

DURBIN), the Senator from Rhode Island (Mr. REED), the Senator from Rhode Island (Mr. WHITEHOUSE) and the Senator from New York (Mr. SCHUMER) were added as cosponsors of S. 2605, a bill to require certain semiautomatic pistols manufactured, imported, or sold by Federal firearms licensees to be capable of microstamping ammunition.

S. RES. 2618

At the request of Ms. KLOBUCHAR, the name of the Senator from Mississippi (Mr. WICKER) was added as a cosponsor of S. 2618, a bill to amend the Public Health Service Act to provide for research with respect to various forms of muscular dystrophy, including Becker, congenital, distal, Duchenne, Emery-Dreifuss Facioscapulohumeral, limb-girdle, myotonic, and oculopharyngeal muscular dystrophies.

S. RES. 439

At the request of Mr. LUGAR, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. Res. 439, a resolution expressing the strong support of the Senate for the North Atlantic Treaty Organization to enter into a Membership Action Plan with Georgia and Ukraine.

AMENDMENT NO. 3910

At the request of Mrs. FEINSTEIN, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of amendment No. 3910 proposed to S. 2248, an original bill to amend the Foreign Intelligence Surveillance Act of 1978, to modernize and streamline the provisions of that Act, and for other purposes.

AMENDMENT NO. 3919

At the request of Mrs. FEINSTEIN, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of amendment No. 3919 proposed to S. 2248, an original bill to amend the Foreign Intelligence Surveillance Act of 1978, to modernize and streamline the provisions of that Act, and for other purposes.

AMENDMENT NO. 3967

At the request of Mr. COBURN, the names of the Senator from New Hampshire (Mr. SUNUNU) and the Senator from Georgia (Mr. ISAKSON) were added as cosponsors of amendment No. 3967 intended to be proposed to S. 2483, a bill to authorize certain programs and activities in the Forest Service, the Department of the Interior, and the Department of Energy, and for other purposes.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 446—RELATIVE TO THE DEATH OF REPRESENTATIVE TOM LANTOS, OF CALIFORNIA

Mr. REID (for himself, Mr. MCCONNELL, Mrs. FEINSTEIN, Mrs. BOXER, Mr. AKAKA, Mr. ALEXANDER, Mr. ALLARD,

Mr. BARRASSO, Mr. BAUCUS, Mr. BAYH, Mr. BENNETT, Mr. BIDEN, Mr. BINGAMAN, Mr. BOND, Mr. BROWN, Mr. BROWNBACK, Mr. BUNNING, Mr. BURR, Mr. BYRD, Ms. CANTWELL, Mr. CARDIN, Mr. CARPER, Mr. CASEY, Mr. CHAMBLISS, Mrs. CLINTON, Mr. COBURN, Mr. COCHRAN, Mr. COLEMAN, Ms. COLLINS, Mr. CONRAD, Mr. CORKER, Mr. CORNYN, Mr. CRAIG, Mr. CRAPO, Mr. DEMINT, Mr. DODD, Mrs. DOLE, Mr. DOMENICI, Mr. DORGAN, Mr. DURBIN, Mr. ENSIGN, Mr. ENZI, Mr. FEINGOLD, Mr. GRAHAM, Mr. GRASSLEY, Mr. GREGG, Mr. HAGEL, Mr. HARKIN, Mr. HATCH, Mrs. HUTCHISON, Mr. INHOFE, Mr. INOUE, Mr. ISAKSON, Mr. JOHNSON, Mr. KENNEDY, Mr. KERRY, Ms. KLOBUCHAR, Mr. KOHL, Mr. KYL, Ms. LANDRIEU, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mr. LIEBERMAN, Mrs. LINCOLN, Mr. LUGAR, Mr. MARTINEZ, Mr. MCCAIN, Mrs. MCCASKILL, Mr. MENENDEZ, Ms. MIKULSKI, Ms. MURKOWSKI, Mrs. MURRAY, Mr. NELSON of Florida, Mr. NELSON of Nebraska, Mr. OBAMA, Mr. PRYOR, Mr. REED, Mr. ROBERTS, Mr. ROCKEFELLER, Mr. SALAZAR, Mr. SANDERS, Mr. SCHUMER, Mr. SESSIONS, Mr. SHELBY, Mr. SMITH, Ms. SNOWE, Mr. SPECTER, Ms. STABENOW, Mr. STEVENS, Mr. SUNUNU, Mr. TESTER, Mr. THUNE, Mr. VITTER, Mr. VOINOVICH, Mr. WARNER, Mr. WEBB, Mr. WHITEHOUSE, Mr. WICKER, and Mr. WYDEN) submitted the following resolution; which was considered and agreed to:

S. RES. 446

Resolved, That the Senate has heard with profound sorrow and deep regret the announcement of the death of the Honorable Tom Lantos, late a Representative from the State of California.

Resolved, That the Secretary communicate these resolutions to the House of Representatives and transmit an enrolled copy thereof to the family of the deceased.

Resolved, That when the Senate adjourns or recesses today, it stand adjourned or recessed as a further mark of respect to the memory of the deceased Representative.

AMENDMENTS SUBMITTED AND PROPOSED

SA 4014. Mr. DODD (for himself and Mr. SHELBY) submitted an amendment intended to be proposed by him to the bill S. 2062, to amend the Native American Housing Assistance and Self-Determination Act of 1996 to reauthorize that Act, and for other purposes; which was ordered to lie on the table.

SA 4015. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill S. 1200, to amend the Indian Health Care Improvement Act to revise and extend the Act; which was ordered to lie on the table.

SA 4016. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill S. 1200, supra; which was ordered to lie on the table.

SA 4017. Mr. DURBIN (for Mrs. FEINSTEIN) submitted an amendment intended to be proposed by Mr. DURBIN to the bill S. 2071, to enhance the ability to combat methamphetamine.

TEXT OF AMENDMENTS

SA 4014. Mr. DODD (for himself and Mr. SHELBY) submitted an amendment intended to be proposed by him to the bill S. 2062, to amend the Native American Housing Assistance and Self-Determination Act of 1996 to reauthorize that Act, and for other purposes; which was ordered to lie on the table; as follows:

On page 19, strike lines 1 through 13 and insert the following:

“(c) APPLICABILITY.—The provisions of paragraph (2) of subsection (a) regarding binding commitments for the remaining useful life of property shall not apply to a family or household member who subsequently takes ownership of a homeownership unit.”.

On page 22, line 9, insert “in accordance with section 202” after “infrastructure”.

On page 29, strike line 18 and insert the following:

“(iv) any other legal impediment.

“(E) Subparagraphs (A) through (D) shall not apply to any claim arising from a formula current assisted stock calculation or count involving an Indian housing block grant allocation for any fiscal year through fiscal year 2008, if a civil action relating to the claim is filed by not later than 45 days after the date of enactment of this subparagraph.”.

SA 4015. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill S. 1200, to amend the Indian Health Care Improvement Act to revise and extend the Act; which was ordered to lie on the table; as follows:

On page ____, between lines ____ and ____, insert the following (at the end of title VIII of the Indian Health Care Improvement Act, as amended by section 101(a) add the following):

“SEC. 818. INDIAN HEALTH SAVINGS ACCOUNT DEMONSTRATION PROJECT.

“(a) IN GENERAL.—The Secretary shall establish a demonstration project under which eligible participants shall be provided with a subsidy for the purchase of a high deductible health plan (as defined under section 223(c)(2) of the Internal Revenue Code of 1986) and a contribution to a health savings account (as defined in section 223(d) of such Code) in order to—

“(1) improve Indian access to high quality health care services;

“(2) provide incentives to Indian patients to seek preventive medical care services;

“(3) create Indian patient awareness regarding the high cost of medical care; and

“(4) encourage appropriate use of health care services by Indians.

“(b) ELIGIBLE PARTICIPANT.—

“(1) VOLUNTARY ENROLLMENT FOR 12-MONTH PERIODS.—

“(A) IN GENERAL.—In this section, the term ‘eligible participant’ means an Indian who—

“(i) is an eligible individual (as defined in section 223(c)(1) of the Internal Revenue Code of 1986); and

“(ii) voluntarily agrees to enroll in the project conducted under this section (or in the case of a minor, is voluntarily enrolled on their behalf by a parent or caretaker) for a period of not less than 12 months in lieu of obtaining items or services through any Indian Health Program or any other federally-funded program during any period in which the Indian is enrolled in the project.

“(B) VOLUNTARY EXTENSIONS OF ENROLLMENT.—An eligible participant may voluntarily extend the participant’s enrollment in the project for additional 12-month periods.

“(2) HARDSHIP EXCEPTION.—The Secretary shall specify criteria for permitting an eligible participant to disenroll from the project before the end of any 12-month period of enrollment to prevent undue hardship.

“(c) SUBSIDY AMOUNT.—The amount of a subsidy provided to an eligible participant for a 12-month period shall not exceed the amount equal to the average per capita expenditure for an Indian obtaining items or services from any Indian Health Program for the most recent fiscal year for which data is available with respect to the same population category as the eligible participant.

“(d) SPECIAL RULES.—

“(1) NO DEDUCTION ALLOWED FOR SUBSIDY.—For purposes of determining the amount allowable as a deduction with respect to amounts contributed to a health savings account by an eligible participant under section 223 of the Internal Revenue Code of 1986, the limitation which would (but for this paragraph) apply under section 223(b) of such Code to such participant for any taxable year shall be reduced (but not below zero) by the amount of any subsidy provided to the participant under this section for such taxable year.

“(2) TREATMENT.—The amount of a subsidy provided to an eligible participant in the project shall not be counted as income or assets for purposes of determining eligibility for benefits under any Federal public assistance program.

“(3) BUDGET NEUTRALITY.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made to carry out the project do not exceed the amount of Federal expenditures which would have been made for the provision of health care items and services to eligible participants if the project had not been implemented.

“(e) DEMONSTRATION PERIOD; REPORTS TO CONGRESS; GAO EVALUATION AND REPORT.—

“(1) DEMONSTRATION PERIOD.—

“(A) INITIAL PERIOD.—The demonstration project established under this section shall begin on January 1, 2007, and shall be conducted for a period of 5 years.

“(B) EXTENSIONS.—The Secretary may extend the project for such additional periods as the Secretary determines appropriate, unless the Secretary determines that the project is unsuccessful in achieving the purposes described in subsection (a), taking into account cost-effectiveness, quality of care, and such other criteria as the Secretary may specify.

“(2) PERIODIC REPORTS TO CONGRESS.—During the 5-year period described in paragraph (1), the Secretary shall periodically submit reports to Congress regarding the success of demonstration project conducted under this section. Each report shall include information concerning the populations participating in the project and the impact of the project on access to, and the availability of, high quality health care services for Indians.

“(3) GAO EVALUATION AND REPORT.—

“(A) EVALUATION.—The Comptroller General of the United States shall enter into a contract with an organization with expertise in health economics, health insurance markets, and actuarial science for the purpose of conducting a comprehensive study regarding the effects of high deductible health plans and health savings accounts in the Indian community. The evaluation shall include an analysis of the following issues:

“(i) Selection of, access to, and availability of, high quality health care services.

“(ii) The use of preventive health services.

“(iii) Consumer choice.

“(iv) The scope of coverage provided by high deductible health plans purchased in conjunction with health savings accounts under the project.

“(v) Such other issues as the Comptroller General determines appropriate.

“(B) REPORT.—Not later than January 1, 2013, the Comptroller General shall submit a report to Congress on the evaluation of demonstration project conducted under this section.”.

SA 4016. Mr. DEMINT submitted an amendment intended to be proposed by him to the bill S. 1200, to amend the Indian Health Care Improvement Act to revise and extend the Act; which was ordered to lie on the table; as follows:

At the end, add the following:

TITLE III—HEALTH CARE CHOICE

SEC. 301. SHORT TITLE.

This title may be cited as “Health Care Choice Act of 2008”.

SEC. 302. SPECIFICATION OF CONSTITUTIONAL AUTHORITY FOR ENACTMENT OF LAW.

This title is enacted pursuant to the power granted Congress under article I, section 8, clause 3, of the United States Constitution.

SEC. 303. FINDINGS.

Congress finds the following:

(1) The application of numerous and significant variations in State law impacts the ability of insurers to offer, and individuals to obtain, affordable individual health insurance coverage, thereby impeding commerce in individual health insurance coverage.

(2) Individual health insurance coverage is increasingly offered through the Internet, other electronic means, and by mail, all of which are inherently part of interstate commerce.

(3) In response to these issues, it is appropriate to encourage increased efficiency in the offering of individual health insurance coverage through a collaborative approach by the States in regulating this coverage.

(4) The establishment of risk-retention groups has provided a successful model for the sale of insurance across State lines, as the acts establishing those groups allow insurance to be sold in multiple States but regulated by a single State.

SEC. 304. COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following new part:

“PART D—COOPERATIVE GOVERNING OF INDIVIDUAL HEALTH INSURANCE COVERAGE

“SEC. 2795. DEFINITIONS.

“In this part:

“(1) PRIMARY STATE.—The term ‘primary State’ means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose covered laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy, may only designate one such State as its primary State with respect to all such coverage it offers. Such an issuer may not change the designated primary State with respect to individual health insurance cov-

erage once the policy is issued, except that such a change may be made upon renewal of the policy. With respect to such designated State, the issuer is deemed to be doing business in that State.

“(2) SECONDARY STATE.—The term ‘secondary State’ means, with respect to individual health insurance coverage offered by a health insurance issuer, any State that is not the primary State. In the case of a health insurance issuer that is selling a policy in, or to a resident of, a secondary State, the issuer is deemed to be doing business in that secondary State.

“(3) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning given such term in section 2791(b)(2), except that such an issuer must be licensed in the primary State and be qualified to sell individual health insurance coverage in that State.

“(4) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term ‘individual health insurance coverage’ means health insurance coverage offered in the individual market, as defined in section 2791(e)(1).

“(5) APPLICABLE STATE AUTHORITY.—The term ‘applicable State authority’ means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State with respect to the issuer.

“(6) HAZARDOUS FINANCIAL CONDITION.—The term ‘hazardous financial condition’ means that, based on its present or reasonably anticipated financial condition, a health insurance issuer is unlikely to be able—

“(A) to meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

“(B) to pay other obligations in the normal course of business.

“(7) COVERED LAWS.—

“(A) IN GENERAL.—The term ‘covered laws’ means the laws, rules, regulations, agreements, and orders governing the insurance business pertaining to—

“(i) individual health insurance coverage issued by a health insurance issuer;

“(ii) the offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage to an individual;

“(iii) the provision to an individual in relation to individual health insurance coverage of health care and insurance related services;

“(iv) the provision to an individual in relation to individual health insurance coverage of management, operations, and investment activities of a health insurance issuer; and

“(v) the provision to an individual in relation to individual health insurance coverage of loss control and claims administration for a health insurance issuer with respect to liability for which the issuer provides insurance.

“(B) EXCEPTION.—Such term does not include any law, rule, regulation, agreement, or order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or adequacy, health care data collection, or quality assurance.

“(8) STATE.—The term ‘State’ means the 50 States and includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

“(9) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term ‘unfair claims settlement practices’ means only the following practices:

“(A) Knowingly misrepresenting to claimants and insured individuals relevant facts

or policy provisions relating to coverage at issue.

“(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

“(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

“(D) Failing to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.

“(E) Refusing to pay claims without conducting a reasonable investigation.

“(F) Failing to affirm or deny coverage of claims within a reasonable period of time after having completed an investigation related to those claims.

“(G) A pattern or practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

“(H) A pattern or practice of attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured individual or his or her beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application.

“(I) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured.

“(J) Failing to provide forms necessary to present claims within 15 calendar days of a requests with reasonable explanations regarding their use.

“(K) Attempting to cancel a policy in less time than that prescribed in the policy or by the law of the primary State.

“(10) FRAUD AND ABUSE.—The term ‘fraud and abuse’ means an act or omission committed by a person who, knowingly and with intent to defraud, commits, or conceals any material information concerning, one or more of the following:

“(A) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by an insurer, a reinsurer, broker or its agent, false information as part of, in support of or concerning a fact material to one or more of the following:

“(i) An application for the issuance or renewal of an insurance policy or reinsurance contract.

“(ii) The rating of an insurance policy or reinsurance contract.

“(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract.

“(iv) Premiums paid on an insurance policy or reinsurance contract.

“(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract.

“(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction.

“(vii) The financial condition of an insurer or reinsurer.

“(viii) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance or reinsurance in all or part of a State by an insurer or reinsurer.

“(ix) The issuance of written evidence of insurance.

“(x) The reinstatement of an insurance policy.

“(B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer reinsurer or other person engaged in

the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction.

“(C) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance.

“(D) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this paragraph.

“SEC. 2796. APPLICATION OF LAW.

“(a) IN GENERAL.—The covered laws of the primary State shall apply to individual health insurance coverage offered by a health insurance issuer in the primary State and in any secondary State, but only if the coverage and issuer comply with the conditions of this section with respect to the offering of coverage in any secondary State.

“(b) EXEMPTIONS FROM COVERED LAWS IN A SECONDARY STATE.—Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), renewal, and issuance of individual health insurance coverage in any secondary State is exempt from any covered laws of the secondary State (and any rules, regulations, agreements, or orders sought or issued by such State under or related to such covered laws) to the extent that such laws would—

“(1) make unlawful, or regulate, directly or indirectly, the operation of the health insurance issuer operating in the secondary State, except that any secondary State may require such an issuer—

“(A) to pay, on a nondiscriminatory basis, applicable premium and other taxes (including high risk pool assessments) which are levied on insurers and surplus lines insurers, brokers, or policyholders under the laws of the State;

“(B) to register with and designate the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process;

“(C) to submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer’s financial condition, if—

“(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

“(ii) any such examination is conducted in accordance with the examiners’ handbook of the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition;

“(D) to comply with a lawful order issued—

“(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment under subparagraph (C); or

“(ii) in a voluntary dissolution proceeding;

“(E) to comply with an injunction issued by a court of competent jurisdiction, upon a petition by the State insurance commissioner alleging that the issuer is in hazardous financial condition;

“(F) to participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required to belong;

“(G) to comply with any State law regarding fraud and abuse (as defined in section 2795(10)), except that if the State seeks an in-

junction regarding the conduct described in this subparagraph, such injunction must be obtained from a court of competent jurisdiction;

“(H) to comply with any State law regarding unfair claims settlement practices (as defined in section 2795(9)); or

“(I) to comply with the applicable requirements for independent review under section 2798 with respect to coverage offered in the State;

“(2) require any individual health insurance coverage issued by the issuer to be countersigned by an insurance agent or broker residing in that Secondary State; or

“(3) otherwise discriminate against the issuer issuing insurance in both the primary State and in any secondary State.

“(c) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in any insurance coverage offered in a secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being appropriately filled with the name of the health insurance issuer, the name of primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned:

‘This policy is issued by _____ and is governed by the laws and regulations of the State of _____, and it has met all the laws of that State as determined by that State’s Department of Insurance. This policy may be less expensive than others because it is not subject to all of the insurance laws and regulations of the State of _____, including coverage of some services or benefits mandated by the law of the State of _____. Additionally, this policy is not subject to all of the consumer protection laws or restrictions on rate changes of the State of _____. As with all insurance products, before purchasing this policy, you should carefully review the policy and determine what health care services the policy covers and what benefits it provides, including any exclusions, limitations, or conditions for such services or benefits.’

“(d) PROHIBITION ON CERTAIN RECLASSIFICATIONS AND PREMIUM INCREASES.—

“(1) IN GENERAL.—For purposes of this section, a health insurance issuer that provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal—

“(A) move or reclassify the individual insured under the health insurance coverage from the class such individual is in at the time of issue of the contract based on the health-status related factors of the individual; or

“(B) increase the premiums assessed the individual for such coverage based on a health status-related factor or change of a health status-related factor or the past or prospective claim experience of the insured individual.

“(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed to prohibit a health insurance issuer—

“(A) from terminating or discontinuing coverage or a class of coverage in accordance with subsections (b) and (c) of section 2742;

“(B) from raising premium rates for all policy holders within a class based on claims experience;

“(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at intervals prescribed by the issuer, if such premium changes or incentives—

“(i) are disclosed to the consumer in the insurance contract;

“(ii) are based on specific wellness activities that are not applicable to all individuals; and

“(iii) are not obtainable by all individuals to whom coverage is offered;

“(D) from reinstating lapsed coverage; or

“(E) from retroactively adjusting the rates charged an insured individual if the initial rates were set based on material misrepresentation by the individual at the time of issue.

“(e) **PRIOR OFFERING OF POLICY IN PRIMARY STATE.**—A health insurance issuer may not offer for sale individual health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.

“(f) **LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE ISSUERS.**—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a non-resident agent or broker.

“(g) **DOCUMENTS FOR SUBMISSION TO STATE INSURANCE COMMISSIONER.**—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

“(1) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

“(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

“(B) written notice of any change in its designation of its primary State; and

“(C) written notice from the issuer of the issuer's compliance with all the laws of the primary State; and

“(2) to the insurance commissioner of each secondary State in which it offers individual health insurance coverage, a copy of the issuer's quarterly financial statement submitted to the primary State, which statement shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by—

“(A) a member of the American Academy of Actuaries; or

“(B) a qualified loss reserve specialist.

“(h) **POWER OF COURTS TO ENJOIN CONDUCT.**—Nothing in this section shall be construed to affect the authority of any Federal or State court to enjoin—

“(1) the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

“(2) the solicitation or sale of individual health insurance coverage that violates the requirements of the law of a secondary State which are described in subparagraphs (A) through (H) of section 2796(b)(1).

“(i) **POWER OF SECONDARY STATES TO TAKE ADMINISTRATIVE ACTION.**—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State's laws described in section 2796(b)(1).

“(j) **STATE POWERS TO ENFORCE STATE LAWS.**—

“(1) **IN GENERAL.**—Subject to the provisions of subsection (b)(1)(G) (relating to injunc-

tions) and paragraph (2), nothing in this section shall be construed to affect the authority of any State to make use of any of its powers to enforce the laws of such State with respect to which a health insurance issuer is not exempt under subsection (b).

“(2) **COURTS OF COMPETENT JURISDICTION.**—If a State seeks an injunction regarding the conduct described in paragraphs (1) and (2) of subsection (h), such injunction must be obtained from a Federal or State court of competent jurisdiction.

“(k) **STATES' AUTHORITY TO SUE.**—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

“(l) **GENERALLY APPLICABLE LAWS.**—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

“(m) **GUARANTEED AVAILABILITY OF COVERAGE TO HIPAA ELIGIBLE INDIVIDUALS.**—To the extent that a health insurance issuer is offering coverage in a primary State that does not accommodate residents of secondary States or does not provide a working mechanism for residents of a secondary State, and the issuer is offering coverage under this part in such secondary State which has not adopted a qualified high risk pool as its acceptable alternative mechanism (as defined in section 2744(c)(2)), the issuer shall, with respect to any individual health insurance coverage offered in a secondary State under this part, comply with the guaranteed availability requirements for eligible individuals in section 2741.

“**SEC. 2797. PRIMARY STATE MUST MEET FEDERAL FLOOR BEFORE ISSUER MAY SELL INTO SECONDARY STATES.**

“A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State if the State insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

“**SEC. 2798. INDEPENDENT EXTERNAL APPEALS PROCEDURES.**

“(a) **RIGHT TO EXTERNAL APPEAL.**—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State under the provisions of this title unless—

“(1) both the secondary State and the primary State have legislation or regulations in place establishing an independent review process for individuals who are covered by individual health insurance coverage, or

“(2) in any case in which the requirements of subparagraph (A) are not met with respect to the either of such States, the issuer provides an independent review mechanism substantially identical (as determined by the applicable State authority of such State) to that prescribed in the ‘Health Carrier External Review Model Act’ of the National Association of Insurance Commissioners for all individuals who purchase insurance coverage under the terms of this part, except that, under such mechanism, the review is conducted by an independent medical reviewer, or a panel of such reviewers, with respect to whom the requirements of subsection (b) are met.

“(b) **QUALIFICATIONS OF INDEPENDENT MEDICAL REVIEWERS.**—In the case of any independent review mechanism referred to in subsection (a)(2)—

“(1) **IN GENERAL.**—In referring a denial of a claim to an independent medical reviewer, or to any panel of such reviewers, to conduct independent medical review, the issuer shall ensure that—

“(A) each independent medical reviewer meets the qualifications described in paragraphs (2) and (3);

“(B) with respect to each review, each reviewer meets the requirements of paragraph (4) and the reviewer, or at least 1 reviewer on the panel, meets the requirements described in paragraph (5); and

“(C) compensation provided by the issuer to each reviewer is consistent with paragraph (6).

“(2) **LICENSURE AND EXPERTISE.**—Each independent medical reviewer shall be a physician (allopathic or osteopathic) 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 condition, makes the diagnosis, 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 subparagraph (A) shall be construed to—

“(i) prohibit an individual, solely on the basis of affiliation with the 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;

“(III) the fact of such an affiliation is disclosed to the issuer and the enrollee (or authorized representative) and neither party objects; and

“(IV) the affiliated individual is not an employee of the issuer and does not provide services exclusively or primarily to or on behalf of the issuer;

“(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as an independent medical reviewer merely on the basis of such affiliation if the affiliation is disclosed to the issuer and the enrollee (or authorized representative), and neither party objects; or

“(iii) 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.**—In a case involving treatment, or the provision of items or services—

“(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

“(ii) by a non-physician health care professional, the reviewer, or at least 1 member of the review panel, shall be a practicing non-physician health care professional of the same or similar specialty as the non-physician health care professional who, acting within the appropriate scope of practice

within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

“(B) PRACTICING DEFINED.—For purposes of this paragraph, the term ‘practicing’ means, with respect to an individual who is a physician or other health care professional, that the individual provides health care services to individual patients on average at least 2 days per week.

“(5) PEDIATRIC EXPERTISE.—In the case of an external review relating to a child, a reviewer shall have expertise under paragraph (2) in pediatrics.

“(6) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by the issuer 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.

“(7) RELATED PARTY DEFINED.—For purposes of this section, the term ‘related party’ means, with respect to a denial of a claim under a coverage relating to an enrollee, any of the following:

“(A) The issuer involved, or any fiduciary, officer, director, or employee of the issuer.

“(B) The enrollee (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 to have a substantial interest in the denial involved.

“(8) DEFINITIONS.—For purposes of this subsection:

“(A) ENROLLEE.—The term ‘enrollee’ means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

“(B) HEALTH CARE PROFESSIONAL.—The term ‘health care professional’ means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

“SEC. 2799. ENFORCEMENT.

“(a) IN GENERAL.—Subject to subsection (b), with respect to specific individual health insurance coverage the primary State for such coverage has sole jurisdiction to enforce the primary State’s covered laws in the primary State and any secondary State.

“(b) SECONDARY STATE’S AUTHORITY.—Nothing in subsection (a) shall be construed to affect the authority of a secondary State to enforce its laws as set forth in the exception specified in section 2796(b)(1).

“(c) COURT INTERPRETATION.—In reviewing action initiated by the applicable secondary State authority, the court of competent jurisdiction shall apply the covered laws of the primary State.

“(d) NOTICE OF COMPLIANCE FAILURE.—In the case of individual health insurance coverage offered in a secondary State that fails to comply with the covered laws of the primary State, the applicable State authority of the secondary State may notify the applicable State authority of the primary State.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to individual health insurance coverage offered, issued, or sold after the date that is one year after the date of the enactment of this Act.

(c) GAO ONGOING STUDY AND REPORTS.—

(1) STUDY.—The Comptroller General of the United States shall conduct an ongoing study concerning the effect of the amendment made by subsection (a) on—

(A) the number of uninsured and under-insured;

(B) the availability and cost of health insurance policies for individuals with pre-existing medical conditions;

(C) the availability and cost of health insurance policies generally;

(D) the elimination or reduction of different types of benefits under health insurance policies offered in different States; and

(E) cases of fraud or abuse relating to health insurance coverage offered under such amendment and the resolution of such cases.

(2) ANNUAL REPORTS.—The Comptroller General shall submit to Congress an annual report, after the end of each of the 5 years following the effective date of the amendment made by subsection (a), on the ongoing study conducted under paragraph (1).

SEC. 305. SEVERABILITY.

If any provision of this title or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this title and the application of the provisions of such to any other person or circumstance shall not be affected.

SA 4017. Mr. DURBIN (for Mrs. FEINSTEIN) submitted an amendment intended to be proposed by Mr. DURBIN to the bill S. 2071, to enhance the ability to combat methamphetamine; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Combat Methamphetamine Enhancement Act of 2007”.

SEC. 2. REQUIREMENT OF SELF-CERTIFICATION BY ALL REGULATED PERSONS SELLING SCHEDULED LISTED CHEMICALS.

Section 310(e)(2) of the Controlled Substances Act (21 U.S.C. 830(e)(2)) is amended by inserting at the end the following:

“(C) Each regulated person who makes a sale at retail of a scheduled listed chemical product and is required under subsection (b)(3) to submit a report of the sales transaction to the Attorney General may not sell any scheduled listed chemical product at retail unless such regulated person has submitted to the Attorney General a self-certification including a statement that the seller understands each of the requirements that

apply under this paragraph and under subsection (d) and agrees to comply with the requirements. The Attorney General shall by regulation establish criteria for certifications of mail-order distributors that are consistent with the criteria established for the certifications of regulated sellers under paragraph (1)(B).”

SEC. 3. PUBLICATION OF SELF-CERTIFIED REGULATED SELLERS AND REGULATED PERSONS LISTS.

Section 310(e)(1)(B) of the Controlled Substances Act (21 U.S.C. 830(e)(1)(B)) is amended by inserting at the end the following:

“(v) PUBLICATION OF LIST OF SELF-CERTIFIED PERSONS.—The Attorney General shall develop and make available a list of all persons who are currently self-certified in accordance with this section. This list shall be made publicly available on the website of the Drug Enforcement Administration in an electronically downloadable format.”

SEC. 4. REQUIREMENT THAT DISTRIBUTORS OF LISTED CHEMICALS SELL ONLY TO SELF-CERTIFIED REGULATED SELLERS AND REGULATED PERSONS.

Section 402(a) of the Controlled Substances Act (21 U.S.C. 842(a)) is amended—

(1) in paragraph (13), by striking “or” after the semicolon;

(2) in paragraph (14), by striking the period and inserting “; or”;

(3) by inserting after paragraph (14) the following:

“(15) to distribute a scheduled listed chemical product to a regulated seller, or to a regulated person referred to in section 310(b)(3)(B), unless such regulated seller or regulated person is, at the time of such distribution, currently registered with the Drug Enforcement Administration, or on the list of persons referred to under section 310(e)(1)(B)(v).”; and

(4) inserting at the end the following: “For purposes of paragraph (15), if the distributor is temporarily unable to access the list of persons referred to under section 310(e)(1)(B)(v), the distributor may rely on a written, faxed, or electronic copy of a certificate of self-certification submitted by the regulated seller or regulated person, provided the distributor confirms within 7 business days of the distribution that such regulated seller or regulated person is on the list referred to under section 310(e)(1)(B)(v).”

SEC. 5. NEGLIGENT FAILURE TO SELF-CERTIFY AS REQUIRED.

Section 402(a) of the Controlled Substances Act (21 U.S.C. 842(a)(10)) is amended by inserting before the semicolon the following: “or negligently to fail to self-certify as required under section 310 (21 U.S.C. 830)”.

SEC. 6. EFFECTIVE DATE AND REGULATIONS.

(a) EFFECTIVE DATE.—This Act and the amendments made by this Act shall take effect 180 days after the date of enactment of this Act.

(b) REGULATIONS.—In promulgating the regulations authorized by section 2, the Attorney General may issue regulations on an interim basis as necessary to ensure the implementation of this Act by the effective date.

FOREIGN TRAVEL FINANCIAL REPORTS

In accordance with the appropriate provisions of law, the Secretary of the Senate herewith submits the following reports for standing committees of the Senate, certain joint committees of the Congress, delegations and groups, and select and special committees of the Senate, relating to expenses incurred in the performance of authorized foreign travel: