SA 821. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 822. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 823. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 824. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 825. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 826. Ms. COLLINS (for herself, Mr. NELSON, of Nebraska, Mr. ESZTI, Mr. VOIOVODICH, Mr. HUTCHINSON, and Mr. ROBERTS) proposed an amendment to the bill S. 1052, supra.

SA 827. Mr. DOMENICI submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 828. Mrs. HUTCHISON submitted an amendment intended to be proposed by her to the bill S. 1052, supra; which was ordered to lie on the table.

SA 829. Mr. DREWNE submitted an amendment intended to be proposed by him to the bill S. 1052, supra; which was ordered to lie on the table.

SA 830. Mr. BREAUX (for himself, Mr. JEFFORDS, Mr. KENNEDY, Mr. MCCAIN, and Mr. EDWARDS) proposed an amendment to the bill S. 1052, supra.

TEXT OF AMENDMENTS

SA 819. Mr. THOMPSON proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 150, strike line 17 and all that follows through page 153, line 8, and insert the following:

(9) REQUIREMENT OF EXHAUSTION.—

(A) IN GENERAL.—A cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102 and 103 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

(B) EXCEPTION FOR NEEDED CARE.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, and 104 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

(C) RECEPT OF BENEFITS DURING APPEALS PROCEEDING.—Receive by the participant or beneficiary involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or of any action commenced under this subsection—

(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

(D) ADMISSIBLE.—Any determination made by a reviewer in an administrative proceeding under section 104 of the Bipartisan Patient Protection Act of 2001 shall be admissible in any Federal court proceeding and shall be presented to the trier of fact.

SA 820. Mr. MCCAIN (for himself, Mr. BAYH, Mr. CARPARK, and Mr. EDWARDS) proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

On page 153, line 17 and all that follows through page 155, insert the following:

(iii) Requirement of exhaustion—

(A) In general.—A cause of action may not be brought under paragraph (1) in connection with any denial of a claim for benefits of any individual until all administrative processes under sections 102 and 103 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

(B) Exception for needed care.—A participant or beneficiary may seek relief exclusively in Federal court under subsection 502(a)(1)(B) prior to the exhaustion of administrative remedies under sections 102, 103, and 104 of the Bipartisan Patient Protection Act of 2001 (if applicable) have been exhausted.

(C) Receipt of benefits during appeals proceeding.—Receive by the participant or beneficiary involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or of any action commenced under this subsection—

(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

(D) Admissible.—Any determination made by a reviewer in an administrative proceeding under section 104 of the Bipartisan Patient Protection Act of 2001 shall be admissible in any Federal or State court proceeding and shall be presented to the trier of fact.

SA 821. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

On page 146, between lines 23 and 24, insert the following:

(D) Exclusion of small employers—

(A) In general.—Notwithstanding any other provision of this paragraph, in addition to excluding certain physicians, other health care professionals, and certain hospitals from liability under paragraph (i), paragraph (j) does not create any liability on the part of a small employer (or on the part of an employee of such an employer acting within the scope of employment).

(B) Definition.—In clause (i), the term ‘small employer’ means an employer—

(1) that, during the calendar year preceding the calendar year for which a determination under this subparagraph is being made, employed an average of at least 2 but not more than 15 employees on business days; and

(2) meeting the plan involved that is acting, serving, or functioning as a fiduciary, trustee, plan administrator, or organization, including—

(aa) a small employer described in section 3(16)(B)(i) with respect to a plan maintained by a single employer; and

(bb) one or more small employers or employee organizations described in section 3(16)(B)(iii) in the case of a multi-employer plan.

(C) Application of certain rules in determination of employer size.—For purposes of this subparagraph:

12079
Section 1676(h)(3)(C) of the Social Security Act (42 U.S.C. 1395m(h)(3)(C)), as redesignated by section 634(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–568), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by striking ‘‘2004’’ and inserting ‘‘2014’’.

SA 823. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

At the end of the bill, add the following:

SEC. 3. NINE-YEAR EXTENSION OF MEDICARE COST CONTRACTS.

Section 1676(h)(3)(C) of the Social Security Act (42 U.S.C. 1395m(h)(3)(C)), as redesignated by section 634(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–568), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by striking ‘‘2004’’ and inserting ‘‘2014’’.

SA 824. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

At the end of the bill, add the following:

SEC. 3. NINE-YEAR EXTENSION OF MEDICARE COST CONTRACTS.

Section 1676(h)(3)(C) of the Social Security Act (42 U.S.C. 1395m(h)(3)(C)), as redesignated by section 634(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–568), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by striking ‘‘2004’’ and inserting ‘‘2013’’.

SA 825. Mr. ALLARD submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

At the end of the bill, add the following:

SEC. 3. SEVEN-YEAR EXTENSION OF MEDICARE COST CONTRACTS.

Section 1676(h)(3)(C) of the Social Security Act (42 U.S.C. 1395m(h)(3)(C)), as redesignated by section 634(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–568), as enacted into law by section 1(a)(6) of Public Law 106–554, is amended by striking ‘‘2004’’ and inserting ‘‘2011’’.

SA 826. Ms. COLLINS (for herself, Mr. NELSON of Nebraska, Mr. ENZI, Mr. VOINOVICH, Mr. HUTCHINSON, and Mr. ROBERTS) proposed an amendment to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; as follows:

At the end of the bill, strike line 19 and add the following:

Beginning on page 122, strike line 19 and add the following:

SEC. 152. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) General Rule.—

(1) No Preemption.—

(A) In General.—Subject to paragraph (2), nothing in subtitiles B, C or D shall be construed to preempt or supersede any provision of State law that is effective prior to the effective date that establishes, implements, or continues in effect any standard or requirement relating to health insurance issuers in connection with group health coverage or otherwise and non-Federal governmental plans with respect to a patient protection requirement.

(b) Notification.—Subparagraph (A) shall apply to a State that has, by not later than the effective date, submitted a notice to the Secretary of the existence of a State law described in such subparagraph.

(2) Appeals.—Subtitle A shall not be construed to supersede any provision of State law that is effective prior to the effective date that establishes, implements, or continues in effect any standard or requirement relating to health insurance issuers in connection with group health coverage or otherwise and non-Federal governmental plans with respect to the application of a requirement of such subtitle.

(3) Continued Preemption with Respect to Group Health Plans.—Nothing in this title shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) with respect to group health plans.

(b) State Certification.—

(1) In General.—Effective beginning on the effective date, a State shall submit to the Secretary a certification that—

(A) the State has enacted one or more State laws or regulations that are consistent with the purposes of the patient protection requirements of this title, with respect to health insurance coverage that is issued in the State, including group coverage and individual coverage, and coverage under non-Federal governmental plans;

(B) the State has not enacted a law described in subparagraph (A) because of the adverse impact that such a law would have on premiums paid for health care coverage in the State and the adverse impact that such increases in premiums would have on the number of individuals in the State with health insurance coverage;

(C) the State has not enacted a law described in subparagraph (A) because the existence of a managed care market in the State is negligible.

(ii) approve the certification unless the Secretary notifies the State in writing, at the time the certification is submitted, that paragraph (1) is considered approved unless the Secretary finds that there is no rational basis for such approval.

(d) Approval Deadlines.—

(1) Initial Review.—A certification submitted under paragraph (1) is considered approved unless the Secretary notifies the State in writing, within 90 days after the date of receipt of the certification, that the certification is disapproved because there is no rational basis for the certification.

(II) with respect to a certification described in paragraph (1)(A), that the Secretary determined that the State law does not provide for patient protections that are
consistent with the purposes of the patient protection requirement to which the law relates;

(III) that specified additional information is needed.

A notice under this clause shall include an explanation of the basis for the determination of the Secretary and shall identify specific deficiencies in the State certification.

(ii) REQUIREMENT.—With respect to a State that has been notified by the Secretary under clause (i)(III) that specified additional information is needed, the Secretary shall make a determination with respect to the section within 60 days after the date on which such specified additional information is received by the Secretary.

(C) APPROVAL FOR FAILURE TO MEET DEADLINE.—If the Secretary fails to meet the deadline applicable under subparagraph (B) with respect to a State certification, the certification shall be deemed to be approved.

(D) STATE CHALLENGE.—A State that has a certification disapproved by the Secretary under paragraph (B) may challenge such disapproval in the appropriate United States district court.

(E) CERTIFICATION OF ALL OR SELECTIVE PROTECTIONS.—A certification under this subsection may be submitted with respect to all patient protection requirements or selective requirements.

(4) TERMINATION OF CERTIFICATION.—

(A) IN GENERAL.—The Secretary, not more frequently than once every 5 years, may request that a State with respect to which a certification has been approved under this subsection, submit an assurance to the Secretary that has been approved under subsection (a)(1); or

(B) TERMINATION.—If a State fails to submit an assurance to the Secretary under subparagraph (A) or that assurance has not been approved by the Secretary under this subsection, the patient protection requirement to which the law relates shall be construed to apply any patient protection requirement to which the law relates.

(5) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to apply any patient protection requirement to which the law relates more frequently than once every 5 years, except as provided in section 1121(b) of the Public Health Service Act (42 U.S.C. 232).
(B) PARTICIPANTS, BENEFICIARIES, AND ENROLLEES.—The disclosure required under paragraph (a) shall include—

(i) jointly to each participant, beneficiary, and enrollee who resides at the same address;

(ii) in the case of a beneficiary or enrollee who does not reside at the same address as the participant or another enrollee, separately to the participant or other enrollees and such beneficiary or enrollee;

(2) PROVISION OF INFORMATION.—Information shall be provided to participants, beneficiaries, and enrollees under this section at the last known address maintained by the plan or issuer with respect to such participants, beneficiaries, or enrollees, to the extent that such information is provided to participants, beneficiaries, or enrollees via the United States Postal Service or other private delivery service.

(b) REQUIRED INFORMATION.—The informational materials to be distributed under this section shall include for each option available under the group health plan or health insurance coverage the following:

(1) BENEFITS.—A description of the covered benefits, including—

(A) any in- and out-of-network benefits;

(B) any description of coverage understood to be noncovered by the plan, issuer, or claims administrator;

(C) any specific exclusions or express limitations on benefits described in section 104(b)(3)(C);

(D) any other benefit limitations, including any annual or lifetime benefit limits and any mandatory limits or limits on the number of visits, days, or services, and any specific coverage exclusions; and

(E) any definition of medical necessity used 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.

(2) COST SHARING.—A description of any cost-sharing requirements, including—

(A) any premiums, deductibles, coinsurance, copayment amounts, and liability for balance billing, for which the participant, beneficiary, or enrollee will be responsible under the plan, issuer, or claims administrator;

(B) any maximum out-of-pocket expense for which the participant, beneficiary, or enrollee may be liable;

(C) any of the following requirements for out-of-network benefits or services received from nonparticipating providers; and

(D) any additional cost-sharing or charges for benefits and services that are furnished without meeting applicable plan or coverage requirements, such as prior authorization or precertification.

(3) COMPENSATION METHODS.—A summary description by category of the applicable methods (such as capitation, fee-for-service, salary, bundled payments, per diem, or a combination thereof) used for compensating prospective or treating health care professionals (including primary care providers and specialists) and facilities in connection with the provision of health care under the plan or coverage.

(c) ADDITIONAL INFORMATION.—The informational materials to be provided under subsection (a) or (b) of this section and the informational materials provided under any section other than this section that is required to be made available by any other provision of this title or any other provision of law that the Secretary determines applicable shall include—

(1) SERVICE AREA.—A description of the plan’s service area, including the provision of any out-of-area coverage.

(2) PARTICIPATING PROVIDERS.—A directory of participating providers (to the extent a plan or issuer provides coverage through a network of providers) that includes, at a minimum, the name, address, and telephone number of each primary care provider, and information about how to inquire whether a participating provider is currently accepting new patients, and the State licensure status of the health care facility or health care physician,Unless otherwise specified, the name, address, and telephone number of each participating provider shall be made available to participants, beneficiaries, or enrollees who does not reside at the same address as the participant or another enrollee, separately to the participant or other enrollees and such beneficiary or enrollee.

(3) CHOICE OF PRIMARY CARE PROVIDER.—A description of any requirements and procedures to be used by participants, beneficiaries, and enrollees to select or change their primary care provider, including the name, address, and telephone number of each participating provider, and the right to select a pediatrician as a primary care provider under section 116 for a participant, beneficiary, or enrollee who is a child if such section applies.

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

(5) EXPERIMENTAL AND INVESTIGATIONAL TREATMENTS.—A description of the process 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.

(6) SPECIALTY CARE.—A description of the requirements and procedures to be used by participants, beneficiaries, and enrollees in accessing specialty care and obtaining referrals to participating and nonparticipating specialists, including any limitations on choice of health care professionals referred to in subsection (b)(3), and the right to timely access to specialists under section 114 if such section applies.

(7) CLINICAL TRIALS.—A description of the circumstances and conditions under which participation in clinical trials is covered under the terms and conditions of the plan or coverage, and the right to obtain coverage under the plan or issuer.

(8) PRESCRIPTION DRUGS.—To the extent the plan or issuer provides coverage for prescription drugs, a description of any provisions and cost-sharing required for obtaining on- and off-formulary medications, and a description of the rights of participants, beneficiaries, and enrollees in obtaining access to access to prescription drugs under section 118 if such section applies.

(9) EMERGENCY SERVICES.—A summary of the rules and procedures for accessing emergency services, including the right of a participant, beneficiary, or enrollee to obtain emergency services under the prudent layperson standard under section 113, if such section applies, and any educational information that the plan or issuer may provide regarding the appropriate use of emergency services.

(10) CLAIMS AND APPEALS.—A description of the process for filing, reviewing, and appealing claims and denials of benefits, including any appeals rights, and a description of any additional legal rights and remedies available under section 502 of the Employee Retirement Income Security Act of 1974 and applicable State law.

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

(12) INFORMATION ON PLANS AND ISSUERS.—The name, mailing address, and telephone number of the plan administrator and the issuer to be used by participants, beneficiaries, and enrollees seeking a request about plan or coverage benefits and services, payment of a claim, or authorization for services and treatment. Notice of whether the benefits under the plan or coverage 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 insurance risk.

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

(14) ACCREDITATION INFORMATION.—Any information that is made public 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, beneficiaries, and enrollees.

(15) NOTICE OF REQUIREMENTS.—A description of any rights of participants, beneficiaries, and enrollees that are established by the Bipartisan Patient Protection Act (excluding those described in paragraphs (1) through (14)) if such sections apply. The description required under this paragraph may be combined with the notices of the type described in sections 711(d), 713(b), or 606(a)(1) of the Employee Retirement Income Security Act of 1974 and with any other notice provision that the appropriate Secretary determines may be combined, so long as such combination is not inconsistent in the information that would otherwise be provided to the recipient.

(16) UTILIZATION REVIEW ACTIVITIES.—A description of procedures used and requires (including circumstances, timeframes, and appeals rights) under any utilization review program under sections 101 and 102, including any drug formulary program under section 118.

(17) EXTERNAL APPEALS INFORMATION.—Aggregate information on the number and outcomes of external medical review relative to the sample size (such as the number of covered lives) under the plan or the coverage of the issuer.

(18) MANNER OF DISCLOSURE.—

(1) IN GENERAL.—The information described in this subsection shall be disclosed in an accessible medium and format that is calculated to be understood by a participant or enrollee.

(2) ADDITIONAL INFORMATION.—The information described in subsection (c) shall be made available in a public and easily accessible, without cost, to participants, beneficiaries, or enrollees upon request. Such information shall be made available in writing and by electronic means, or in any other manner determined appropriate by the Secretary.
SA 889. Mr. DeWINE submitted an amendment intended to be proposed by him to the bill S. 1052, to amend the Public Health Service Act and the Employee Retirement Income Security Act of 1974 to protect consumers in managed care plans and other health coverage; which was ordered to lie on the table; as follows:

On page 171, between lines 14 and 15, insert the following:

SEC. 303. LIMITATION ON CERTAIN CLASS ACTION LITIGATION.

Section 303 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 302, is further amended by adding at the end the following:

"(o) LIMITATION ON CLASS ACTION LITIGATION.—

"(1) IN GENERAL.—Any claim or cause of action that is maintained under this section in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative claimant, or the group of claimants is limited to the participants or beneficiaries of a plan or group of plans established by only 1 plan sponsor. No action maintained by such class, such derivative claimant, or such group of claimants may be joined in the same action maintained by any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, a group health plan and 'health insurance coverage' have the meanings given such terms in section 738."
of a State law under this subsection solely because it provides for greater protections for patients than those protections otherwise required to establish substantial compliance.

(b) Petitions.—

(1) In General.—A petition submitted under subparagraph (A) within the 60-day period beginning on the date on which such petition is submitted.

(2) Definition.—For purposes of this section:

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

(b) Definitions.—For purposes of this section:

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

(2) Agreements.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on Wednesday, June 27, 2001 at 10:00 a.m. to conduct a hearing. The committee will consider the nominations of Dionei M. Aviles to be Assistant Secretary of the Navy (Financial Management and Comptroller); Reginald Jude Brown to be Assistant Secretary of the Army (Manpower and Reserve Affairs); Steven A. Cambone to be Deputy under Secretary of Defense for Policy; Michael Montelongo to be Assistant Secretary of the Air Force (Financial Management and Comptroller); and John J. Young, Jr. to be Assistant Secretary of the Navy (Research, Development and Acquisition).

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on Wednesday, June 27, 2001 at 9:30 a.m. to conduct a hearing. The committee will consider the nominations of Vicky A. Bailey to be Assistant Secretary of Energy (International Affairs and Domestic Policy); Francois P. Malinella to be Director of the National Park Service, and John Walton Keys, III, to be Commissioner of the Bureau of Reclamation.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet to conduct a markup on "Protecting the Innocent: Ensuring Competent Counsel in Death Penalty Cases" on Wednesday, June 27, 2001 at 10:00 a.m., in SD226. No witness list is available yet.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON RULES AND ADMINISTRATION

Mr. DORGAN. Mr. President, I ask unanimous consent that the Committee on Rules and Administration be authorized to meet during the session of the Senate on Wednesday, June 27, 2001 at 9:30 a.m. to receive testimony from the U.S. Commission on Civil Rights regarding its latest report on the November 2000 election and from other witnesses on election reform in general.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. DORGAN. Mr. President, I ask unanimous consent that the Select...