—Upon the filing of a request for independent external review with the group health plan, or health insurance issuer offering group health coverage, the group health plan, the plan or issuer shall refer such request to a qualified external review entity selected in accordance with this section.

(B) ACCESS TO PLAN OR ISSUER AND HEALTH PROFESSIONAL INFORMATION.—With respect to an independent external review conducted under this section, the participant or beneficiary involved is not eligible for independent medical review for purposes of sections 503A or 503B.

(C) SCREENING OF REQUESTS BY QUALIFIED EXTERNAL REVIEW ENTITIES.—

(A) IN GENERAL.—With respect to a request referred to an independent medical reviewer under paragraph (1) relating to a denial of a claim for benefits, the entity shall refer such request for the conduct of an independent medical review unless it determines that—

(i) any of the conditions described in subsection (b)(2)(A) have not been met;
"(1) In general.—If a qualified external review entity determines under subsection (c) that a denial of a claim for benefits is eligible for independent medical review, the entity shall refer the denial to an independent medical reviewer for the conduct of an independent medical review under this subsection.

(2) MEDICALLY REVIEWABLE DECISIONS.—A denial is medically reviewable when:

(a) the denial is based on medical necessity or appropriateness of a service or on one (or more) of the following determinations:

(i) whether the item or service is covered under the plan or policy.

(ii) whether the item or service is necessary or appropriate.

(iii) whether the item or service is experimental or investigational.

(b) DENIALS OTHERWISE BASED ON AN EVALUATION OF MEDICAL FACTS.—A determination that the item or service is experimental or investigational.

(c) NO COVERAGE FOR EXCLUDED BENEFITS.—Nothing in this subsection shall be construed to authorize the denial of coverage if the denial is based on information reviewed under subsection (c)(2), or on the determination by the reviewer or submitted to the plan, that the item or service is:

(A) DENIALS BASED ON MEDICAL NECESSITY AND APPROPRIATENESS.—The basis of the determination is that the item or service is not medically necessary and appropriate.

(B) DENIALS BASED ON EXPERIMENTAL OR INVESTIGATIONAL TREATMENT.—The basis of the determination is that the item or service is experimental or investigational.

(d) NO COVERAGE FOR EXCLUDED BENEFITS.—Nothing in this subsection shall be construed to authorize the denial of coverage if the denial is based on information reviewed under subsection (c)(2), or on the determination by the reviewer or submitted to the plan, that the item or service that is the subject of the denial is not covered under the terms and conditions of the plan or coverage and that are not covered by another State statute or regulation; or

(e) NO COVERAGE FOR ExPERIMENTAL OR INVESTIGATIONAL.—The basis of the determination is the item or service is experimental or investigational.

(3) TIMELINES AND NOTIFICATIONS.—

(A) PRIOR AUTHORIZATION DETERMINATION.—

(i) In general.—The independent medical reviewer shall make a determination on a request for prior authorization of a claim for benefits that is referred to the reviewer under subsection (c)(3) not later than 14 business days after the receipt of information under subsection (c)(2) if the reviewer involves a prior authorization of items or services.

(ii) Expedited determination.—Notwithstanding clause (i), the independent medical reviewer shall make an expedited determination of a denial of a claim for benefits described in clause (i), when a request for such an expedited determination is made by a participant or beneficiary (or authorized representative) at any time during the process for making a determination, and the reviewer involves a prior authorization of items or services.

(B) RETROSPECTIVE DETERMINATION.—The independent medical reviewer shall make a determination on a request for a retrospective determination of a denial of a claim for benefits that is referred to the reviewer under subsection (c)(3) not later than 24 hours after the receipt of information under subsection (c)(2) if the reviewer involves a discontinuation of coverage.

(C) CONCURRENT DETERMINATION.—The independent medical reviewer shall make a determination on a request for a concurrent determination of a denial of a claim for benefits that is referred to the reviewer under subsection (c)(3) not later than 24 hours after the receipt of information under subsection (c)(2) if the reviewer involves a discontinuation of coverage.

(4) TERMINATION OF EXTERNAL REVIEW PROCESS IF APPROVAL OF A CLAIM FOR BENEFITS DURING PROCESS.—

(A) In general.—If a plan or issuer, or a health care professional, pays for any items or services provided by a participant or beneficiary on a particular claim for benefits that is the subject of an external review under this section, the external review process shall be terminated with respect to such denial and any filing fee paid under subsection (b)(2)(A)(iv) shall be refunded.

(B) TREATMENT OF TERMINATION.—An authorization of coverage under subparagraph (A) by the plan or issuer shall be treated as a written determination to reverse a denial under section 503A and, for purposes of liability under section 503A, shall be treated as approval of a claim for benefits.

(5) COMPLIANCE.—

(A) COMPLIANCE.—

(i) Declaration.—The external review entity and an independent medical reviewer under this section shall be binding on the plan or issuer, participant or beneficiary, where such failure to comply is caused by the plan or issuer, the participant or beneficiary, where such failure to comply is caused by the plan or issuer, or the participant or beneficiary (or authorized representative) and the treating health care professional (if any) and, the external review entity and an independent medical reviewer under this section shall be binding on the plan or issuer, participant or beneficiary, where such failure to comply is caused by the plan or issuer, the participant or beneficiary, or any other entity or reviewer.

(ii) Payments.—The plan or issuer shall fully reimburse a professional, participant or beneficiary under subparagraph (A) for the total costs of the items or services provided (regardless of whether such costs or services are provided as coverage of such items of services) so long as—

(iii) the items or services would have been covered under the terms of the plan or coverage if provided by the plan or issuer; and

(iv) the items or services were provided in a manner consistent with the determination of the independent medical reviewer.
"(4) FAILURE TO REMBURSE.—Where a plan or issuer fails to provide reimbursement to a professional, participant or beneficiary in accordance with this subsection, the professional, participant or beneficiary may commence a civil action (or utilize other remedies available under law) to recover only the amount of any such reimbursement that is unpaid and any necessary legal costs or expenses (including attorneys' fees) incurred in pursuing such reimbursement.

"(g) QUALIFICATIONS OF INDEPENDENT MEDICAL REVIEWERS.—

"(1) IN GENERAL.—In referring a denial to 1 or more independent medical reviewers to conduct independent medical review under subsection (c), the qualified external review entity shall ensure that—

"(A) each independent medical reviewer meets the qualifications described in paragraphs (2) and (3); and

"(B) with respect to each review at least 1 such reviewer meets the requirements described in paragraphs (4) and (5); and

"(C) compensation provided by the entity to the reviewer is consistent with paragraph (6).

"(2) LICENSURE AND EXPERTISE.—Each independent medical reviewer shall be a physician or health care professional who—

"(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

"(B) typically treats the diagnosis or condition or provides the type of treatment under review.

"(3) INDEPENDENCE.—

"(A) IN GENERAL.—Subject to subparagraph (B), each independent medical reviewer in a case shall—

"(i) not be a related party (as defined in paragraph (7));

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

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

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

"(i) prohibit an individual, solely on the basis of affiliation with the plan or issuer, from serving as an independent medical reviewer if—

"(I) a non-affiliated individual is not reasonably available;

"(II) the affiliated individual is not involved in the provision of items or services in the case under review; and

"(iii) the effect of such an affiliation is disclosed to the plan or issuer and the participant or beneficiary (or authorized representative) and neither party objects;

"(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer if the affiliation is disclosed to the plan or issuer and the participant or beneficiary (or authorized representative), and neither party objects;

"(iii) permit an employee of a plan or issuer, or an individual who provides services exclusively or primarily to or on behalf of a plan or issuer, from serving as an independent medical reviewer; or

"(iv) prohibit receipt of compensation by an independent medical reviewer from an entity if the compensation is provided consistent with paragraph (6).

"(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

"(A) IN GENERAL.—The requirement of this paragraph with respect to a reviewer in a case involving treatment, or the provision of items or services, by—

"(i) a physician, is that the reviewer be a practicing physician of the same or similar specialty, when reasonably available, as a physician who typically treats the diagnosis or condition or provides such treatment in the case under review; or

"(ii) a health care professional (other than a physician), is that the reviewer be a health care professional who—

"(A) is typically certified (and periodically recertified) to provide the services, by—

"(B) not exceed a reasonable level; and

"(C) not be contingent on the decision rendered by the reviewer.

"(7) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a denial of a claim under a plan or coverage relating to a participant or beneficiary, any of the following:

"(A) The plan, plan sponsor, or issuer involved, or any fiduciary, officer, director, or employee of such plan, plan sponsor, or issuer.

"(B) The participant or beneficiary (or authorized representative).

"(C) The health care professional that provides the items or services involved in the denial.

"(D) The institution at which the items or services (or treatment) involved in the denial are provided.

"(E) The manufacturer of any drug or other item that is included in the items or services involved in the denial.

"(F) Any other party determined under any regulations.

"(8) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified external review entity to an independent medical reviewer in connection with a review under this section shall—

"(A) not exceed a reasonable level; and

"(B) not be contingent on the decision rendered by the reviewer.

"(9) SELECTION OF QUALIFIED EXTERNAL REVIEW ENTITIES.—

"(A) LIMITATION ON PLAN OR ISSUER SELECTION.—The Secretary shall implement procedures with respect to the selection of qualified external review entities by a plan or issuer to assure that the selection process among qualified external review entities will not create any incentives for external review entities to make a decision in a biased manner.

"(B) STATE AUTHORITY WITH RESPECT TO QUALIFIED EXTERNAL REVIEW ENTITIES FOR HEALTH INSURANCE ISSUERS.—With respect to health insurance issuers offering health insurance coverage in connection with a group health plan in a State or the State may, pursuant to a State law that is enacted after the date of enactment of the Patients’ Bill of Rights Plus Act, provide for the designation or selection of qualified external review entities in a manner determined by the State to assure an unbiased determination in conducting external review activities. In conducting reviews under this section, an entity designated or selected under this subparagraph shall comply with the provision of this section.

"(C) CONTRACT WITH QUALIFIED EXTERNAL REVIEW ENTITY.—Except as provided in paragraph (1)(A), the qualified external review process of a plan or issuer under this section shall be conducted under a contract between the plan or issuer and 1 or more qualified external review entities (as defined in paragraph (4)(A)).

"(2) TERMS AND CONDITIONS OF CONTRACT.—The terms and conditions of a contract under paragraph (2) shall—

"(A) be consistent with the standards the Secretary shall establish to assure there is no real or apparent conflict of interest in the conduct of external review activities; and

"(B) provide that the costs of the external review process shall be borne by the plan or issuer.

Subparagraph (B) shall not be construed as applying to the imposition of a filing fee under subsection (b)(2)(A)(iv) or costs incurred by the participant or beneficiary (or authorized representative) or treating health care professional (if any) in support of the review, including the provision of additional evidence or information.

"(4) QUALIFICATIONS.—

"(A) IN GENERAL.—In this section, the term 'qualified external review entity' means, in relation to a plan or issuer, an entity that is initially certified (and periodically recertified) under subparagraph (C) as meeting the following requirements:

"(i) The entity has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to carry out duties of a qualified external review entity under this section on a timely basis, including making determinations under subsection (b)(2)(A) and providing for independent medical review under subsection (d).

"(ii) The entity is not a plan or issuer or an affiliate or a subsidiary of a plan or issuer, and is not an affiliate or subsidiary of a professional organization of plans or issuers or of health care providers.

"(iii) The entity has provided assurances that it will conduct external review activities consistent with the applicable requirements of this section and the standards specified in subparagraph (C), including that it will not conduct any external review activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

"(iv) The entity has provided assurances that it will provide information in a timely manner under subparagraph (D).

"(B) INDEPENDENCE REQUIREMENTS.—

"(i) IN GENERAL.—Subject to clause (ii), an entity meets the independence requirements of this subparagraph with respect to any case if the entity—

"(I) is not a related party (as defined in subsection (g)(7));

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

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

"(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified external review entity of compensation from a plan or issuer for the conduct of external review activities under this section if the compensation is provided consistent with clause (iii).

"(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by a plan or issuer to a qualified external review entity in connection with reviews under this section shall—

"(I) not exceed a reasonable level; and

"(II) not be contingent on the decision rendered by the entity or by any independent medical reviewer.

"(C) CERTIFICATION AND RECERTIFICATION PROCESS.—
(I) IN GENERAL.—The initial certification and recertification of a qualified external review entity shall be made—

(I) under a process that is recognized or approved by the Secretary; or

(II) by a qualified private standard-setting organization that is approved by the Secretary under clause (iii).

(ii) PROCESS.—The Secretary shall not recognize or approve a process under clause (I) unless the process applies standards (as promulgated in regulations) that ensure that a qualified external review entity—

(I) will carry out (and has carried out, in the case of recertification) the responsibilities of such an entity in accordance with this section, including meeting applicable deadlines;

(II) will meet (and has met, in the case of recertification) appropriate indicators of fiscal integrity;

(III) will maintain (and has maintained, in the case of recertification) appropriate confidentiality with respect to individually identifiable health information obtained in the course of conducting external review activities; and

(IV) in the case recertification, shall review the matters described in clause (ii).

(iii) APPROVAL OF QUALIFIED PRIVATE STANDARD-SETTING ORGANIZATIONS.—For purposes of clause (ii), the Secretary may approve a qualified private standard-setting organization if the Secretary finds that the organization only certifies (or recertifies) external review entities that meet at least the standards required for the certification (or recertification) of external review entities under clause (ii).

(iv) CONSIDERATIONS IN RECERTIFICATIONS.—In conducting recertifications of a qualified external review entity under this paragraph, the Secretary shall conduct the recertification to ensure compliance of the entity with the requirements for conducting external review activities under this section, including the following:

(I) Provision of information under subparagraph (D).

(II) Adherence to applicable deadlines (both by the entity and by independent medical reviewers) it refers cases to.

(III) Compliance with limitations on compensation (with respect to both the entity and independent medical reviewers it refers cases to).

(IV) Compliance with applicable independence requirements.

(v) PERIOD OF CERTIFICATION OR RECERTIFICATION.—A certification or recertification provided under this paragraph shall extend for a period not to exceed 5 years.

(vi) REVOCATION.—A certification or recertification under this paragraph may be revoked by the Secretary or by the organization providing such certification upon a showing of cause.

(D) PROVISION OF INFORMATION.—

(I) IN GENERAL.—A qualified external review entity shall provide to the Secretary, in such manner and at such times as the Secretary may require, such information (relating to the denials with respect to which the entity certified to the Secretary for the conduct of external review under this section) as the Secretary determines appropriate to ensure compliance with the independence and other requirements of this section to monitor and assess the quality of its external review activities and lack of bias in making determinations. Such information shall include information described in clause (ii) but shall not include individually identifiable medical information.

(ii) INFORMATION TO BE INCLUDED.—The information described in this subclause with respect to an entity is as follows:

(1) The number and types of denials for which a request for review has been received by the entity.

(2) The disposition by the entity of such denials, including the number referred to an independent medical reviewer and the reasons for such denials (including the application of exclusions, on a plan or issuer-specific basis and on a health care specialty-specific basis).

(3) The length of time in making determinations with respect to such denials.

(4) Updates on the information required to be submitted as a condition of certification with respect to the entity's performance of external review activities.

(III) INFORMATION REQUIRED TO BE PROVIDED TO CERTIFYING ORGANIZATION.—

(I) IN GENERAL.—In the case of a qualified external review entity which is certified (or recertified) under this subsection by a qualified private standard-setting organization, the Secretary shall make available to the public in an appropriate manner—

(A) a person authorized by law to provide professional services to such entity (including as an independent medical reviewer), shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this section, to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

(2) LIMITATION ON LIABILITY.—No qualified external review entity having a contract with a plan or issuer, and no person who is employed by such entity or who furnishes professional services to such entity (including as an independent medical reviewer), shall be held liable for the performance of any duty, function, or activity required or authorized pursuant to this section, to be civilly liable under any law of the United States or of any State (or political subdivision thereof) if there was no actual malice or gross misconduct in the performance of such duty, function, or activity.

(3) CLAIM FOR BENEFITS.—The term ‘claim for benefits’ means procedures for group health plans.

(4) GROUP HEALTH PLAN.—The term ‘group health plan’ shall mean the group health plan the Secretary, or organization conducting the recertification of such entities, and shall be made available to the public in an appropriate manner.

(5) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ has the meaning given such term in section 733(b)(2).

(6) PRIOR AUTHORIZATION DETERMINATION.—The term ‘prior authorization determination’ means a determination by the group health plan or health insurance issuer offering health insurance coverage in connection with a group health plan prior to the provision of the items and services as a condition of coverage of the item or service under the terms and conditions of the plan or coverage.

(7) TREATING HEALTH CARE PROFESSIONAL.—The term ‘treating health care professional’ with respect to a group health plan, health insurance issuer or qualified private standard-setting organization means a physician (medical doctor or doctor of osteopathy) or other health care practitioner who is acting within the scope of his or her State licensure for the delivery of health care services and who is primarily responsible for delivering those services to the participant or beneficiary.

(B) UTILIZATION REVIEW.—The term ‘utilization review’ with respect to a group health plan or health insurance coverage means procedures used in the determination of coverage for a participant or beneficiary, such as procedures to evaluate the medical necessity, appropriateness, efficacy, quality, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plans beginning on or after 2 years after the date of enactment of this Act. The Secretary shall issue all regulations necessary to carry out the amendments made by this section before the effective date thereof.

SEC. 2222. ENFORCEMENT.

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

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

"(1) IN GENERAL.—"

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

"(A) FAILURE TO COMPLY WITH EXTERNAL MEDICAL REVIEW.—In any case in which—"

"(A) a designated decision-maker described in paragraph (2) fails to exercise ordinary care in
approving coverage pursuant to the written determination of an independent medical reviewer under section 503B(d)(3)(F) that reverses a denial of a claim for benefits; and

(ii) the failure of a group of persons to provide that the designated decision-maker is liable only for the amount of any charge, payments, or damages for which a participant or beneficiary for the injury that was the subject of such action.

(8) LIMITATION ON RELIEF WHERE DEFENDANT'S POSITION PREVIOUSLY SUPPORTED UPON EXTERNAL REVIEW.—In any case in which the court finds the defendant to be liable in an action under this subsection in addition to the relief which such liability is based on a finding by the court that the defendant's position was, or will be, supported under subsection (a)(1)(B), which is commenced more than 1 year after—

(A) the failure of a group health plan or health insurance issuer offering coverage in connection with a group health plan to make determinations described in section 503A with respect to claims for benefits under section 503A(b); or

(B) the effect of an expedited review under section 503A or 503B would have been to reverse the amount paid by such participant or beneficiary for the injury that was the subject of such action.

(9) DETERMINATION ON CREDIBILITY.—In any case in which a natural person is a party to a cause of action under paragraph (1), the court shall not determine the credibility of a natural person in connection with the cause of action except with the consent of the natural person (and in the case of a minor, the consent of the guardian of such participant or beneficiary) to know that an expedited review under section 503A or 503B would have been authorized by an independent medical reviewer to reverse such final determination has been issued with respect to such review.

(4) LIMITATIONS ON RECOVERY OF DAMAGES.—

(a) In general.—The aggregate amount of liability for any cause of action under paragraph (1) may not exceed $350,000.

(b) Amount otherwise recoverable.—Such amount shall be an affirmative defense that—

(A) the failure of a group health plan or health insurance issuer offering coverage in connection with a group health plan to make determinations described in section 503A with respect to claims for benefits under section 503A(b) has been referred for independent medical review under section 503A(b) (with respect to an internal review), or for approving coverage pursuant to the written determination of an independent medical reviewer under section 503B, with respect to a denial of a claim for benefits shall be treated as the designated decision-maker for purposes of liability under this section.

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

(A) the group health plan or health insurance issuer offering health insurance coverage in connection with a group health plan, health insurance issuer offering health insurance coverage in connection with a group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall not be used in determining liability where a qualified external review entity or an independent medical reviewer to meet the timelines applicable under section 503B.

B. WAIVER OF INTERNAL REVIEW.—In the case of any cause of action under paragraph (1), the waiver or nonwaiver of internal review under section 503A(1)(A)(D) by the group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall not be used in determining liability where a qualified external review entity or an independent medical reviewer to meet the timelines applicable under section 503B.

C. LIMITATIONS ON ACTIONS.—(Paragraph (1) shall not apply in connection with any action that commenced before December 31, 2001, and the refusal or nonwaiver of internal review under section 503A(1)(A)(D) by the group health plan or health insurance issuer offering health insurance coverage in connection with a group health plan, shall not be used in determining liability where a qualified external review entity or an independent medical reviewer to meet the timelines applicable under section 503B.

D. TREATMENT OF COLLATERAL SOURCE PAYMENTS.—(1) In general.—In the case of any action commenced pursuant to paragraph (1), the total amount of damages received by a participant or beneficiary under such action shall be reduced, in accordance with clause (ii), by any other payment that has been, or will be, made to such participant or beneficiary to compensate such participant or beneficiary for the injury suffered by the participant or beneficiary. In all such cases, the liability of a defendant for non-economic damages shall be several and not joint.

(2) TREATMENT OF COLLABORATIVE CARE PAYMENTS.—(A) The amount by which an award of damages to a participant or beneficiary for an injury shall be reduced under clause (i) shall be—

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

(ii) the amount paid by such participant or beneficiary (or by the spouse, parent, or legal guardian of such participant or beneficiary) to secure the performance of any service which an award of damages to a participant or beneficiary for an injury shall be reduced under clause (i);

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

(E) FAILURE TO DESIGNATE.—In any case in which a designated decision-maker is not appointed under section 503A(b); or

(F) the cause of action is based solely on the failure of a qualified external review entity or an independent medical reviewer to meet the timelines applicable under section 503B.

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

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

(iii) the cause of action is not timely commenced solely on the failure of a qualified external review entity or an independent medical reviewer to meet the timelines applicable under section 503B.

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

(A) the group health plan or health insurance issuer offering health insurance coverage in connection with a group health plan, health insurance issuer offering health insurance coverage in connection with a group health plan, or health insurance issuer offering health insurance coverage in connection with a group health plan, shall not be used in determining liability where a qualified external review entity or an independent medical reviewer to meet the timelines applicable under section 503B.
“(A) AUTHORIZED REPRESENTATIVE.—The term ‘authorized representative’ has the meaning given such term in section 503(b)(1).

(B) CLAIM FOR BENEFITS.—The term ‘claim for benefits’, so defined in section 503(b)(1), except that such term shall only include claims for prior authorization decisions (as such term is defined in section 503(b)(1)).

(C) GROUP HEALTH PLAN.—The term ‘group health plan’ shall have the meaning given such term in section 733(b)(1).

(D) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ has the meaning given such term in section 733(b)(2) (including health maintenance organizations as defined in section 733(b)(2)).

(E) ORDINARY CARE.—The term ‘ordinary care’ means the care, skill, prudence, and diligence under the circumstances prevailing at the time the care is provided that a prudent individual acting in a like capacity and familiar with the care being provided would use in providing such care.

(F) SUBSTANTIAL HARM.—The term ‘substantial harm’ means the loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, or severe and chronic physical pain.

(2) EFFECTIVE DATE.—The provisions of this subsection shall apply to acts and omissions occurring on or after the date of enactment of this Act.''

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

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

“(o) IMMUNITY FROM LIABILITY FOR PROVISION OF INSURANCE OPTIONS.—

(1) No liability shall arise under subsection (n) with respect to a participant or beneficiary against a group health plan (other than a fully insured group health plan) if such plan offers the participant or beneficiary the coverage option described in paragraph (2).

(2) COVERAGE OPTION.—The coverage option described in paragraph (1) is one under which the group health plan (other than a fully insured group health plan), at the time of enrollment or as provided for in paragraph (3), provides the participant or beneficiary with the option to—

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

(B) receive an individual benefit payment, in an amount equal to the amount that would be contributed on behalf of the participant or beneficiary by the plan sponsor for enrollment in the group health plan, for use by the participant or beneficiary in obtaining health insurance coverage in the individual market.

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

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

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

(c) AMENDMENTS TO ERISA.—

(1) IN GENERAL.—Subpart B of part 7 of subchapter B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 2231, is further amended by adding at the end the following:

“SEC. 715. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND FOR SECONDARY CONSULTATIONS.

“(a) INPATIENT CARE.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician, in consultation with the patient, to be medically necessary and appropriate following—

“(A) a mastectomy; or

“(B) a lymph node dissection for the treatment of breast cancer.

“(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

“(c) CONFORMING MODIFICATIONS.—In implementing the requirements of this section, a group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not modify the terms and conditions of coverage based on the determination by a participant or beneficiary to request less than the minimum coverage required under subsection (a).

“(d) SECONDARY CONSULTATIONS.—

(A) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, shall provide notice to each participant and beneficiary under such plan regarding the coverage required by this section in accordance with regulations promulgated by the Secretary. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the plan or issuer and shall be transmitted—

“(1) in the next mailing made by the plan or issuer to the participant or beneficiary; or

“(2) not later than January 1, 2001;

which is earlier:

“(B) SECONDARY CONSULTATIONS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides coverage with respect to medical and surgical services provided in relation to the diagnosis and treatment of cancer, shall ensure that full coverage is provided for secondary consultations by specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis. Such plan or issuer shall ensure that full coverage is provided for such secondary consultation whether such consultation is based on a positive or negative initial diagnosis. In any case in which a physician certifies in writing that services necessary for such a secondary consultation are not sufficiently available from specialists operating under a plan with respect to whose services coverage is otherwise provided under such plan or by such issuer, such plan or issuer shall ensure that such coverage is provided with respect to those services in accordance with the attending physician’s consultation with any other specialist selected by the attending physician for such purpose at no additional cost to the individual beyond that which would have been incurred if the specialist was participating in the network of the plan.
“(2) EXCEPTION.—Nothing in paragraph (1) shall be construed as requiring the provision of secondary consultations where the patient determines not to seek such a consultation.

(e) PENALTIES ON PENALTIES OR INCENTIVES.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, may not

(1) penalize or otherwise reduce or limit the reimbursement of a provider or specialist because the provider or specialist provided care to a participant or beneficiary in accordance with this section;

(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from seeing the length of inpatient stays of patients following a mastectomy, lumpectomy, or a lymph node dissection for the treatment of breast cancer below certain limits or to limit referrals for secondary consultations;

(3) provide financial or other incentives to a physician or specialist to refrain from referring a participant or beneficiary for a secondary consultation that would otherwise be covered by the plan or coverage involved under subsection (a).

(2) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the entry relating to section 714 the following new item:

“Sec. 715. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.”.

d) AMENDMENT TO PHS ACT RELATING TO THE GROUP MARKET.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following new section:

“Sec. 2707. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND COVERAGE FOR SECONDARY CONSULTATIONS.

(a) IN GENERAL.—A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, shall ensure that inpatient coverage with respect to the treatment of breast cancer is provided for a period of time as is determined by the attending physician in consultation with the patient, to be medically necessary and appropriate following—

(1) a mastectomy;

(2) a lumpectomy; or

(3) a lymph node dissection for the treatment of breast cancer.

(b) NOTICE.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.

(e) PROHIBITION ON CERTAIN MODIFICATIONS.—In implementing the requirements of this section, a group health plan may not modify the terms and conditions of coverage based on the diagnosis otherwise covered by the plan with respect to whose services coverage is otherwise provided under such plan. Such plan or issuer shall ensure that full coverage is provided for secondary consultations with specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis.

Provided that if the patient or such plan or issuer shall ensure that full coverage is provided for secondary consultations with specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis.

(f) AMENDMENTS TO THE IRC.—(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986, as amended by section 2202, is further amended by inserting after section 5111 the following new section:

“Sec. 5114. REQUIRED COVERAGE FOR MINIMUM HOSPITAL STAY FOR MASTECTOMIES AND LYMPH NODE DISSECTIONS FOR THE TREATMENT OF BREAST CANCER AND SECONDARY CONSULTATIONS.

(a) IN GENERAL.—A group health plan that provides medical and surgical services shall ensure that full coverage is provided for secondary consultations with specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis.

Provided that if the patient or such plan or issuer shall ensure that full coverage is provided for secondary consultations with specialists in the appropriate medical fields (including pathology, radiology, and oncology) to confirm or refute such diagnosis.

(2) EXCEPTION.—Nothing in this section shall be construed as requiring the provision of inpatient coverage if the attending physician and patient determine that a shorter period of hospital stay is medically appropriate.
"(2) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from recommending an individual or a family member for a genetic education and counseling program, including any information about a request for or receipt of genetic services.

"(3) provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from recommending an individual or a family member for a genetic education and counseling program, including any information about a request for or receipt of genetic services.

"(4) Collection of predictive genetic information.—

"(a) Limitation on requesting or requiring predictive genetic information.—Except as provided in paragraph (2), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require predictive genetic information from an individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).

"(b) Information needed for diagnosis, treatment, or payment.—(A) In general.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, that provides health care items and services to an individual or dependent may request (but may not require) that such individual or dependent disclose, or authorize the collection of or disclosure of, predictive genetic information for purposes of diagnosis, treatment, or payment relating to the provision of health care items and services to such individual or dependent.

"(B) Notice of confidentiality practices and description of safeguards.—As a part of a request under subparagraph (A), the group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall provide to the individual or dependent a description of the procedures in place to safeguard the confidentiality, as described in section 162(f), of such predictive genetic information.

"(c) Confidentiality with respect to predictive genetic information.—(1) Notice of confidentiality practices.—(A) Preparation of written notice.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall post or provide, in writing and in a clear and conspicuous manner, notice of the plan or issuer's confidentiality practices that shall include—

"(i) a description of an individual's rights with respect to predictive genetic information; and

"(ii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

"(B) Model notice.—The Secretary, in consultation with the National Institutes of Health and the Secretary of Health and Human Services, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

"(2) Establishment of safeguards.—A group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, used, transmitted, or disposed of by such plan or issuer.

"(d) Effect of notice or confidentiality practices.—(1) In general.—The Secretary shall determine whether a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, has established and is maintaining appropriate administrative, technical, and physical safeguards, and shall approve the notice or confidentiality practices of any group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, that meet the criteria described in subsection (c)(2).

"(2) Effect of notice or confidentiality practices.—(A) In general.—The Secretary shall determine whether a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, has established and is maintaining appropriate administrative, technical, and physical safeguards, and shall approve the notice or confidentiality practices of any group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, that meet the criteria described in subsection (c)(2).

"(B) Enforcement.—The Secretary, in consultation with the National Institutes of Health and the Secretary of Health and Human Services, shall develop and disseminate model notices of confidentiality practices. Use of the model notice shall serve as a defense against claims of receiving inappropriate notice.

"(c) Conforming amendment.—Section 2702(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(b)) is amended by adding at the end the following:

"(D) A dependent child of the individual, including information about a request for or receipt of genetic services.

"(E) Provide financial or other incentives to a physician or specialist to induce the physician or specialist to refrain from recommending an individual or a family member for a genetic education and counseling program, including any information about a request for or receipt of genetic services.

"(F) Collection of predictive genetic information.—The term ‘predictive genetic information’ means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member (including information about a request for or receipt of genetic services).

"(G) PREDICTIVE GENETIC INFORMATION.—

"(1) In general.—The term ‘predictive genetic information’ means information about the risk of disease or disorder for an individual or family member of the individual; or

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

"(2) Exceptions.—The term ‘predictive genetic information’ shall not include—

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

"(ii) information derived from physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests; and

"(iii) information about physical exams of the individual.

"(3) GENETIC SERVICES.—The term ‘genetic services’ means the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites, including analysis of genotypes, mutations, pathogens, or karyotypes, or the purpose of predicting risk of disease in asymptomatic or undiagnosed individuals. Such term does not include physical tests, such as the chemical, blood, or urine analyses of the individual including cholesterol tests, and physical exams of the individual, in order to detect symptoms, clinical signs, or a diagnosis of disease.

"(d) Effective date.—Section 2702(a) as amended by this section, this section and the amendments made by this section shall apply with respect to group health plans for plan years beginning 1 year after the date of the enactment of this Act.

"SEC. 2403. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.

"(a) Amendments relating to the Group Market.—

"(1) Prohibition of health discrimination on the basis of genetic information in the Group Market.—

"(A) No enrollment restriction for genetic information.—Section 2702(a)(1)(F) of the Public Health Service Act (42 U.S.C. 300g-1(a)(1)(F)) is amended by inserting before the period the following: ‘‘including in connection with a group health plan, or a health plan or issuer offering group health insurance coverage in connection with a group health plan, shall not adjust premium or contribution amounts for a group on the basis of predictive genetic information of an individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services).’’

"(B) No discrimination in group premiums based on predictive genetic information.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 2301(c), is further amended by adding at the end the following:

"(2) Table of contents.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974, as amended by section 2301, is further amended by inserting after the item relating to section 715 the following new item:

"(Sec. 716. Prohibiting premium discrimination against groups on the basis of predictive genetic information.

"(3) Reference to related provision.—For a provision prohibiting the adjustment of premium or contribution amounts for a group under a group health plan on the basis of predictive genetic information of an individual (including a dependent) or family member of the individual (including information about a request for or receipt of genetic services), see section 2708.

"(b) Limitation on collection of predictive genetic information.—Section 2702 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182) is amended by adding at the end the following:

"(4) Collection of predictive genetic information.—The term ‘predictive genetic information’ means information about
Section 7202 of the Public Health Service Act (42 U.S.C. 300gg–1) is amended by adding at the end the following:

“(c) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

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

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

(A) IN GENERAL.—Notwithstanding paragraph (1), a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services).

(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the health insurance issuer offering health insurance coverage in the individual market shall provide to the individual or dependent or family member of the individual (including information about a request for or receipt of genetic services) a description of appropriate safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information provided in paragraph (2), a group health plan, or a health insurance issuer offering health insurance coverage in the individual market shall provide to the individual or dependent or family member of the individual (including information about a request for or receipt of genetic services) a notice: (i) a description of an individual’s rights with respect to predictive genetic information; (ii) procedures established by the plan or issuer for the exercise of the individual’s rights; and (iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

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

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

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

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

(2) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—

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

(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

(A) IN GENERAL.—Notwithstanding paragraph (1), a health insurance issuer offering health insurance coverage in the individual market that provides health care items and services to such individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services) (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services) relating to the provision of health care items and services to such individual or dependent.

(B) NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the health insurance issuer offering health insurance coverage in the individual market shall provide to the individual or dependent or family member of the individual (including information about a request for or receipt of genetic services) a notice: (i) a description of an individual’s rights with respect to predictive genetic information; (ii) procedures established by the issuer for the exercise of the individual’s rights; and (iii) the right to obtain a copy of the notice of the confidentiality practices required under this subsection.

(C) ESTABLISHMENT OF SAFEGUARDS.—A health insurance issuer offering health insurance coverage in the individual market shall establish and maintain appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of predictive genetic information created, received, obtained, maintained, used, transmitted, or disposed of by such plan or issuer. (including information about a request for or receipt of genetic services).

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

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

(C) PROHIBITION OF PREDICTIVE GENETIC INFORMATION.—

(1) LIMITATION ON REQUESTING OR REQUIRING PREDICTIVE GENETIC INFORMATION.—Except as provided in paragraph (2), a health insurance issuer offering health insurance coverage in the individual market shall not request or require predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services) (but may not require) that such individual or dependent disclose, or authorize the collection or disclosure of, predictive genetic information concerning any individual (including a dependent) or a family member of the individual (including information about a request for or receipt of genetic services) relating to the provision of health care items and services to such individual or dependent.

(2) INFORMATION NEEDED FOR DIAGNOSIS, TREATMENT, OR PAYMENT.—
or a family member of the individual (including information about a request for or receipt of genetic services)."

(b) CONFORMING AMENDMENT. —Section 9820(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"(3) REFERENCE TO RELATED PROVISION. —For a provision prohibiting the adjustment of premium amounts for a group under a group health plan on the basis of predictive genetic information (including information about a request for or the receipt of genetic services) see section 9815.".

(C) AMENDMENT TO TABLE OF SECTIONS. —The table of sections for chapter 100 of the Internal Revenue Code of 1986, as amended by this subtitle and further amended by adding at the end the following:

"Sec. 9815. Prohibiting premium discrimination against groups on the basis of predictive genetic information.".

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

"(a) COLLECTION OF PREDICTIVE GENETIC INFORMATION.—

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

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

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

"(B) NOTICE OF CONFIDENTIALITY PRACTICES; DESCRIPTION OF SAFEGUARDS.—As a part of a request under subparagraph (A), the group health plan shall provide to the individual or dependent a description of the procedures in place to safeguard confidentiality, as described in subsection (e), of such predictive genetic information.

"(3) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE GENETIC INFORMATION.—

"(A) IN GENERAL.—The term 'predictive genetic information' means information about genes, gene products, or inherited characteristics that may derive from an individual or a family member of the individual (including information about a request for or receipt of genetic services).

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

"(C) PREDICTIVE GENETIC INFORMATION.—

"(1) IN GENERAL.—The term 'predictive genetic information' means information about genes, gene products, or inherited characteristics that are developed for safety and quality improvement purposes; and

"(2) EFFECTIVE DATE.—Except as provided in this section, this amendment shall take effect 1 year after the date of the enactment of this Act.

TITLE XXV—PATIENT SAFETY AND ERRORS REDUCTION

SEC. 2500. AMENDMENT TO PUBLIC HEALTH SERVICE ACT.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended (1) in paragraph (a) of section 921 as redesignated by section 921(c) to read "in" as a preposition; (2) by redesigning subparts A through D of such a section as subparts A through D, respectively; (3) by redesigning sections 921 through 928, as sections 911 through 938, respectively; (4) by redesigning section 921(a), as redesignated by section 921(c), by striking "921" and inserting "931"; and

(4) by inserting after part B the following:

"PART C—REDUCING ERRORS IN HEALTH CARE

"SEC. 921. DEFINITIONS.

"In this part:

"(1) ADVERSE EVENT.—The term 'adverse event' means, with respect to the patient of a provider of services, an untoward incident, through misadventure, omission, or commission, injury directly associated with the provision of health care items and services by a health care provider or provider of services.

"(2) CENTER.—The term 'Center' means the Center for Quality Improvement and Patient Safety established under section 922.

"(2) CLOSE CALL.—The term 'close call' means, with respect to the patient of a provider of services, any event or situation that—

"(A) but for chance or a timely intervention, could have resulted in an accident, injury, or illness;

"(B) is directly associated with the provision of health care items and services by a provider of services;

"(C) consists of an event that, while occurring at a later time, is causally related to an adverse event;

"(D) provides evidence that a timely intervention or action could have prevented a close call or an adverse event.

"(3) MEDICAL EVENT.—The term 'medical event' means, with respect to the patient of a provider of services, any event, or close call.

"(4) MEDICAL EVENT ANALYSIS ENTITY.—The term 'medical event analysis entity' means an entity that performs an analysis of safety events that—

"(A) is organized to assess, report, and disseminate information related to safety events that—

"(B) has the characteristics described in subparagraph (B).

"(5) MEDICAL EVENT ANALYSIS ENTITY.—The term 'medical event analysis entity' means an entity certified under section 923(a).

"(6) ROOT CAUSE ANALYSIS.—

"(A) IN GENERAL.—The term 'root cause analysis' means a process for identifying the basic or contributing causal factors that underlie variation in performance associated with medical errors and their consequences.

"(B) REQUIREMENTS.—A root cause analysis shall—

"(i) identify the characteristics described in subparagraph (B);

"(ii) include participation by the leadership of the health care provider, provider of services, and other individuals most closely involved in the processes and systems under review;
(iii) is internally consistent; and
(iv) includes the consideration of relevant literature.

(B) CHARACTERISTICS.—The characteristics described in this subparagraph include the following:

(i) The analysis is interdisciplinary in nature and individuals who are responsible for administering the reporting systems.

(ii) The analysis focuses primarily on systems and processes rather than individual performance.

(iii) The analysis involves a thorough review of all aspects of the process and all contributing factors involved.

(iv) The analysis identifies changes that could be made in systems and processes, through either redesign or development of new processes or systems, that would improve performance and reduce medical errors.

(12) SENTINEL EVENT.—The term ‘sentinel event’ means, with respect to the patient of a health care provider, or provider of services, an unexpected occurrence that—

(A) involves death or serious physical or psychological injury (including loss of a limb); and

(B) results from the provision of health care items and services by a health care provider or provider of services.

SEC. 922. RESEARCH TO IMPROVE THE QUALITY AND SAFETY OF PATIENT CARE.

(a) IN GENERAL.—To improve the quality and safety of patient care, the Director shall—

(1) establish a center to support research, evaluations and training, support demonstration projects, provide technical assistance, and develop and support partnerships that will identify and determine the causes of medical errors and other threats to the quality and safety of patient care;

(2) identify and evaluate interventions and strategies for preventing or reducing medical errors and threats to the quality and safety of patient care;

(3) identify, in collaboration with experts from both the private and public sectors, reporting parameters to provide consistency throughout the errors reporting system;

(4) identify approaches for the clinical management of complications from medical errors; and

(5) establish mechanisms for the rapid dissemination of interventions and strategies identified under this section for which there is scientific evidence of effectiveness.

(b) CENTER FOR QUALITY IMPROVEMENT AND PATIENT SAFETY.

(1) ESTABLISHMENT.—The Director shall establish a center to be known as the Center for Quality Improvement and Patient Safety to assist the Director in carrying out the requirements of subsection (a).

(2) MISSION.—The Center shall—

(A) provide national leadership for research and other initiatives to improve the quality and safety of patient care;

(B) build public-private sector partnerships to improve the quality and safety of patient care; and

(C) serve as a national resource for research and learning from medical errors.

(3) DUTIES.—(A) IN GENERAL.—In carrying out this section, the Director, acting through the Center, shall consult and build partnerships, as appropriate, with all segments of the health care industry, including health care practitioners and providers of services in the United States, and partnerships, as appropriate, with all segments of the health care industry, including health care practitioners and providers of services in the United States, and

(B) REQUIRED DUTIES.—In addition to the broad responsibilities that the Director may assign to the Center for research and related activities that are designed to improve the quality of health care, the Director shall ensure that the Center—

(i) builds scientific knowledge and understanding of the causes of medical errors in all health care settings and identifies or develops and validates effective interventions and strategies to reduce errors and improve the quality and safety of patient care;

(ii) provides and private sector research on patient safety by—

(1) developing a national patient safety research agenda;

(2) identifying promising opportunities for preventing or reducing medical errors; and

(3) tracking the progress made in addressing the highest priority research questions with respect to patient safety;

(iii) facilitates the development of voluntary national patient safety goals by convening all segments of the health care community in the United States to discuss and track the progress made in meeting those goals;

(iv) analyzes national patient safety data for inclusion in the annual report on the quality of health care required under section 923(b)(2);

(v) strengthens the ability of the United States to learn from medical errors by—

(1) developing the necessary tools and advances the scientific techniques for analysis of errors;

(2) providing technical assistance as appropriate to reporting systems; and

(3) entering into contracts to receive and analyze aggregate data from public and private sector reporting systems;

(vi) supports dissemination and communication activities about patient safety, including the development of tools and methods for educating consumers about patient safety; and

(vii) undertakes related activities that the Director determines are necessary to facilitate dissemination and communication of efforts.

(2) NATIONAL PATIENT SAFETY DATABASE.—The Director shall—

(A) ensure that the database is only used for the purposes described in this section; (D) does not include specific patient, health care provider, or provider of service identifiers.

(B) identify approaches for the purposes described in this section; (D) does not include specific patient, health care provider, or provider of service identifiers.

(C) ensure that information contained in the database developed under subparagraph (D) does not include specific patient, health care provider, or provider of service identifiers.

(D) national patient safety goals by convening all segments of the health care community in the United States to discuss and track the progress made in meeting those goals;

(E) conduct and support research, using the database developed under subparagraph (D), into the causes and potential interventions to decrease the incidence of medical errors and close calls; and

(F) ensure that information contained in the database developed under subparagraph (D) does not include specific patient, health care provider, or provider of service identifiers.

(E) analyze patient safety data and to act on that data to improve patient safety.

(3) EVALUATION.—The Director shall require that the entities described in subsections (b), (c), and (d), the Director may contract with public or private entities on a national or local level with appropriate expertise.

SEC. 923. MEDICAL EVENT ANALYSIS ENTITIES.

(a) IN GENERAL.—The Director, based on information collected under section 922(c), shall provide for the certification of entities to collect and analyze information on medical errors, and to collaborate with health care providers or providers of services in collecting information about, or evaluating, certain medical events.

(b) COMPATIBILITY OF COLLECTED DATA.—To ensure that data reported to the National Patient Safety Database under section 923(c)(2) concerning medical errors and close calls are comparable and useful on an analytic basis, the Director shall require that the entities described in subsection (c) follow the recommendations regarding a common set of core measures for reporting data that are developed by the National Forum for Health Care Quality Measurement and Reporting, or other voluntary or private standard-setting organization that is designated by the Director taking into account existing measurement systems and in collaboration with experts from the public and private sector.
"(c) DUTIES OF CERTIFIED ENTITIES.—
"(1) IN GENERAL.—An entity that is certified under subsection (a) shall conduct and analyze information, consistent with the requirements of subsection (a), received from the entity under section 924(a)(4) to improve patient safety.

"(2) INFORMATION TO BE REPORTED TO THE ENTITY.—A medical event analysis entity shall, on a periodic basis and in a format that is specified by the Director, submit to the Director a report that contains—

"(A) a description of the medical events that were reported to the entity during the period covered under the report;

"(B) a description of any corrective action taken by providers of services with respect to such medical events or any other measures that are necessary to prevent similar events from occurring in the future; and

"(C) a description of the systemic changes that entities have identified, through an analysis of the medical events included in the report, as being needed to improve patient safety.

"(3) COLLABORATION.—A medical event analysis entity that is collaborating with a health care provider or provider of services to address close calls and adverse events may, at the request of the health care provider or provider of services—

"(A) provide expertise in the development of root cause analyses and corrective action plans relating to such close calls and adverse events; or

"(B) collaborate with such provider of services to identify on-going risk reduction activities that may enhance patient safety.

"(d) CONFIDENTIALITY AND PEER REVIEW PROTECTIONS.—Notwithstanding any other provision of law, any information (including any data, reports, records, memoranda, analyses, statements, and other communications) collected by a medical event analysis entity or developed by or on behalf of a provider of services with respect to a medical event pursuant to a system established under subsection (a) shall be privileged in accordance with section 923.

"(2) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting—

"(A) disclosure of a patient's medical record to the patient;

"(B) a provider of services from complying with the requirements of a health care oversight agency or public health authority; or

"(C) such an agency or authority from disclosing information transferred by a provider of services to the public in a form that does not identify or permit the identification of the health care provider or provider of services or patient.

"SEC. 923. CONFIDENTIALITY.

"(a) CONFIDENTIALITY AND PEER REVIEW PROTECTIONS.—Notwithstanding any other provision of law—

"(1) any information (including any data, reports, records, memoranda, analyses, statements, and other communications) developed by or on behalf of a health care provider or provider of services with respect to medical events that are necessary to prevent similar events from occurring in the future; and

"(2) the transfer of any such information by or on behalf of a health care provider or provider of services to a health care oversight agency, or a public health authority, that is contained in the National Patient Safety Database, collected by a medical event analysis entity, or developed by or on behalf of such an entity, or collected by a health care provider or provider of services for use under systems that are developed for safety and quality improvement purposes—

"(A) shall be privileged, strictly confidential, and may not be disclosed by any other person to which such information is transferred without the authorization of the health care provider or provider of services; and

"(B) shall—

"(i) be protected from disclosure by civil, criminal, or administrative subpoena;

"(ii) not be subject to discovery or otherwise discoverable in connection with a civil, criminal, or administrative proceeding;

"(iii) not be used in any proceeding pursuant to section 532 of title 5, United States Code (the Freedom of Information Act) and any other similar Federal or State statute or regulation; and

"(iv) not be admissible as evidence in any civil, criminal, or administrative proceeding; without regard to whether such information is held by the provider or by another person to which such information was transferred;

"(3) the transfer of any such information by a provider of services to a health care oversight agency, an expert organization, a medical event analysis entity, or a public health authority, shall not be treated as a waiver of any privilege or protection established under paragraph (1) or established under any other Federal law;

"(4) PENALTY.—It shall be unlawful for any person to disclose any information described in subsection (a) other than for the purposes provided in such subsection. Any person violating the provisions of this section shall, upon conviction, be fined in accordance with title 18, United States Code, and imprisoned for not more than 6 months, or both.

"(a) APPLICATION OF PROVISIONS.—The protections provided under subsection (a) and the penalties established under paragraph (4) shall apply to any information (including any data, reports, memoranda, analyses, statements, and other communications) collected or developed pursuant to the system established under subsection (b) or (c), including demonstration projects, with respect to medical error reporting supported by the Director under this part.