

EXTENSIONS OF REMARKS

INTRODUCTION OF NUCLEAR
WEAPONS CUSTODIANSHIP RESOLUTION**HON. EDWARD J. MARKEY**

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. MARKEY. Mr. Speaker, today I am introducing a resolution to express the Sense of Congress regarding the proper direction of U.S. efforts to maintain the safety and reliability of the nuclear weapons stockpile in the post-Cold War era.

Currently, the Department of Energy's Stockpile Stewardship squanders billions of dollars on facilities to research and design new warheads, and continue nuclear weapons development as if the Cold War had never ended. In doing so, it bolsters nuclear weapons aspirations of other nations who follow our lead, and puts our real security at risk. It is time to stop this wasteful approach and develop a custodianship program more adequately suited to modern needs. The resolution I am introducing today urges DOE to cease its ill-advised stockpile stewardship program and develop a program that is less costly, less provocative, and less likely to spend billions on facilities with little relevance to the safety of the arsenal.

Many experts have suggested that there are alternatives to the Department of Energy's current stockpile stewardship program that can maintain the U.S. nuclear arsenal at a significantly lower cost. None of these alternatives have been seriously considered by DOE. In reality, many of the projects funded under this program are nothing more than a jobs program for nuclear scientists, but a jobs program with serious non-proliferation consequences. Other nations already look to our massive investment into nuclear weapons research and use it to justify their expanding nuclear programs.

To promote the kind of curatorship of the arsenal that is really needed with the end of the Cold War, I am today introducing a resolution which expresses support for a program that protects our national security without being a guise for new weapons programs that will further undermine the already unsteady international nuclear non-proliferation regime. This resolution expresses the Sense of Congress that the nuclear weapons stockpile can be maintained with a program that is far smaller, less expensive, and which does not require the facilities or experiments that are likely to be used for warhead design or development. In addition, the resolution urges the Secretary of Energy to direct the Department of Energy program for custodianship of the nuclear weapons arsenal towards less costly and less provocative methods and to cease the current stockpile stewardship plans of the Department.

It is my hope that this resolution will serve as a useful vehicle for educating the Congress and the public about the nature of the current stockpile stewardship program and promoting a more informed debate and consideration of less destabilizing and costly alternatives. I urge my colleagues to join in cosponsoring this important resolution.

HAPPY 100TH ANNIVERSARY, ST.
VALENTINE'S PARISH—BEAVER**HON. JAMES A. BARCIA**

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. BARCIA. Mr. Speaker, the stability of one's church is a source of strength for many people. The members of St. Valentine's Parish—Beaver, located in Beaver Township, Michigan, this weekend are celebrating their centennial of being a positive influence in the community.

Prior to 1888, Catholic pioneers who came to Kawkawlin, Michigan, had to travel ten to fifteen miles to St. Joseph Church in Auburn. Father Szulak, a Jesuit missionary from Detroit, began offering monthly services in 1888 at the home of John Nowak. On St. Valentine's Day that year, Bartholomew Zboralski donated five acres of land which were used for a school where church services were also held. Students were taught in both English and Polish. The first teacher at the school was Miss Cecilia Warczynski. Bishop Henry Richter of Detroit then asked Rev. Joseph Lewandowski, the administrator of St. Stanislaus Parish, and his assistant, Father Bieniawski, to attend to the needs of the people of this area. This action resulted in the formal establishment of St. Valentine's Parish—Beaver, 100 years ago.

Since the first official act at St. Valentine's—a baptism on February 14, 1898, the first marriage of John Rozek and Mary Grzegorzczuk on September 27, 1898, and the first funeral of Victor Milkowski with burial in the church cemetery in the spring of 1898, this institution has been of great importance to the community.

A new church was built in 1909 during the pastorate of Father John Kaplanowski. The first baptism at the new facility took place on February 4. Lucy Tomczak was baptized just three days after her birth. The first funeral was for Anna Hyrek, who died on August 24 at the age of three. The first wedding was November 22, joining Anthony Solinski and Helen Kukla.

In 1947, Father Joseph Kaminski began the efforts to construct a new school. This modern four room school was completed in the fall of 1948, and is celebrating its own fiftieth anniversary this year as well. Sister Mary Angelica served as the first Principal. A new convent was built in 1959, and with its completion, more room was also available for the expanding needs of the school.

The church has had its own tragic events. A fire in the early 1920's destroyed the altar, which was replaced at a cost of \$600. And then on February 22, 1991, the church was hit by a truck, and suffered extensive damage. Repairs this time cost \$571,411. Religious celebrations again returned to the parish center until a replacement facility was completed in 1993. In an ironic fashion, while Father Kaminski had celebrated the first mass in the church in 1908, the last mass celebrated before the accident was for the repose of his soul.

Father Richard Ratajczak, the current pastor, is originally from St. Valentine's Parish, having had the good fortune to live through much of its wonderful history. Father Ratajczak also celebrated his 40th anniversary as a priest last month.

Mr. Speaker, St. Valentine's Parish—Beaver has been a wonderful influence for the past 100 years. I urge you and all of our colleagues to join me in wishing the parish many more blessed years to come.

CONGRATULATIONS TO CENTRAL
UNION ELEMENTARY SCHOOL**HON. GEORGE P. RADANOVICH**

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. RADANOVICH. Mr. Speaker, I rise today to congratulate Central Union Elementary School. Central Elementary has been honored as a California Distinguished School. The faculty and students of Central Union Elementary exemplify excellence with exceptional student achievement.

Central Union is located in the outskirts of Lemoore, in Kings County. Central Union's heterogeneous groupings, extensive use of active learning projects, and popular extra-curricular programs take full advantage of richly diverse population and provide the students with opportunities to learn and play with children from different cultural, ethnic, linguistic, religious, and socio-economic backgrounds.

Central Union Elementary has over 308 diverse students in grades K-8. The student body is composed of 29% Native American, 4% African American, 28% Hispanic, and 39% White students. Central Union Elementary's motto: "Together, We Achieve" shows a tradition of support for, and pride in, their excellent educational program. Evidence of Central Union's history of quality education is seen in the large participation by parents in school events, traditional celebrations, and programs. 90% of the parents attended their recent parent-teacher conferences; 85% of the parents attended the programs and visited classrooms during Open House and Back to School Night last year.

Central Union Elementary places emphasis on student results. The school's educational

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

strategies and practices are consistent with this goal. Their content and student performance standards aligned with and are as rigorous as the "Draft Interim Content and Performance Standards." Central Union Elementary has a safe, clean, friendly, orderly, and supportive environment for children. Parents are involved in their children's education and collaborate with staff members to ensure achievement. Parent volunteer records document that over 3,337 hours were volunteered to assist students, programs and special events last year. Volunteer activities included collaborating with staff members in planning and evaluating programs in a shared decision making process, serving as chairs or members of committees, such as safe schools team, SSC, advisories, and supervising field trips, serving at the snack bar, correcting reports, and publishing newsletters.

Mr. Speaker, it is with great honor that I congratulate Central Union Elementary, a California Distinguished School. The students and faculty of this school exemplify a care for the community and a dedication to hard work. I ask my colleagues to join me in wishing Central Union Elementary many more years of success.

**KEN STARR SHOULD REPORT:
CASE CLOSED**

HON. JOHN J. LaFALCE

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. LaFALCE. Mr. Speaker, I commend to the attention of our colleagues the following editorial on Independent Counsel Kenneth Starr's investigation which appeared this month in the three "Greater Niagara Newspapers" published in my district in Western New York: The Niagara Gazette (Niagara Falls); The Union Sun & Journal (Lockport); and The Journal-Register (Medina). Among other things, the editorial faults Kenneth Starr for his failure to submit an interim report to Congress, as required by law. If, after three years and \$40 million, Mr. Starr has been unable to find any substantial and credible information about possible crimes by the president, the editorial concludes, "Starr's report should start and end with the phrase, 'Case closed.'"

The editorial follows:

WRITE A CLOSING CHAPTER

What has Special Prosecutor Kenneth Starr been up to lately in his \$40 million quest to nail President Clinton on charges of being a Democrat? You won't find out from him. The special prosecutor won't deliver an interim report on his publicly funded wild goose chase.

Spokesman Charles Bakaly said Starr will report to Congress only if and when he has "substantial and credible information about possible crimes by the president." It may be a cold day in hell before that happens. Any claim Starr had on credibility expired about three years and \$30 million ago.

The obligation to file such a report is written right into the independent counsel law under which Starr was appointed. But there's no time element in the requirement. Oops, it looks as if Starr is riding that loophole into the sunset. His method of choice for report-

ing apparently is well-orchestrated leaks to the media.

Starr began his quest for a crime to pin on Clinton by investigating "Whitewater," a series of Arkansas land deals the president and Mrs. Clinton were involved in. He found no evidence of criminal wrongdoing by the Clintons.

Attorney General Janet Reno helped Starr turn his attention and the taxpayers' money to an inquiry into the president's relationship with former White House intern Monica Lewinsky. Our question is, does the public need or want to know anything about the president's private affairs or lack thereof? We say no. It's Hillary Rodham Clinton's call on whether to investigate such matters, and questions about marital fidelity are best handled by private, not public investigators.

It's long past time for the American public to refuse to pay for Starr's attack dogs to nip at Clinton's heels. The special prosecutor role has become an excuse to find some dirt on a president the opposition political party wishes hadn't been elected. Get over it.

If there's no substantial and credible information by now, Starr's report should start and end with the phrase, "Case closed."

**IN RECOGNITION OF PAUL E.
GOULDING**

HON. PATRICK J. KENNEDY

OF RHODE ISLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. KENNEDY of Rhode Island. Mr. Speaker, in last month's Financial Executive magazine a featured interview with Paul E. Goulding, a management consultant to businesses large and small, focused on procurement of Federal contracts. Mr. Goulding, who is a constituent of mine and an expert in procurement issues, has had broad experience in the field of government contracting in a long distinguished career that includes senior executive positions in Federal service as well as the private sector.

As an Administrative Assistant to Senator Claiborne Pell, he worked closely with Rhode Island businesses, advising and assisting them in obtaining Federal contracts. While Deputy and Acting Administrator of the General Services Administration in 1979 and 1980, he developed an 8 point program to cut operating costs at GSA. And as a Professional Staff member of the Senate Committee on Rules and Administration, he conducted the first comprehensive study of the Senate's major operations, including how to improve its procurement procedures.

Mr. Goulding has, in fact, played active roles as advocate, administrator, and advisor in the government procurement process. First, as a congressional staff member in assisting the business community in our state of Rhode Island. Secondly, as head of the largest non-defense agency buying goods and services for the government. Lastly, as a consultant to major international corporations as well as to small businesses.

Mr. Speaker, I respectfully submit this interview to be included in the RECORD as part of my remarks. Mr. Goulding has offered some worthwhile and common sense advice for companies who are seeking to do business with the Federal government:

[From FEI News, May/June 1998]

Q&A: MAKING UNCLE SAM YOUR CUSTOMER

Financial Executive recently interviewed Paul E. Goulding, a Washington, D.C.-based consultant and expert in the arcane art of government procurement.

Q: Your firm has helped clients obtain more than \$30 billion in government contracts during the last 10 years, companies like AT&T and Hewlett Packard. Do large companies have a big advantage when it comes to selling to Uncle Sam?

PEG: While you might assume they would, my experience indicates that isn't the case. For instance, some big companies get involved in bidding on major contracts and find they are lost because their marketing people, who want to make the sale, are saying one thing while their government relations people have an entirely different view of what should be submitted in the bid.

A dilemma for top management?

PEG: Exactly. Some small niche companies, on the other hand, know exactly what their market is and how best to sell to it. Each case is different and there is no cookie-cutter formula. I keep an open mind and try to evaluate each situation as I see it.

Although small and medium-sized firms frequently need more help steering through the process, they are often more successful than larger companies because they tend to be more flexible and less bureaucratic when faced with complex challenges.

Why should firms of any size bother to do business with the U.S. government given all the red tape involved?

PEG: When I hear that question, I tell the story of the businessman who buys a hardware store after moving to a small town. He asks his new employees who the biggest hardware customer in town is. He is surprised to learn that the customer isn't doing business with his store. When the owner asks why not, his employees say the customer is difficult to do business with and requires that a lot of forms be filled out. I point out that same customer is probably very wealthy, doesn't bounce his checks and usually does repeat business when satisfied. That's the type of customer the federal government can be.

Just how big a customer is the U.S. government?

PEG: The U.S. government buys goods and services valued at over \$200 billion. That makes Uncle Sam the biggest customer in the world. And it's not just the dollar figure that's large, but the number of individual acquisitions. According to the GSA Procurement Data Center, over 20 million individual contract actions are processed every year.

Now that we're in a global economy and even small businesses are entering the overseas export market, and given all the problems in dealing with tariffs, quotas, foreign currency exchange, international letters of credit and shipping, it doesn't make sense for U.S. companies to fail to maximize their U.S. government business, which is right on their doorstep.

What would you advise firms that want to do business with the government?

PEG: It will require an investment of time, money and resources. Starting a relationship with the government is very similar to a company entering a new market overseas. The company has to make a commitment to the market. Sometimes companies will ask me why they can't just go after one contract and see how they do. Well, that system is just about as effective as the guy who goes to the race track and bets on one race to see if he's going to win that day.

Like any start-up marketing effort, the company has to be willing to allocate manpower and resources to help develop their government business.

What would you advise a company that already does some business with the government?

PEG: I would first ask what percentage of the domestic U.S. market the firm services. If you answer 10 percent, then I would ask what percentage of the government market for your product you control. If the answer is 5 percent, then at the very least you need to double your government sales.

What else do you tell a new client looking to grab government business?

PEG: I explain how often doing business with the government is the reverse of doing business in the private sector. Before you can make a government sale, in many instances you must do considerable research to find out how the government buys your product or service, who buys it, where they buy it and, often overlooked, when they buy it. Also, the government sometimes changes the rules or methods by which it procures goods and services.

If you take the time and trouble to learn the system, you can figure it out.

Why do companies turn to consultants like yourself to help them?

PEG: The principal reason is that it's more efficient. It is less time consuming and, in the final analysis, less expensive to involve qualified people on your team.

Is doing business in Washington different from doing business in, say, Cleveland?

PEG: It certainly is. It's important for corporate leaders to make a commitment of time and effort to learn the business practices here, which are often different from those in the private sector. At the same time, a similar commitment has to be made to develop long-term political and social relationships with the leading players on Capitol Hill and in the bureaucracy. Success in Washington absolutely requires both.

THANK YOU TO PATTON LANE
FOR SERVICE ON MY STAFF

HON. BART GORDON

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. GORDON. Mr. Speaker, at the end of this month, Mr. Joe Patton Lane III will leave my office to enter the School of Law at Roger Williams University in Rhode Island.

Patton has been a loyal and effective member of my congressional staff for the past three years. However, I have known Patton for over a decade. As a college student, he assisted with my re-election campaigns. My then-campaign manager made the statement, "Come election time, I wish I had fifteen Patton Lanes working for me!"

In a congressional personal staff office, there are thousands of demands made on hundreds of issues. Success in this environment requires attention to detail and conscientiousness. These are Patton's strengths. He has been a hard-working, dedicated employee.

Patton is part of a rare breed, one of which should be required in each congressional office. A native of Carthage, Tennessee, he knows every town, every zip code, and most

of the elected officials in Middle Tennessee. He is well-regarded by his co-workers and is recognized as someone who willingly undertakes any assignment without complaint.

Patton is from a long line of attorneys recognized in the state of Tennessee for their competence and ability. With his commitment to public service and his abilities, I am confident he will do well in his new endeavor.

It has been a pleasure to have Patton serve in my office and I join my staff in wishing him the best of fortune in his new undertaking.

TRIBUTE TO THE LATE CARL
HENRY SMITH, SR.

HON. JAMES A. BARCIA

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. BARCIA. Mr. Speaker, our nation's history is filled with stories of individuals who loved their nation, worked for their communities, led lives of professional accomplishment, and did all of this while remembering the importance of their families, offering love, support and a strong example for their children and grandchildren. I am proud to be able to relay another impressive life story to our colleagues: that of Carl Henry Smith, Sr., of Bay City, Michigan, who would have celebrated his 100th birthday on July 9.

Carl Henry Smith, Sr., was born in Peter and Molly Smith on July 9, 1898. He was their fifth child. The family worked hard on their farm, and that spirit of hard work stayed with Carl throughout his life. He graduated at the top of his class at Western High School in 1915, and then enlisted in the Michigan National Guard. His military service included time with the Second Michigan Ambulance Company during difficulties with Mexico at El Paso, Texas, and then saw his unit federalized into the United States Army in 1917. He served in France during World War I, and lost his left arm on August 29, 1918, at Soissons Juvigny. For his courage and bravery in caring for the wounded even though seriously injured himself, he was awarded the French Croix de Guerre with Silver Star and the Purple Heart. He met his eventual first wife, Jane, who was a Red Cross worker at Walter Reed Hospital here in Washington. She passed away in 1945.

After the military, he attended the University of Michigan, earning his law degree and being elected to the Board of Editorial Assistance for the Law Review. He was a member of the last graduating class of Lane Hall, Michigan Law School, before going on to service as the Bay City assistant prosecuting attorney, the Bay City prosecuting attorney, Probate Judge of Bay County, and Circuit Judge of Bay County. He continued his education, earning his doctorate of laws in 1950. He also served as the 15th President of the State Bar of Michigan—a post later earned by his son Carl H. Smith, Jr.

Carl Henry Smith supported his fellow veterans, being the only State Commander of the American Legion elected without opposition, unanimously, on the first ballot. He was a member of the First Presbyterian Church, the

Elks, the Red Cross, and a Trustee of Alma College. He was also a prominent member of the Bay County Republican Party.

He remarried in 1957, but then himself died from a stroke in 1961. His wife Caryl Jane Smith currently lives in Rochester Hills, Michigan. His sons Richard and Carl, Jr., and his daughter Elisabeth and their families live in Bay City. His grandson, Dr. Peter D. Smith, is the individual who brought Carl Henry Smith to my attention, telling me that his grandfather was his "best friend" and taught him the "spirit of family."

Mr. Speaker, when we want to know of the importance of family, let us think of individuals like Carl Henry Smith, Sr., who earned so much love that his family wants to celebrate what would have been his centennial by reminding us of what this great man did. If only there were more people like him.

CONGRATULATIONS TO GETTYSBURG
ELEMENTARY SCHOOL

HON. GEORGE P. RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. RADANOVICH. Mr. Speaker, I rise today to congratulate Clovis Unified's Gettysburg Elementary School for being nominated as a "California Distinguished School" and for achieving the "Clovis Distinguished School Award." Gettysburg Elementary has educated students with great success over the years and has served as a tremendous catalyst to the community. The faculty and students of Gettysburg Elementary exemplify excellence in student achievement and are very deserving of this recognition.

Gettysburg Elementary School is located 10 miles east of Fresno in the heart of the San Joaquin Valley. The school has a student population of 691 students in Kindergarten through grade Six. The school has students who range from the middle to lower-middle class socio-economically, with actively involved parents that provide the critical link between the school and home.

The foundation of Gettysburg Elementary School lies within the concept of being a community-centered school. Gettysburg enjoys an unusually high degree of volunteering and support from community based businesses. In the 1997-98 school year approximately 275 parents volunteered their time as classroom helpers and in the library. In a combined effort with teachers, students, parents and the community Gettysburg was recognized as a National Exemplary Safe and Drug Free School.

Gettysburg prepares all students for the challenges of the 21st century by developing confidence and skills in critical thinking through participation in a wide range of goal oriented experiences. Gettysburg School's Administration concept of education is to nurture the whole child and is emphasized through focusing on development of each child's mind, body, and spirit. Each student participates with both parents and teachers in the "Goal Sharing Programs," where they set both academic and behavioral goals. As a result, Gettysburg Elementary School was elected as a model

program by Phi Delta Kappa and received the "Award for Value and Character Education."

In the 1997-98 school year, the students achieved superior academic scores in reading, language, and mathematics on the California Assessment Tests. Gettysburg maintained an average daily attendance of 99.78% last school year.

Mr. Speaker, I rise today to congratulate Clovis Unified School District's Gettysburg Elementary School for being nominated as a "California Distinguished School." I applaud both the school and the community for their commitment to their children's lives. I ask my colleagues to join me in wishing Gettysburg Elementary School many years of success.

DEPARTMENT OF THE INTERIOR
AND RELATED AGENCIES APPROPRIATIONS ACT, 1999

SPEECH OF

HON. EARL BLUMENAUER

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 22, 1998

The House in Committee of the Whole House on the State of the Union had under consideration the bill (H.R. 4193) making appropriations for the Department of the Interior and related agencies for the fiscal year ending September 30, 1999, and for other purposes:

Mr. BLUMENAUER. Mr. Chairman, last night the House voted on Mr. PARKER of Mississippi's amendment No. 18 to strike certain provisions of the Interior Appropriations bill, H.R. 4193. These provisions direct the Indian Health Service to allocate contract support costs funding on a pro rata basis to all tribal contractors. I voted against that amendment in error. Removal of this provision is vitally important to the Tribes in my district and throughout the Northwest which are working to identify thoughtful, participatory solutions to an inadequate system of health care provision. I wish the record to reflect my support for the Parker amendment and the tribal self-determination it encourages.

ZLAN, LTD. DEVELOPS MAJOR ADVANCEMENT IN ELECTRICAL FIRE SAFETY

HON. RALPH M. HALL

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. HALL of Texas. Mr. Speaker, one of the new high-tech firms in my district, Zlan, Ltd. of Wylie, TX, has come up with an affordable solution to a major cause of the loss of life and property in this country: electrical fires. Each year thousands of people die or are seriously injured and billions of dollars of property is destroyed because of electrical fires. I am told that Zlan's technology, properly installed in the home, can improve electrical fire safety by as much as one-hundred fold, dramatically reducing electrical fires.

This is not a new problem. As early as 1978, the House Interstate and Foreign Com-

merce Committee's Oversight and Investigations Subcommittee found that ". . . often the dangerous malfunctions of these systems, which may lead to fire, takes place behind the walls of one's home over a period of time and finally fire erupts without warning. . . . (I)t is essential that industry and government work together to find a solution to this problem."

In 1994 the Consumer Product Safety Commission (CPSC) asked Underwriters Laboratories (UL) to identify new technology products for reducing residential electrical fires. George A. Spencer, who is Zlan's founder and CEO, invented an electronic circuit breaker and has spent many years developing and improving this technology. Zlan, Ltd. began demonstrating prototypes of its Digitally Enhanced Circuit Breaker®, to the CPSC and UL. CPSC has indicated substantial interest in this technology.

Last spring Spencer and the Zlan team presented to the CPSC staff an update of their electronic circuit breaker technology designed to detect arcing faults. Key features include:

Microprocessor controller for state of the art technology.

Arc detection to analyze low and high current problems in wiring.

False trip protection for routine power surges, i.e., motor start-ups, etc.

Auto self-test plus manual test capability.

LED status light for performance assurance and fault identification.

Serial Port options for remote monitoring, test and remote trip capability.

Zlan's Load Center Monitor works with the Digitally Enhanced Circuit Breakers to provide audible and visual indicators of faults, store performance data, identify causes of electrical malfunctions as well as communication capabilities to monitor electrical systems.

Zlan has entered into an agreement with STMicroelectronics, Inc. (ST) to manufacture a custom chip-set using Zlan's Arc Fault Interrupter (AFCI) technology that will provide a low cost solution to the circuit breakers manufacturers. Most homes can be upgraded to the new AFCI circuit breaker at a cost estimated to be as low as \$800.

This major advancement in electrical fire safety is expected to be on the market in time to meet new electrical building codes now being drafted.

Innovative use of new technology to improve flawed and dated technology has always been the hallmark of American ingenuity. I am extraordinarily pleased that the creative minds at Zlan have chosen to locate and build their business in my district to advance a promising technology that can save lives and give families the opportunity to make their homes safer places to live.

DISAPPROVAL OF MOST-FAVORED-NATION TREATMENT FOR CHINA

SPEECH OF

HON. CASS BALLENGER

OF NORTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, July 22, 1998

Mr. BALLENGER. Mr. Speaker, once again, legislation to overturn our current trade rela-

tions with the People's Republic of China has reached the House floor. This annual exercise divides our nation over our relationship with the most populous nation in the world. The only thing which has changed is the terminology. We now refer to Most Favored Nation (MFN) trading status as simply Normal Trade Relations (NTR), a more accurate description of this annual trade vote.

I will reluctantly vote against the resolution, Disapproving the Extension of Nondiscriminatory Treatment to the Products of the People's Republic of China (H.J. Res. 121), before us today. I do recognize China's deplorable record on human rights and our moral obligation to speak out for the weak and voiceless in China. However, in reaching my decision, I again asked myself these questions, "In the long run, will revoking China's trade status be good or harmful to the Chinese and the American people, and will it improve human rights in China?" I must conclude that revoking China's trade status would be counterproductive to these objectives.

As I have stated previously, the U.S. can do more to advance the cause of human rights and foster religious, economic and political freedom if we continue to engage the Chinese in economic cooperation. Social freedom—like freedom of religion—are a direct result of economic liberalization. If we remove all of China's trade privileges, we are not only isolating that country, but we are losing any opportunity to improve the human condition there.

Terminating normal trade relations with China will hurt the American worker and consumer as well. From 1991 to 1997, U.S. exports to China rose 71% from \$7.5 billion to \$12.8 billion. In addition, exports of U.S. goods and services to China and Hong Kong support an estimated 450,000 American jobs. From an agricultural perspective, the American Farm Bureau has called China "the most important growth market for U.S. agriculture in the twenty-first century." The United States Department of Agriculture estimates that China could account for one-third of future growth in U.S. farm exports in the years ahead.

Despite my position on NTR with China, I remain concerned about allegations that the Clinton White House violated existing campaign finance laws by accepting illegal foreign contributions from China. In return, the Clinton administration sacrificed American national security by allowing the Loral Space and Communications Ltd. and another U.S. company to provide China's space industry with specific technological expertise, strengthening its nuclear and missile capabilities. I believe the Congress has an obligation to look into these critical charges, and I support all efforts to continue House and Senate investigations.

In conclusion, if we choose to cut off our ties with China, we end up harming those who need our help the most—the Chinese people. Just as important, we hurt American workers, farmers and businesses which would export to china, now and in the future. I urge my colleagues to vote down H.J. Res. 121.

IN HONOR OF PUERTO RICO ON
ITS CONSTITUTION DAY

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. KUCINICH. Mr. Speaker, I rise to honor the citizens of Puerto Rico on Constitution Day, July 24, 1998. The people of Puerto Rico established the Constitution of the Commonwealth of Puerto Rico for the very same reasons our forefathers wrote the Constitution of the United States of America, to establish themselves as a democracy.

The Puerto Rican Constitution ensures basic welfare and human rights for the people, enconces the idea of a government which reflects the will of the people, and pays tribute and loyalty to the Constitution of the United States of America.

The Puerto Rican culture is a distinctly unique culture. By pledging allegiance to the Constitution of the United States of America, the people of Puerto Rico celebrate shared beliefs and the co-existence of both cultures. By ratifying their own Constitution, the people of Puerto Rico retain and honor their original heritage while expressing the desire to pursue democracy and happiness for themselves.

Mr. Speaker, I would like to recognize the following individuals for their contributions to the Greater Cleveland community. Dr. Milagros Acevedo Cruz, Michelle Melendez, Mario Ortiz, David Plata, Raquel Santiago, Lydia Esparra, Orlando Salinas, Ana Garcia, Yolanda Perdomo, and Jundy Caraballo. I hope that my fellow colleagues will join me in honoring these individuals and praising the Puerto Rican people as they celebrate Constitution Day.

IN RECOGNITION OF KATHLEEN S.
BLACKMAR

HON. PATRICK J. KENNEDY

OF RHODE ISLAND

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. KENNEDY of Rhode Island. Mr. Speaker, I would like to bring to your attention the recognition of a Warren post office employee who was recently recognized as the Federal Employee of the Year in Rhode Island. Kathleen S. Blackmar was honored at the 27th annual awards ceremony held at the BankBoston Operations Center in East Providence by the Federal Executive Council of Rhode Island. She was nominated for the award by Warren postmaster Erick B. Lawson.

Kathy has become known as a very valuable asset to the Warren post office. In her job as custodian, she is responsible for making building repairs, performing janitorial duties, and assisting customers with lost or broken post office box keys. Her fellow workers share the belief that she has a work ethic that cannot be identified by level of job title. She has educated herself about boiler repair and diagnosis and she makes minor repairs to the office's fleet of vehicles. On top of this, Ms. Blackmar maintains and landscapes the

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grounds and clears snow. She readily has given her time to serve as coordinator for the Combined Federal Campaign, the annual drive for the contribution to community organizations. She has also coordinated the post office's Toys for Tots campaign and the annual "Christmas Wish List."

I am proud to recognize Kathleen Blackmar as an outstanding individual and to commend her for her contribution to public service.

30TH ANNIVERSARY OF LOCKPORT
HIGH SCHOOL 100-MILE RELAY
RECORD

HON. JOHN J. LaFALCE

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. LaFALCE. Mr. Speaker, I would like to call to the attention of our colleagues the 30th anniversary of an extraordinary high school track and field record that still stands today. In June, 1968, eight members of Lockport Senior High School in Lockport, New York ran the 100-mile relay in a time of seven hours, 27 minutes and 53.6 seconds. This mark beat the previous New York State record by a full nine minutes. It is also an astonishing 26 minutes 36.5 seconds faster than the existing world record as listed in the Guinness Book of Records. And that so-called world record involved 100 runners—not eight.

Members of the record-setting relay team, led by Coach John Chew, were Jim Rycyna, Charlie Quagliano, Bob Brown, Brian Brooks, Jeff Helshoff, Frank Pfeil, George Bickford, and Jeff Watkins. Each of these student-athletes ran 12½ miles in spurts of 110 yards, 220 yards, and 440 yards. The overall average time was less than four minutes and 30 seconds per mile.

Mr. Speaker, the State of New York recently passed a resolution congratulating the 1968 Lockport High School relay team, and the Mayor of Lockport issued a proclamation commending their achievement. I too am pleased to recognize these eight men on the occasion of the 30th anniversary of their 100-mile relay record, and ask all Members to join me in congratulating them as they reunite this month to celebrate their tremendous athletic performance.

OUR WAR ON DRUGS BEST WEAPON:
GOOD PERSONNEL—HELP,
DON'T HINDER, OUR CUSTOMS
EMPLOYEES

HON. BOB FILNER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. FILNER. Mr. Speaker, this morning, I had the honor and privilege to speak to the National Treasury Employees Union and other national law enforcement groups. I outlined the successes that Customs employees have had in our War on Drugs and spoke of my opposition to H.R. 3809, which would undermine that success.

In my own district, Robert Hood, a Customs inspector, is considered one of the "Best of the West" in Operation Brass Ring, a concerted effort to increase drug seizures among all agencies policing the border. From February through June of this year, Robert lead the San Diego region in drug interdiction, seizing more than 8,745 pounds of marijuana and 11 pounds of methamphetamine. Robert Hood is joined by other heroes—in the San Diego Customs area, the valiant men and women policing the border have been responsible for nearly tripling the amount of cocaine and methamphetamine seized, while the number of seizures of marijuana have nearly doubled.

In just the past six months, Customs personnel have made an incredible impact on the amount of drugs getting to our streets and into our children's pockets! That is why the Fraternal Order of Police, the National Association of Police Organizations, and the Border Patrol Council, among others, join me in opposing H.R. 3809 and asking those who support it, "What could you be thinking?"

The bill undermines the partnership that has flourished between Customs personnel and their managers in the successful drug interdiction efforts. It would restrict employees' rights to have significant input on safety issues—and it would cut their pay. How does cutting Customs' employees' pay for working their regular night shifts help to bolster our War on Drugs? I simply don't understand it.

I support the provisions in H.R. 3809 that boost 1999 funding for Customs, and I urge the Senate and the President to also support an increase in Customs funding, while rejecting the provisions that cut Customs personnel negotiating rights and their hazard pay for essential nighttime shifts.

H.R. 3809 gives us tools to fight the War on Drugs, but puts those who will use the tools in straightjackets. We will lose the War on Drugs and waste taxpayers' money if we spend money on expensive, cutting-edge equipment at the same time we undermine employee morale and labor standards.

Listen to the partners in the War on Drugs—police officers know they cannot win the war if Customs efforts to keep drugs from entering the country are thwarted. I support the front-line soldiers in the War on Drugs—our Customs personnel—and urge support only for legislation that enhances, rather than detracts, from their good work.

IN HONOR OF DR. MARGARET
STORTZ AND REV. VICTOR
POSTOLAKI, MINISTERS OF THE
FIRST CHURCH OF RELIGIOUS
SCIENCE

HON. BARBARA LEE

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Ms. LEE. Mr. Speaker, it is with honor that I share with you the accomplishments and religious commitment of Dr. Margaret Stortz and Rev. Victor Postolaki, who will be honored by the First Church Religious Science on Sunday, July 26 in Oakland, California.

Dr. Stortz will be stepping down as senior minister after 14 years and Rev. Postolaki, as

assistant minister after 12 years of service. As ministers each has provided guidance and support to its congregants and the residents of Oakland and the East Bay.

As leaders of First Church, they encouraged community outreach on an economic level and have generated monies to assist the survivors of the 1989 Loma Prieta Earthquake, the Oakland Firestorm. Their fund-raising efforts such as the "Love Project" in conjunction with Allen Temple Baptist Church assisted in the rebuilding of the Black churches burned in the south, the North Dakota Flood, and the Mexico Earthquake. They have, through the church volunteer programs, arrange for the creation and distribution of grocery baskets and food vouchers for numerous economically disadvantaged families and organizations servicing this constituency.

They worked with Bay Area Ministries to make Oakland a better community for all its residents. Both were concerned about youth and were actively involved in programs that educated our children specially the teen empowering program serving the East Bay.

Dr. Stortz served as Assistant Minister in 1981 and as the senior minister since 1984. In 1983, she was elected President of the Northern California United Church of Religious Science. Over the years Dr. Stortz held numerous offices within the United Church of Religious Science organization as member of the International Board of Trustees and the President of the United Church of Religious Science.

Besides her ministerial duties she is an author and has an extensive list of works. Her written works include *Start Living Every Day of Your Life*, *How to Enjoy Life and Flight into Life*. She has produced *Seven Spiritual Laws of Success* based on Deepak Chopra's Book of the *You Prosper, We Prosper*—a 10-day prosperity meditation series, and *Here's to Your Health*—a 10-day health meditation series. She has written articles for the *Oakland Tribune* regarding the local clergy. Dr. Stortz served as a member of the Oakland Police and Clergy Together, and trained numerous assistant ministers.

Rev. Postolaki, originally from Romania, prior to coming to First Church, served the Santa Rosa Church, both as a Practitioner and as an Assistant Minister. In 1986 he became the assistant minister at First Church of Religious Science, Oakland. He conducted weekly circles of Prayer and headed the Pastoral Care.

Rev. Postolaki has brought his spiritual strength, his creativity, and his artistic talents to First Church. He created unique banners reflecting the world's religious beliefs and "The Season for Non-Violence" banner honoring the anniversaries of the deaths of Mahatma Gandhi and Dr. Martin Luther King, Jr.

Dr. Stortz and Rev. Postolaki have been pillars whose commitment has established First Church as a fifty-year-old Oakland spiritual institution.

BIPARTISAN CAMPAIGN INTEGRITY ACT OF 1997

SPEECH OF

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Monday, July 20, 1998

The House in Committee of the Whole House on the State of the Union had under consideration the bill (H.R. 2183) to amend the Federal Election Campaign Act of 1971 to reform the financing of campaigns for elections for Federal office, and for other purposes:

Mr. KUCINICH. Mr. Chairman, I rise in opposition to the amendment by Mr. PAXTON to the bill being discussed on campaign finance reform. This amendment would require labor unions to report all financial activities under current labor laws by categories, such as organizing activities and strike activities and political activities. The amendment further requires that reports be posted on the Internet.

These provisions single out unions for special treatment. They would impose expensive, burdensome regulations upon the organizations that represent working people. Companies are not subject to such treatment. This would further tilt the political playing field towards corporations and against working families.

The amendment imposes a substantial accounting burden on union members. It is the responsibility of the Department of Labor to determine the appropriate level of accounting that is needed to fulfill the requirements of American labor laws. This measure amounts to harassment and discrimination against labor unions.

Also, Mr. Chairman, this amendment is clearly a "poison pill." It is part of a continuing effort to load up the major, bipartisan campaign finance reform proposal with provisions that will drive away certain categories of supporters. The attempt is NOT to further campaign finance reform for the good of the American people. The purpose is to obstruct the process. I therefore urge my colleagues to defeat this destructive amendment.

FUNDING OF THE NEA AND CENSORSHIP

HON. BERNARD SANDERS

OF VERMONT

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. SANDERS. Mr. Speaker, I would like to have printed in the RECORD statements by high school students from my home State of Vermont, who were speaking at my recent town meeting on issues facing young people today.

FUNDING OF THE NEA AND CENSORSHIP

(By Daniel Luzer)

There has been a great deal of controversy lately about the National Endowment for the Arts. The Supreme Court is expected to rule in July in the case of National Endowment for the Arts versus Finley to decide if the federal law requiring the head of the Endow-

ment to consider general standards of decency and respect for the diverse beliefs and views of the American public when considering whether or not to award a grant. In Congress last month, Senator John Ashcroft, together with Senator Jesse Helms, attempted, in an appropriations bill, to kill the endowment program entirely.

From the beginning, the National Endowment for the Arts has been a controversial program. Certainly the endowment is a valuable program. Before 1965, when the endowment was instituted, the arts were, to a great extent, still on the fringes of society and accessible only to the cultural elite. Since then, the arts have expanded greatly, and are now accessible to the masses and have thus begun to educate the majority, which was the point.

In the words of Maryanne Peters, the President of the Board of Directors of the National Campaign for Freedom of Expression, "In creating the NEA, Congress recognized that the arts are integral to fostering imaginative thinking in our culture." In the 33 years which the National Endowment for the Arts has existed, the role of art in our culture has greatly increased. One of the main contributions that the Endowment has made to our culture is to expand the American art world from a largely market-driven world to a system which allows artists to explore and to expose communities to new creative fields, without having to worry about how to purchase materials, or even purchase food.

It is important to remember, though, that money from the National Endowment for the Arts is a prize, bestowed upon artists whose work is either exceptionally good or greatly needed in a given community. Artists who receive money from the Endowment are singled out for the content of the work. Organizations like National Campaign for Freedom of Expression would like us to believe that the law requiring the head of the Endowment to consider standards of decency when awarding grants amounts to a violation of the rights to free speech.

This line of reasoning is flawed, however, in that The First Amendment to the Constitution states that "Congress shall make no law restricting freedom of speech." The fact of the matter is that the above-mentioned law is not a law restricting freedom of speech. The National Endowment for the Arts is not an organization which punishes artists for poor quality work; it is an organization which awards prizes to artists of first quality.

The law simply requires potential grant-givers to consider decency with respect to art. The law does not restrict the freedom to speak in any way, since no artist is restricted from anything; they will simply find it slightly more difficult to receive federal money for offensive work, which seems a logical and acceptable state for an artist to be in. So the law is not unconstitutional.

That being said, the other issue that artists and artists' groups have brought up is the law's potentially harmful vagueness, which could lead to arbitrary and dangerous selection and rejection of an artist's work, which is absurd in a federal program, where standards are needed in order to determine an artistic piece's relevance in relation to the policies and purpose of the National Endowment for the Arts.

This is certainly a legitimate concern, and one which needs to be addressed in order for the National Endowment for the Arts to continue to function in a manner that benefits society. What the National Endowment for

the Arts needs to continue in a way that benefits America are clearer laws and a stricter codification of the grant system. In this way, artists can be granted money based on whether and where their work is needed. If a given community was seriously lacking in, say, quality theater, then playwrights could be sent, with NEA grants, to the said community.

To a certain extent, the National Endowment for the Arts already works in this manner. However, greater clarity on this issue would lead to a better relationship between the art and political communities, which would decrease artists' frustration and improve the quality of the overall art program in the United States.

This plan does, to a certain extent, lead to discrimination against certain forms of art. While that is unfortunate, there is no way that the United States government could ever equally support all forms of art. But that was never the purpose of the National Endowment for the Arts. Another objection that could be raised for this plan for greater codification of the endowments program is that placing restrictions would adversely affect the quality of art. While that is a legitimate concern, as the arts are an expression of emotion, it is important to realize that, in order for the arts to flourish, they do not need to be unrestricted. Some of the greatest works of art were created under severe restrictions. The entire Renaissance, which for example, produced such masterpieces as Michelangelo's Sistine Chapel, Donatello's Madonna and Child, and Dante's Divine Comedy, was funded in large part by the Florentine banking families, not to mention the Vatican.

An additional argument against the idea of greater codification for the National Endowment for the Arts might be that the organization would therefore not be supporting the artistic community at all, since the award of grants would be based on the need for certain artists, rather than absolute support for artistic expression. One needs to realize, however, that the purpose of the National Endowment for the Arts should not be to encourage artistic expression among the artistic community. That would exist whether the National Endowment for the Arts does or not.

The purpose for the NEA ought to be to support the viewers of art, extending their horizon so as to foster the greater artistic understanding of the nation as a whole, not to support the ever-expanding imagination of the elite artistic community.

STATEMENT BY DAN WELCH REGARDING
VERMONT EDUCATION STANDARDS

My name is Dan Welch, and two years ago—well, last year, second semester, I was given the opportunity to work with the Vermont Institute for Math, Science and Technology on developing a handbook for understanding the Vermont framework of standards that is in place in our education system right now. And I found, through visiting other schools and talking to college-level people, that the Vermont frameworks are not understood by anyone, and they are the basis for our entire education system for the next decade.

I think that putting standards into education is asking a lot of students for a lot of things, especially the standards as high as these, and my concern is that, when students see standards for the first time, which won't be for a couple years, they are going to choke.

I come from CVU, which is a school where you have to do a standard-based project to

graduate, and when this project first started off—the number was 88 percent of kids, three years ago, failed to meet the standards on their first time around. Had there not been a second chance to meet that standard, had it been like an exam for their final in the course, 88 percent of those kids, of a class of 200, would have stayed back and joined the class behind them.

Putting standards into schools is a good thing, to level the playing field and say, well, everyone's getting their education based around this one concept or these ideas. But putting it into such pass-fail stringencies and saying that they are a standard is going far beyond what should be done. And the setup for Vermont's framework of standards is based on a program that was started in Essex, I believe, and they want to work like a rubric for point systems, where it is not necessarily pass-fail.

The Vermont framework for standards is an excellent idea, it is a little vague in the English area, but I would like to see programs like it going up nationwide, because it would really make a difference in the education system as soon as it is fully implemented.

My biggest concern is that, once it is implemented, at what point do students find out about the standards that are expected to be met? I found out my junior year. I would have liked to have known my freshman year, and maybe earlier. This is one of the issues I brought up when I was working with VISMT on rewriting the handbook for understanding the standards, is that the students should know what is expected of them from day one, and the handbooks that I was given should be made available to everyone from, probably, 7th grade, or earlier, on. And parents should be kept informed of what the standards are from the time their child enters the school system until long after, because they should continue their role as an active member of the community to know what is being expected of their local students and how they can get involved to change that.

STATEMENT BY RHYD MARSH REGARDING ACT
60/FEDERAL EDUCATION FUNDING

Act 60 is one of the most controversial and monumental bills to pass the Vermont legislature in recent years. It comes in response to a 1996 decision by the Vermont Supreme Court which declared Vermont's system of education funding illegal according to the Vermont constitution.

The main purpose of Act 60 is therefore to equalize public school funding opportunities in the State of Vermont. Act 60 accomplishes this by introducing a statewide property tax of \$1.10 per \$100 of property value, which funds block grants of approximately \$5,000 per student for each local school district.

As all but 13 of Vermont's 252 towns are currently spending more than the \$5,000 block grant per student, towns are given the option of raising additional money for their schools through a local property tax. Under Act 60, the distribution of moneys raised through local taxes has been equalized as well. A tax increase of one cent per \$100 of property value in Vernon, which has a fair market property value of about \$9 million would obviously not yield as much money as a one cent increase would in Stowe, which has a fair market property value of \$769 million. Because of this discrepancy, so-called gold towns such as Stowe and Stratton must give some of their money raised through local taxes to the state. This has the effect of making a one cent tax increase in Stowe

produce as much money for the school system as a one cent tax increase would produce in Vernon.

Opponents of the bill say Act 60 has put an unfair tax burden on the more wealthy towns, as they must now share their property tax dollars with other, poorer towns. Some also complain that less affluent families who own property in gold towns will be hurt by the tax increase those towns are likely to face.

However, Act 60 has, in reality, only given all Vermont students equal chance for education funding, regardless of geographical location. Before Act 60 was passed, property taxes varied immensely within the State of Vermont. For example, Stratton provided lavish funds to its schools with a tax rate of only 42 cents per \$100. However, in Standard, a grueling tax rate of \$4.39 per \$100 was necessary to provide adequate school funding. This means that property valued at \$100,000 in Stratton would be taxed only \$420, while, in Standard, the same property would be taxed \$4,390. Under Act 60, both properties will be taxed \$1,100, unless their towns decide to spend more than the \$5,000 per pupil block grants the state provides.

This means that the property-rich towns will now get the same bang for the buck as property-poor towns. Even if the gold towns continue to fund their schools at the current high levels, the property taxes will not increase the levels any greater than the rates some towns currently pay to send moderate moneys to their schools.

In addition, families with incomes of less than \$75,000 have been protected from the possible tax increases associated with Act 60, by capping their property taxes at between 3 and 5 percent of the household income. Act 60 has provided an effective and equitable solution to the problems of Vermont's property taxes and education funding.

However, the property tax is still a regressive tax, and there are still enough inequalities in the state and local taxes within the nation. While there is no stipulation in the Federal Constitution that requires equal education funding from state to state, increased equalized federal aid to states could help to ease the downfalls of the property tax and the funding inequities nationally.

Therefore, I believe the Federal Government should write new legislation based on the ideas behind Act 60 and increase the contributions to public education. This would help to distribute the wealth of the United States more homogeneously and improve school quality, especially in the nation's poorer school districts. It also would move more of the tax burden on Americans from the regressive and volatile local property tax to the progressive income tax of the Federal Government.

Act 60 has done wonders for Vermont. The United States of America could utilize the benefits of legislation similar to Act 60 on a national level, to reduce our reliance on regressive taxes and provide more equal funding for our nation's schools.

Thank you.

DEPARTMENTS OF VETERANS AFFAIRS AND HOUSING AND URBAN DEVELOPMENT, AND INDEPENDENT AGENCIES APPROPRIATIONS ACT, 1999

SPEECH OF

HON. EARL POMEROY

OF NORTH DAKOTA

IN THE HOUSE OF REPRESENTATIVES

Friday, July 17, 1998

The House in Committee of the Whole House on the State of the Union had under consideration the bill (H.R. 4194) making appropriations for the Departments of Veterans Affairs and Housing and Urban Development, and for sundry independent agencies, boards, commissions, corporations, and offices for the fiscal year ending September 30, 1999, and for other purposes:

Mr. POMEROY. Mr. Chairman, I rise in opposition to the Lazio Amendment to the VA-HUD Appropriations bill. While I supported H.R. 2, the housing reform bill when it was brought to the floor last year, I do not believe the appropriations bill before us in an appropriate vehicle to move the bill forward. I am supportive of reforming our public housing, however, reform needs to take place in the proper forum.

Attaching a complicated bill like H.R. 2 to an appropriations bill has the potential to delay critical funding for our nation's veterans, housing for low income families and other vital programs. Conference negotiations on the bill could even be delayed to the point of another government shutdown. After witnessing the negative effects of the government shutdown in 1995, we must ensure that we never face that situation again.

I have concerns about the provision in H.R. 2 dealing with the untested home rule provision. The home rule provision would essentially eliminate the role of housing authorities in any decision affecting Section 8 and public housing programs by turning the administration of these programs over to local governments. This and other modifications to public housing need to be thought through carefully. Unfortunately, an appropriations bill does not provide for that type of comprehensive consideration.

TRIBUTE TO FOCUS: HOPE

HON. JOHN D. DINGELL

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. DINGELL. Mr. Speaker, I rise today to recognize an organization that is near and dear to my heart. They are celebrating their 30th anniversary this year and on July 25, 1998, they will celebrate another triumph over adversity as they cut the ribbon to re-open their resource center which was badly damaged last year by a tornado. This civil and human rights organization was created by my beloved friends Father William T. Cunningham (1930-1997) and Ms. Eleanor M. Josaitis, and since Father Cunningham's passing, Ms. Josaitis has valiantly continued their work assisting those in need in our community.

Its name is Focus: HOPE, and it unites our multi-cultural community with common efforts to overcome injustice and build racial harmony. This organization is an important part of our great city of Detroit promoting social justice and practical solutions to the problems that plague our inner-cities like: hunger, economic disparity, inadequate education, and racial divisiveness. Focus: Hope combats these problems with technical training, educational and corporate partnerships, and food programs. These are not handouts but a helping hand to give people the tools and means to rejoin society.

This wonderful organization came into being as a result of the riots of 1967 which caused such turmoil in our community. Out of all this Focus: Hope was created like the Phoenix rising from the ashes to turn a city that was ravaged by civil disturbance and racism into a city that has so much to offer for everyone who lives within its borders—a city I am proud to call home.

Focus: Hope's food program helps feed and provide nutrition to pregnant women, postpartum mothers, children from infancy to six and senior citizens 60 years and older. It pays particular attention to at-risk mothers by providing free food, nutritional education and food demonstrations on how to prepare various dishes for the mother and her baby with the monthly food they receive.

Academic skills and job training are an important aspect of Focus: Hope's mission. Fast Track and First Step are two successful programs which help people get back on their feet and learn to advance into good paying technical jobs. First Step works to upgrade the math, communications and computer skills of trainees so that they may enroll in Fast Track or the Machinist Training Institute. Fast Track focuses on academic skills and the disciplines of high school to give folks the tools they need to pursue further technical training or higher educational pursuits.

Mr. Speaker, I would like to close by reading Focus:Hope's mission statement that describes so well what they have done, do and will continue to do hopefully for many more years to come.

"Recognizing the dignity and beauty of every person, we pledge intelligent and practical action to overcome racism, poverty and injustice, and to build a metropolitan community where all people may live in freedom, harmony, trust and affection. Black and white, yellow, brown and red from Detroit and its suburbs of every economic status, national origin and religious persuasion we join in this covenant."

Mr. Speaker, I ask that all my colleagues join me in paying tribute to this wonderful organization which gives people a second chance and also, gave the city of Detroit a second chance.

SECURITIES LITIGATION UNIFORM STANDARDS ACT OF 1998

SPEECH OF

HON. ROSA L. DeLAURO

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Tuesday, July 21, 1998

Ms. DELAURO. Mr. Speaker, in the 104th Congress, I voted to pass the Private Securities Litigation Reform Act, which was signed into law. The purpose of the law was to reduce the number of frivolous lawsuits brought against companies or stock brokers for fraud.

The bill was aimed at stopping lawsuits by investors in high tech companies that didn't make as much money as expected. These lawsuits are so commonplace, that sometimes clients are even brought into the suit after the suit is filed by a legal representative.

High-tech companies, of which there are many in Connecticut, have volatile stocks and are particularly susceptible to such suits. These companies are often forced to settle with investors to avoid court costs.

Now we need to further refine the law for litigants who try to skirt the law by suing in state instead of federal court. We need one standard for all fifty states. I am pleased to offer my support for the Securities Litigation Uniform Standards Act, and I urge my colleagues to support this measure and close a frivolous lawsuit loophole.

THE PATIENT PROTECTION ACT OF 1998

HON. J. DENNIS HASTERT

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 23, 1998

Mr. Mr. Speaker, I submit for the RECORD, a section-by-section analysis of H.R. 4250 the Patient Protection Act for my colleagues to review.

THE PATIENT PROTECTION ACT OF 1998

Section 1. Short Title And Table of Contents. This section provides for the short title, "Patient Protection Act of 1998" and a table of contents.

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

Subtitle A—Patient Protections

Section 1001. Patient Access to Unrestricted Medical Advice, Emergency Medical Care, Obstetric and Gynecological Care, and Pediatric Care.

Subsection (a). In General. This subsection amends subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 by adding a new Section 713, which follows.

Section 713. Patient Access to Unrestricted Medical Advice, Emergency Medical Care, Obstetric And Gynecological Care, Pediatric Care.

Subsection (a). Patient Access to Unrestricted Medical Advice. This subsection states that a group health plan or health insurance issuer may not prohibit or restrict health care professionals under contract from advising participants or beneficiaries about their health status or treatment, even

if benefits for such care or treatment are not covered by the plan or health insurance. Health care professional is defined as a physician (section 1861(r) of the Social Security Act) or other health care professional whose services are provided under the group health plan. This includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Subsection (b). Patient Access to Emergency Medical Care. This subsection prohibits group health plans or health insurance issuers from requiring beneficiaries to get preauthorization before seeking emergency medical services and requires them to cover emergency medical screening examinations obtained at any emergency medical care facility, whether in or outside a plan's network of affiliated providers, if a prudent layperson with an average knowledge of health and medicine would judge the examination necessary in order to determine whether emergency medical care is needed. The plan or issuer must provide additional emergency medical services to the extent a prudent emergency medical professional determines necessary to avoid the consequences described in section 503(b)(8)(I) of ERISA as amended by this Act. These requirements apply to the extent the group health plan or health insurance issuer covers emergency medical care benefits (as defined in section 503(b)(8)(I) of ERISA as amended by this Act), except for items or services specifically excluded; and to items or services within the capability of the emergency facility, including routinely available ancillary services. This subsection does not prevent a group health plan or issuer from imposing any form of cost-sharing for emergency medical services so long as the cost-sharing is uniformly applied.

Subsection (c). Patient Access to Obstetric and Gynecological Care. If the group health plan or health insurance issuer covers routine gynecological or obstetric care by a participating physician specializing in such care, and the participant's designated primary care provider is not such a specialist, authorization or referral by a primary care provider must not be required for routine gynecological or obstetric care. Ordering of other similar routine gynecological or obstetric care by such a participating specialist is treated as authorized by the primary care provider. Plan requirements relating to medical necessity or appropriateness for obstetric and gynecological care will be allowed.

Subsection (d). Patient Access to Pediatric Care. This subsection states that if the group health plan or health insurance issuer covers routine pediatric care, and requires the designation of a primary care provider, the parent or guardian of any plan beneficiary under 18 years of age may designate a participating physician who specializes in pediatrics, if available, as the primary care provider. Plan requirements relating to medical necessity or appropriateness for pediatric care will be allowed.

Subsection (e). Treatment of Multiple Coverage Options. This subsection requires plans that have two or more coverage options to provide patient access to obstetric and gynecological care and pediatric care as defined in subsections (c) and (d) under each option.

Subsection (b). Conforming Amendment. This subsection simply amends the table of contents of the Employee Retirement Income Security Act of 1974.

Section 1002. Effective Date and Related Rules.

Subsection (a). In General. This subsection states that the amendments made by Subtitle A will apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of the Act. The Secretary is also required to issue all necessary regulations before the effective date.

Subsection (b). Limitation on Enforcement Actions. If the group health plan or health insurance issuer has sought to comply in good faith with the amendments of Subtitle A, no enforcement action shall be taken against a plan or issuer for violating a requirement imposed by the amendments before implementing regulations are issued.

Subsection (c). Special Rule for Collective Bargaining Agreements. If a group health plan is maintained pursuant to one or more collective bargaining agreements ratified before the date of enactment of this Act, the provisions relating to patient access (subsections (b), (c), and (d) of section 713 of ERISA as added by this subtitle) will not apply before the date of termination of the last collective bargaining agreement relating to the plan, or January 1, 2001, which ever is later. Any amendment in the plan made solely to conform to requirements of this subtitle must not be treated as a termination of the collective bargaining agreement.

Subsection (d). Assuring Coordination. This subsection requires the Secretary of Labor, the Secretary of the Treasury, and the Secretary of Health and Human Services to execute an interagency memorandum of understanding to ensure that regulations, rulings, and interpretations on the same matter over which two or more such Secretaries have responsibility are administered so as to have the same effect at all times, and that enforcement policies are coordinated to assign priorities and avoid duplication.

Subsection (e). Treatment of Religious Nonmedical Providers. Among other things, this section clarifies that nothing in this Act shall be construed to prevent a group health plan or health insurance issuer offering coverage in connection with a group health plan from include as covered providers religious nonmedical providers.

Subtitle B—Patient Access to Information

Section 1101. Patient Access to Information Regarding Plan Coverage, Managed Care Procedures, Health Care Providers, And Quality of Medical Care.

Subsection (a). In General. This subsection amends Part 1 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 by (1) redesignating section 111 as section 112; and (2) inserting after section 110 the following new Section 111.

Section 111. Disclosure by Group Health Plans.

Subsection (a). Disclosure Requirement. This subsection requires the administrator of each group health plan to ensure that the summary plan descriptions required under ERISA section 102 contain the information described in subsections (b), (c), (d), and (e)(2)(A). Each health insurance issuer connected with a group health plan is also required to provide the necessary information to the administrator or to plan participants and beneficiaries on a timely basis.

Subsection (b). Plan Benefits. The information required under subsection (a) includes a

description of: (A) covered benefits categorized by the types of items and services and the types of health care professionals providing the items and services; (B) plan coverage for emergency medical care, the extent of access to urgent care centers, and definitions of terminology referring to emergency medical care; (C) plan benefits for preventive services; (D) any use or application of a drug formulary, including a summary of the process for determining the formulary; (E) and COBRA benefits available under the plan.

Information must also be provided on any limitations, exclusions, or restrictions on covered benefits, including: (A) benefits specifically excluded from coverage, categorized by types of items and services; (B) whether coverage for medical care can be limited or excluded based on utilization review or preauthorization requirements; (C) any lifetime, annual, or other period limitations on coverage, categorized by types of benefits; (D) any limitations or exclusions for custodial care; (E) experimental treatment or technology; or (F) failure to meet the plan's requirements for medical appropriateness or necessity; (G) coverage of second or subsequent opinions; (H) whether referral from a primary care provider is required for specialty care; (I) if continuity of care may be affected by the departure by the health care professional from a defined set of providers; restrictions on coverage of emergency services; and (J) any financial responsibility of participants or beneficiaries for emergency services.

Subsection (c). Participant's Financial Responsibilities. The summary plan description must also explain the participant's financial responsibility for payment of premiums, co-insurance, copayments, deductibles, and whether this may vary if the health care provider is not one of a defined set of providers.

Subsection (d). Dispute Resolution Procedures. The summary plan description must describe the process for dispute resolution adopted by the plan pursuant to section 503(b) of ERISA as amended by this Act. This must explain the procedures and time frames for coverage decisions and internal and external review.

Subsection (e). Information Available on Request. Upon written request, a group health plan or health insurance issuer offering coverage in connection with a group health plan must provide access to plan benefit information in electronic form. This information, in electronic format, must include, in addition to information required by section 104(b)(4) of ERISA, the latest summary plan description, summary of material modifications, and the actual plan provisions with available benefits. This is required no more than once a year, and a reasonable charge is permitted which may be subject to a maximum amount set by the Secretary. Requirements may also be met by making the information generally available on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries.

A summary description of the types of information available on request must be included in the summary plan description made available to participants and beneficiaries.

In addition to information described above, a group or health plan issuer must provide to participants or beneficiaries upon request information on: (i) any network characteristics with detailed lists of primary care providers and specialists and their geographic locations; (ii) any special disease management programs or programs for persons with

disabilities, whether these programs are voluntary and if benefits would differ significantly for participants in care management; (iii) whether a specific drug or biological is included in the plan's formulary and procedures for waiver requests; (iv) the procedures and medically-based criteria used in an adverse coverage decision if the determination relates to medical necessity, an experimental treatment or technology; (v) the basis on which any preauthorization and utilization review requirement has resulted in an adverse coverage decision; (vi) the accreditation and licensing status of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licensing authority; (vii) the latest information on enrollee satisfaction maintained by the plan or health insurance issuer; (viii) the latest information, if any, on quality performance maintained by the plan or health insurance issuer; and (ix) information about the frequency and outcome of external review decisions requested by enrollees of the plan or health insurance issuer.

Upon request, any health care professional treating a participant or beneficiary under a group health plan must provide to the participant or beneficiary a description of his or her professional qualifications, privileges, experience and general description of the method of compensation for medical care according to categories that may be specified by the Secretary.

In addition, upon request, any health care facility from which a participant or beneficiary has sought treatment under a group health plan must provide to the participant or beneficiary a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status, if any, with standard-setting organizations.

Subsection (f). Access to Information Relevant to the Coverage Options under which the Participant or Beneficiary is Eligible to Enroll. Upon written request, and in connection with a period of enrollment, the group health plan and health insurance issuer must make the summary plan description available for any coverage option in which the participant or prospective participant is eligible to enroll and any information described in clauses (i),(ii),(iii),(vi),(vii), and (viii) of subsection (e)(2)(B).

Subsection (g). Advance Notice of Changes in Drug Formularies. The plan must inform participants not later than 30 days before the effective date of any exclusion of a specific drug or biological from any drug formulary used by the plan in the treatment of a chronic illness or disease.

Subsection (h). Definitions.—For purposes of this section: the term "group health plan" has the meaning under section 503(b)(6); the term "medical care" has the meaning under section 733(a)(2); the term "health insurance coverage" has the meaning under section 733(b)(1) and the term "health insurance issuer" has the meaning under section 733(b)(2).

Subsection (b). Conforming Amendments. This section makes miscellaneous conforming amendments to ERISA.

Section 1102. Effective Date and Related Rules.

Subsection (a). In General. Amendments made by Subtitle B—Patient Access to Information will apply to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of

this Act. The subsection also requires the Secretary to issue all necessary regulations before that date.

Subsection (b). Limitation on Enforcement Actions. If the group health plan or health insurance issuer has sought to comply in good faith with the amendments of Subtitle B, no enforcement actions shall be taken against a plan or issuer for violating a requirement imposed by the amendments before final regulations are issued.

Subsection (c). Assuring Coordination. This subsection requires the Secretary of Labor, the Secretary of the Treasury, and the Secretary of Health and Human Services to execute an interagency memorandum of understanding to ensure that regulations, rulings, and interpretations on the same matter over which two or more such Secretaries have responsibility are administered so as to have the same effect at all times, and that enforcement policies are coordinated to assign priorities and avoid duplication.

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

Section 1201. Special Rules for Group Health Plans.

Subsection (a). Section 503 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1133) is amended by adding at the end the following new subsections:

Subsection (b). Special Rules for Group Health Plans.

(1) Coverage Determinations. Every group health plan must provide notice in writing to a participant of any adverse coverage decision with respect to requested benefits under the plan. The notice sets forth the specific reasons for the coverage decision and must be written in a manner that can be understood by the participant. The notice must inform the participant or beneficiary of their ability to file a written request for review of the initial coverage decision (i.e. internal appeal) within 180 days after receipt of the notice. A notice must also be sent to the participant or beneficiary's medical care provider if the provider initiated the claim or seeks reimbursement from the plan. A full and fair de novo review of the decision must be made by an appropriate named fiduciary who did not make the initial decision. Group health plans must also meet the additional requirements of this subsection.

(2) Time Limits for Making Initial Coverage Decisions for Benefits and Completing Internal Appeals.

(A) Time Limits for Deciding Requests for Benefit Payments, Requests for Advance Determination of Coverage, and Requests for Required Determination of Medical Necessity.

(i) Initial Coverage Decisions. If a request for benefit payments, a request for advance determination of coverage, or a request for required determination of medical necessity is submitted to a group health plan in a reasonable form under the plan, the plan must issue in writing an initial coverage decision within 30 days of the filing completion date. Failure of the plan to issue a coverage decision will be treated as an adverse coverage decision, thus allowing for an internal appeal.

(ii) Internal Review of Initial Denials. Upon written request, a review by an appropriate named fiduciary (who pursuant to paragraph (3) must be a physician) must be issued within 30 days of the review filing date and must include a written decision affirming, reversing, or modifying the initial coverage decision setting forth the grounds

for the decision. The decision is treated as the final decision of the plan except in the case of an adverse coverage decision with respect to which the participant elects an external review as described below. Failure of the plan to issue a coverage decision will be treated as an adverse coverage decision, thus allowing for an external review.

(B) Time Limits for Making Coverage Decisions Relating to Urgent and Emergency Medical Care and for Completing Internal Appeals.

(i) Initial Coverage Decisions. In general, for any request for expedited advance determination of coverage, a group health plan must issue in writing an initial coverage decision within 10 days in cases involving urgent medical care or within 72 hours in cases involving emergency medical care. Failure of the plan to issue a coverage decision will be treated as an adverse coverage decision, thus allowing for an internal appeal.

(ii) Internal Review of Initial Denials. Upon written request, a review by an appropriate named fiduciary (who pursuant to paragraph (3) must be a physician) must be issued within 10 days for urgent medical care and 72 hours for emergency medical care and must include a written decision affirming, reversing, or modifying the initial coverage decision and setting forth the grounds for the decision. The decision is treated as the final decision of the plan except in the case of an adverse coverage decision with respect to which the participant elects an external review as described below. Failure of the plan to issue a coverage decision will be treated as an adverse coverage decision, thus allowing for an external review.

(3) Physicians Must Review Initial Coverage Decisions Involving Medical Appropriateness or Necessity or Experimental Treatment. If an initial coverage decision is based on a determination that a particular item or service is excluded from coverage under the terms of the plan because the provision of such item or service does not meet the plan's requirements for medical appropriateness or necessity or would constitute experimental treatment or technology, the internal review shall be conducted by a physician who did not make the initial denial.

(4) Participant Election of External Review by Independent Medical Expert and Reconsideration of Initial Review Decision.

(A) General Requirements for External Review. The external review requirements described in (B), (C), and (D) apply in the case of (1) any failure to timely issue a coverage decision under an internal review, or (2) the internal review decision is based on a determination that a particular item or service is excluded from coverage under the terms of the plan because it does not meet the plan's requirements for medical appropriateness or necessity or would constitute experimental treatment or technology.

(B) Limits on Allowable Advance Payments. The external review in connection with an adverse coverage decision is available subject to any requirement of the plan (unless waived by the plan for financial or other reasons) for payment in advance by the participant or beneficiary seeking review of an amount equal to \$25, or if greater 10 percent of the cost of the medical care involved up to a maximum of \$100. No payment may be required of a participant enrolled in a plan pursuant to a program under Medicaid (Title XIX of the Social Security Act) or under a State Children's Health Insurance Program (Title XXVI of such Act). The payment is to be refunded if the recommendation under external review is to modify or reverse the internal review decision.

(C) Reconsideration of Initial Review Decision. If an internal appeal results in an adverse coverage decision, a participant or beneficiary can make a request in writing within 30 days for an external review and reconsideration of the initial review decision denying coverage. The plan must provide for a procedure under which one or more independent medical experts selected under the plan will review the coverage decision to determine whether the decision was in accordance with the terms of the plan and Title I. The record for review (including a specification of the terms of the plan and other criteria serving as the basis for the initial review decision denying coverage) will be presented to such expert(s) who must maintain such record in a manner to ensure confidentiality. The expert(s) will then report in writing to the plan their recommendation as to whether the coverage decision should be affirmed, modified, or reversed. An explanation of the grounds (including the clinical basis) for the recommendation must be included. A physician selected under the plan, who did not make the initial internal review decision, must then reconsider the decision denying coverage to determine whether the decision was in accordance with the terms of the plan and Title I and must issue a written decision affirming, modifying, or reversing the decision, taking into account the recommendation of the external review medical expert(s). The decision must set forth the grounds for the decision.

(D) Time Limits for Reconsideration. The review must be completed within 72 hours for emergency medical care, within 10 days for urgent medical care or within 25 days in other cases. The decision affirming, reversing, or modifying the initial review decision of the plan denying coverage is the final decision of the plan. Failure to issue a written decision will be treated as a final decision affirming the initial review decision of the plan, thus allowing for court review.

(E) Independent Medical Expert.

(1) In General. The term 'independent medical expert' means a medical professional who is a physician (or if appropriate another medical professional) who has appropriate credentials (including licensing in the applicable medical field) and has attained recognized expertise in the applicable medical field. Under the selection procedures in clause (ii), the expert must also meet strict rules of independence as described below.

(ii) Selection of Medical Experts. To ensure independence of the recommendation with respect to a particular external review, a plan must have procedures that follow one of the following means of selecting independent medical expert(s). Under the first option, the independent expert must be selected by an independent intermediary by means of a method that ensures that the identity of the expert is not disclosed and the identity of the plan, issuer and patient is not disclosed to the expert. Under the second option, the independent expert must be selected by an independent and appropriately credentialed panel of physicians established by a fully accredited teaching hospital. Under the third option, the independent expert must be selected by an independent peer review organization as described in section 1152(1)(A) of the Social Security Act. Under the fourth option, the independent expert must be selected by an independent external review organization accredited by a private standard-setting organization recognized by the Secretary. The independent expert may also be selected, under a plan, by an intermediary or otherwise that sufficiently ensures the ex-

pert's independence as prescribed under regulations issued pursuant to negotiated rule-making. Nothing in this section shall be construed to require that the external review be conducted by a governmental entity.

(iii) Independence Requirements. A professional or entity meets the independence requirements if they are not affiliated with any related party, if they are not receiving any compensation in connection with the external review that is contingent on any decision rendered by the professional, if the plan and the issuer have no recourse against the professional in connection with the recommendation under external review, and if the professional or entity does not otherwise have a conflict of interest with a related party.

(iv) Related Party. The term 'related party' means the plan or any health insurance issuer offering health insurance coverage in connection with the plan (or any officer, director, or management employee of such plan or issuer), the physician or other medical care provider that provided the medical care involved in the coverage decision, the institution at which the medical care involved in the coverage decision is provided, the manufacturer of any drug or other item that was included in the medical care involved in the coverage decision, or any other party determined to have a substantial interest in the coverage decision.

(v) Affiliated. The term 'affiliated' means, in connection with any entity, having a familial, financial, or professional relationship with, or interest in, such entity.

(F) Inapplicability with Respect to Items and Services Specifically Excluded from Coverage. An adverse coverage decision that is based on a determination that an item or service is excluded from coverage under the terms of the plan shall not be subject to external review, unless the determination is found in the decision to be based solely on the fact that the item or service does not meet the plan's requirements for medical appropriateness or necessity, or would constitute experimental treatment or technology.

(5) Permitted Alternatives to Required Internal Review.

(A) In General. A group health plan will not fail to meet the requirements relating to the review of initial coverage decisions for benefits, if in lieu of the procedures relating to review, the aggrieved participant or beneficiary elects an alternative dispute resolution procedure or the plan provides for an alternative dispute resolution procedure pursuant to a collective bargaining agreement. The time limits of the alternative dispute resolution procedure are not to exceed the time limits otherwise applicable. In any case in which such an alternative dispute resolution procedure is voluntarily elected by the aggrieved participant or beneficiary, the plan may require or allow the participant or beneficiary to waive review of the coverage decision, to waive further review of the coverage decision, and to elect an alternative means of external review.

(B) Additional Requirements. The dispute resolution must allow for adequate presentation by the aggrieved participant or beneficiary of scientific and medical evidence supporting the participant's or beneficiary's position.

(6) Permitted Alternatives to Required External Review. A group health plan does not fail to meet the external review requirements if the participant or beneficiary elects to utilize a procedure which is generally available under the plan, the plan agrees in

advance to abide by the recommendation of the independent medical expert(s), and the participant or beneficiary waives in advance any right to further review of the final decision.

(7) Special Rule for Access to Specialty Care. In the case of a request by a physician for advance determination of coverage of a specialist's services, if those services are otherwise provided under the plan, then the initial coverage decision shall be issued within the specialty decision period (72 hours). The term 'specialist' means with respect to a condition, a physician who has a high level of expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to treat the condition.

(8) Group Health Plan Defined. The term 'group health plan' has the meaning provided in section 733(a).

(9) Other Definitions.

(A) Request for Benefit Payments. The term 'request for benefit payments' means a request, for payment of benefits by a group health plan for medical care, which is made by or on behalf of a participant or beneficiary after the medical care has been provided.

(B) Required Determination Of Medical Necessity. The term 'required determination of medical necessity' means a determination that the proposed medical care meets the plan's requirements for medical appropriateness or necessity (which may be subject to exceptions under the plan for fraud or misrepresentation), irrespective of whether the proposed medical care otherwise meets other terms and conditions of coverage, but only if the determination does not constitute an advance determination of coverage.

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

(D) Request for Advance Determination of Coverage. The term 'request for advance determination of coverage' means a request for an advance determination of coverage of medical care which is made by or on behalf of a participant or beneficiary before the medical care is provided.

(E) Request for Expedited Advance Determination of Coverage. The term 'request for expedited advance determination of coverage' means a request for advance determination of coverage, in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

(F) Request for Required Determination of Medical Necessity. The term 'request for required determination of medical necessity' means a request for a required determination of medical necessity for medical care which is made by or on behalf of a participant or beneficiary before the medical care is provided.

(G) Request for Expedited Required Determination of Medical Necessity. The term 'request for expedited required determination of medical necessity' means a request for required determination of medical necessity in any case in which the proposed medical care constitutes urgent medical care or emergency medical care.

(H) Urgent Medical Care. The term 'urgent medical care' means medical care in any case in which an appropriate physician has certified in writing that failure to provide

the participant or beneficiary with such medical care within 45 days can reasonably be expected to result in either the imminent death of the participant or beneficiary, or the immediate, serious, and irreversible deterioration of the health of the participant or beneficiary which will significantly increase the likelihood of death, or irreparable harm.

(I) Emergency Medical Care. The term 'emergency medical care' means medical care in any case in which an appropriate physician has certified in writing that failure to immediately provide the care to the participant or beneficiary could reasonably be expected to result in placing the health of such participant or beneficiary (or, with respect to a participant or beneficiary who is a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, or that immediate provision of the care is necessary because the participant or beneficiary has made or is at serious risk of making an attempt to harm himself or herself or another individual.

(J) Initial Decision Period. The term 'initial decision period' means a period of 30 days. In general, the calendar days specified in the various decision and review periods may be extended pursuant to regulations prescribed by the Secretary.

(K) Internal Review Period. The term 'internal review period' means a period of 30 days.

(L) Urgent Decision Period. The term 'urgent review period' means a period of 10 days.

(M) Emergency Decision Period. The term 'emergency review period' means a period of 72 hours.

(N) Specialty Decision Period. The term 'specialty decision period' means a period of 72 hours.

(O) Reconsideration Period. The term 'reconsideration period' means a period of 25 days. In cases involving urgent medical care, this term means the urgent decision period (generally, 10 days). In cases involving emergency medical care, this term means the emergency decision period (generally, 72 hours).

(P) Filing Completion Date. The term 'filing completion date' means, in connection with a group health plan, the date as of which the plan is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make an initial coverage decision.

(Q) Review Filing Date. The term 'review filing date' means the date as of which the appropriate named fiduciary (or the independent medical expert(s)) is in receipt of all information reasonably required (in writing or in such other reasonable form as may be specified by the plan) to make a decision to affirm, modify, or reverse a coverage decision.

(R) Medical Care. The term 'medical care' has the meaning provided such term by section 733(a)(2).

(S) Health Insurance Coverage. The term 'health insurance coverage' has the meaning by section 733(b)(1).

(T) Health Insurance Issuer. The term 'health insurance issuer' has the meaning provided by section 733(b)(2).

(U) Written or in Writing.

(i) In General. A request or decision shall be deemed to be 'written' or 'in writing' if the request or decision is presented in a generally recognized printable or electronic format.

(ii) Medical Appropriateness or Experimental Treatment Determinations. In the case of a request for advance determination of coverage, a request for expedited advance determination of coverage, a request for required determination of medical necessity, or a request for expedited required determination of medical necessity, if the decision is conveyed to the provider of medical care or to the participant or beneficiary by means of telephonic or other electronic communications, that decision will be treated as a written decision.

Subsection (b). Civil Penalties. Section 502(c) of ERISA (29 U.S.C. 1132(c)) is amended to insert a new paragraph (6):

(6)(A). If a benefit under a group health plan is not timely provided to a participant or beneficiary pursuant to a plan's final decision, which did not follow the terms of the plan or Title I and the final decision under the plan is contrary to the recommendation made under the external review, then any person acting in the capacity of a fiduciary who takes an action (or fails to take an action) in violation of the plan or title I may, in the court's discretion, be liable to the aggrieved participant or beneficiary for a civil penalty in the amount of up to \$500 a day (or up to \$1,000 in the case of a bad faith violation) from the date on which the recommendation was made to the plan until the date the failure to provide benefits is corrected, up to a total amount not to exceed \$250,000.

(6)(B). If a person acting in the capacity of a fiduciary took or failed to take action that resulted in an adverse coverage decision violating the terms of the plan or Title I, upon a court finding in favor of the plaintiff, if this occurred in connection with the action described in (A) or under section (b)(4), then the court is to issue an order requiring the defendant to cease and desist from the alleged action or failure to act, and to pay to the plaintiff a reasonable attorney's fee and other reasonable costs relating to the prosecution of the action on the charges on which the plaintiff prevails.

(6)(C). (i) The Secretary may assess a civil penalty against a person acting in the capacity of a fiduciary of one or more group health plans for any pattern or practice of repeated adverse coverage decisions that violates the terms of the plan(s) or Title I. A penalty must be paid upon proof by clear and convincing evidence of such pattern or practice.

(ii) A penalty shall be in an amount not to exceed the lesser of 5 percent of the aggregate value of benefits shown by the Secretary to have not been provided or unlawfully delayed, or \$100,000.

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

Subsection (c). Expedited Court Review. Section 502 of ERISA (29 U.S.C. 1132) is amended by adding the following new paragraph (b)(4):

(4) In a case in which it is demonstrated to the court by means of a certification by an appropriate physician that exhaustion of administrative remedies is not reasonably attainable under the facts and circumstances without undue risk of irreparable harm to the health of a participant or beneficiary, a civil action may be brought by the partici-

pant or beneficiary to obtain appropriate equitable relief.

Subsection (d). Standard of Review Unaffected. The standard of review under section 502 ERISA shall continue on and after the date of the enactment to be the standard of review applicable immediately prior to enactment.

Subsection (e). Concurrent Jurisdiction. State courts have concurrent jurisdiction in actions arising under new sections 502(b)(4) and (a)(1)(A) for relief under subsection (c)(6).

Section 1202. Effective Date.

Subsection (a). In General. The amendments made by this subtitle shall apply to grievances arising in plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act.

Subsection (b). Limitation on Enforcement Actions. No enforcement action shall be taken against a group health plan or health insurance issuer before the date that final regulations are issued, if the plan or issuer has sought to comply in good faith with such requirement.

Subsection (c). Collective Bargaining Agreements. Any amendments made to a plan solely to conform to requirements added by this subtitle shall not be treated as a termination of a collective bargaining agreement.

Nothing in the amendments made by this Subtitle C shall be construed to affect whether or the extent to which the provisions of Title I of the Employee Retirement Income Security Act of 1974 supersede State laws. It is intended that the addition of more explicit internal review and external review provisions under section 503 of ERISA and the additional remedies under 502 of ERISA not expand or contract existing law as to whether or the extent to which ERISA supersedes state law. The ERISA section 514 clause has not been changed in this connection and, therefore, whether ERISA does or does not preempt any particular state statute is left unchanged. Accordingly, this section is not intended to affect the outcome of any matters pending in court as to the extent or scope of such ERISA preemption of state laws.

Subtitle D—Affordable Health Coverage for Employees of Small Businesses

Section 1301. This Subtitle may be cited as the "Small Business Affordable Health Coverage Act of 1998".

Section 1302. Rules Governing Association Health Plans

Subsection (a). Rules governing regulation of association health plans This subsection adds a new Part 8 (Rules Governing Regulation of Association Health Plans) to Title I of ERISA, as follows:

Section 801. Association Health Plans. The term "association health plan" means a "group health plan" (which is defined in ERISA as added by the Health Insurance Portability and Accountability Act or HIPAA; under HIPAA such group health plans are subject to all of the portability, preexisting condition, nondiscrimination, special enrollment, renewability and other provisions of ERISA Part 7)—

(1) under which at least one option of fully-insured "health insurance coverage" offered by a health insurance issuer is made available to plan participants and beneficiaries, and

(2) whose sponsor of the plan meets the following conditions:

The sponsor of an Association Health Plan (AHP) must be organized and maintained in

good faith, with a constitution and bylaws specifically stating its purpose and providing for at least annual meetings, as a trade association, an industry association (including a rural electric or rural telephone cooperative), a professional association, or a chamber of commerce (or similar business association, including a similar organization that operates on a cooperative basis within the meaning of section 1381 of the IRC), for substantial purposes other than that of obtaining or providing medical care. Also, the applicant must demonstrate that the sponsor is established as a permanent entity, has the active support of its members, and collects dues from its members without conditioning such on the basis of the health status or claims experience of plan participants or beneficiaries or on the basis of the member's participation in a group health plan.

In addition to the associations described above, certain other entities are eligible to seek certification as AHPs. These include franchise networks and multiemployer plans. Section 812 also makes eligible certain church plans voluntarily electing to come under the fiduciary, reporting, and actuarial standards contained in the subsection.

Section 802. Certification of Association Health Plans. This section establishes a procedure for the certification of Association Health Plans by the applicable authority (a state authority or, if a state does not elect to become the applicable authority, the Secretary). The applicable authority shall grant certification only if such certification is administratively feasible, not adverse to the interests of the individuals covered under it, and protective of the rights and benefits of the individuals covered under the plan. In essence, this procedure has the same effect as requiring the provision in ERISA section 514(b)(6)(B) under current law to be implemented so as to enable association health plans to operate. A "class certification" procedure is established to speed the approval of plans which offer only fully-insured health insurance coverage. An AHP that is certified must also meet the applicable requirements of Part 8 as described below.

Section 803. Requirements Relating to Sponsors and Boards of Trustees. This section establishes additional eligibility requirements for AHPs. Applicants must demonstrate that the arrangement's sponsor has been in existence for a continuous period of at least 3 years for substantial purposes other than providing coverage under a group health plan.

Subsection (b) also requires that the plan be operated, pursuant to a trust agreement, by a "board of trustees" which has complete fiscal control and which is responsible for all operations of the plan. The board of trustees must develop rules of operation and financial control based on a three-year plan of operation which is adequate to carry out the terms of the plan and to meet all applicable requirements of the certification and Title I of ERISA. The board of trustees must consist of individuals who are owners, officers, directors or employees of the employers who participate in the plan.

Section 804. Participation and Coverage Requirements. This section prohibits discrimination against eligible employers and employees by requiring that all employers who are association members be eligible for participation under the terms of the plan, that benefit options be actively marketed to all eligible members, and that eligible individuals of such participating employers not be excluded from enrolling in the plan because of health status. The legislation will

not affect the individual health insurance market adversely inasmuch as the bill requires that no participating employer may exclude an employee from enrollment under an AHP by purchasing an individual policy of health insurance coverage for such person based on their health status.

Section 805. Other Requirements Relating to Plan Documents, Contribution Rates, and Benefit Options. This section requires an association health plan to meet the following requirements: (1) its governing instruments must provide that the board of trustees serves as the named fiduciary and plan administrator, that the sponsor serves as plan sponsor, and that the reserve requirements of section 806 are met; (2) the contribution rates for any particular small employer must be nondiscriminatory—they cannot be based on the claims experience of the particular employer or on the type of business or industry in which the employer is engaged (any variation in a state must be limited to that permitted under state small group rating laws), (3) the plan has at least 1,000 participants and beneficiaries if the plan does not consist solely of fully-insured health insurance coverage, and (4) the plan meets such other requirements as may be set forth in regulations.

The rules also stipulate that association health plans must be allowed to design benefit options. Specifically, no provision of state law shall preclude an AHP or health insurance issuer from exercising its discretion in designing the items and services of medical care to be included as health insurance coverage under the plan, except to the extent that such law (1) prohibits the exclusion of a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to the matters governed by section 711 (relating to maternal and newborn hospitalization) and section 712 (relating to mental health coverage).

In addition, no provision of law shall be construed to preclude an AHP or health insurance issuer from setting contribution rates based on the experience under the plan to the extent such rates are nondiscriminatory as described above.

Section 806. Maintenance of Reserves and Provisions for Solvency for Plans Providing Health Benefits in Addition to Health Insurance Coverage. This section requires AHPs offering benefit options that do not consist solely of fully-insured health insurance coverage to establish and maintain reserves sufficient for unearned contributions, benefit liabilities incurred but not yet satisfied and for which risk of loss has not been transferred, expected administrative costs, any other obligations and a margin for error recommended by the plan's qualified actuary. In addition, each plan must secure coverage from a state licensed insurer consisting of (1) aggregate stop-loss insurance with an attachment point not greater than 125% of expected gross claims, (2) specific stop-loss insurance with an attachment point, as recommended by the plan's qualified actuary, up to \$200,000, and (3) to prevent insolvency, indemnification insurance for any claims which a plan is unable to satisfy by reason of a mandatory termination described under section 809(b). The plan must maintain minimum surplus in the amount of \$2,000,000 reduced to not less than \$500,000 based on the level of the stop-loss coverage maintained by the plan. The applicable authority may provide additional requirements relating to reserves and excess/stop loss insurance. To ensure that indemnification insurance will be available to pay all claims in the event of

the termination of a plan, AHPs must make annual payments to an AHP fund which would guarantee that indemnification insurance is always available to pay such claims.

Section 807. Requirements for Application and Related Requirements. This section sets forth additional criteria which association health plans must meet to qualify for certification. The applicable authority shall grant certification to a plan only if: (1) a complete application has been filed, accompanied by the filing fee of \$5,000; and (2) all other terms of the certification are met (including financial, actuarial, reporting, participation, and such other requirements as may be specified as a condition of the certification).

The application must include the following: (1) identifying information about the arrangement and the states in which it will operate; (2) evidence that the bonding requirements will be met; (3) copies of all plan documents and agreements with service providers; (4) a funding report indicating that the reserve requirements of 806 will be met, that contribution rates will be adequate to cover obligations, and that a qualified actuary (a member in good standing of the American Academy of Actuaries or an actuary meeting such other standards the applicable authority considers adequate) has issued an opinion with respect to the arrangement's assets, liabilities, and projected costs; and (5) any other information prescribed by the applicable authority. Certified association health plans must notify the applicable authority of any material changes in this information at any time, must file annual reports with the applicable authority, and must engage a qualified actuary.

Section 808. Notice Requirements for Voluntary Termination. This section requires that, except as provided in section 809, an AHP may terminate only if the board of trustees provides 60 days advance written notice to participants and beneficiaries and submits to the applicable authority a plan providing for timely payment of all benefit obligations.

Section 809. Corrective Actions and Mandatory Termination. This section requires an AHP which offers benefit options which are not fully-insured to continue to meet the reserve requirements under section 806 even if its exemption is no longer in effect. The board of trustees of such an AHP must quarterly determine whether the reserve requirements of section 806 are being met and, if they are not, must, in consultation with the qualified actuary, develop a plan to ensure compliance and report such information to the applicable authority. In any case where an AHP notifies the applicable authority that it has failed to meet the reserve requirements and corrective action has not restored compliance, and the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements applicable to such AHPs, the applicable authority may direct the board to terminate the arrangement.

Section 810. Trusteeship of Insolvent Association Health Plans Providing Health Benefits in Addition to Health Insurance Coverage. Whenever an association health plan is unable to provide benefits when due or is otherwise in a financially hazardous condition, the Secretary is to give notice to the plan and participants and apply to the appropriate court to act as a trustee to administer the plan for the duration of the insolvency.

Section 811. State Assessment Authority. A state may impose a nondiscriminatory tax on an association health plan described in

section 806(a)(2), with respect to operations in the state commenced after the date of the enactment, if the rate does not exceed the rate of similar premium or contribution taxes on health maintenance organizations and other insurers.

Section 812. Special Rules for Church Plans. This section permits church plans providing medical care to voluntarily elect to apply to the Department of Labor for certification. In order to receive an exemption from state insurance law, an electing church plan would be subject to the requirements of section 810 providing for compliance with fiduciary standards (exclusive purpose and prudence rules); claims procedures; annual certification by a qualified actuary that the plan maintains reserves, capital, insurance or other financial arrangements adequate to enable the plan to meet all of its financial obligations on a timely basis; and annual statements certifying plan compliance with the above.

Section 813. Definitions and Rule of Construction. This section defines the following terms: group health plan, medical care, health insurance coverage, health insurance issuer, health status-related factor, individual market, participating employer, qualified actuary and applicable state authority. The terms are consistent with those added to ERISA by the Health Insurance Portability and Accountability Act. In addition, the terms "employer" and "employee" include self-employed individuals and partners for purposes of the application of Part 8 and the provisions of Title I as applicable to association health plans.

Subsection (b). Conforming Amendments. This subsection contains (1) conforming changes to the definition of "plan sponsor" to include the sponsor of an AHP; (2) conforming changes to the Title I exception for church plans electing association health plan status; and (3) as described below, conforming changes to the section 514 preemption rules to reflect the policy changes under Part 8 with respect to association health plans. First, paragraph (6) of section 514(b) is made inapplicable with respect to any state law in the case of a certified AHP. Secondly, a new subsection 514(d) (current subsection (d) is redesignated as (e)) clarifies the ability of health insurance issuers to offer health insurance coverage under AHPs and clarifies the ability of any health insurance issuer to offer health insurance coverage of the same policy type as offered in connection with a particular AHP to eligible employers, regardless of whether such employers choose or do not choose to become members of the particular association. Health insurance coverage policy forms filed and approved in a particular state in connection with an insurer's offering under an association health plan are deemed to be approved in any other state in which such coverage is offered when the insurer provides a complete filing in the same form and manner to the authority in the other state. Also, this section removes the current restriction on state regulation of self-insured multiple employer welfare arrangements providing medical care (which do not elect to meet the certification requirements for AHPs) under section 514(b)(6)(A)(ii) by eliminating the requirement that such state laws otherwise "be consistent with the provisions of ERISA Title I." Other than as described above, the preemptive provisions of section 514 continue to apply as under current law, including their application with respect to self-insured plans and direct contracting with providers under such plans.

Section 1303. Clarification of Treatment of Single Employer Arrangements. This section clarifies the treatment of certain single employer arrangements under the section of ERISA that defines a multiple employer welfare arrangement (section 3(40)). The treatment of a single employer plan as being excluded from the definition of such an arrangement is clarified by defining the minimum interest required for two or more entities to be in "common control" as a percentage which cannot be required to be greater than 25%. Also a plan would be considered a single employer plan if less than 25% of the covered employees are employed by other participating employers.

Section 1304. Clarification of Treatment of Certain Collectively Bargained Arrangements. This section clarifies the conditions under which multiemployer and other collectively-bargained arrangements are exempted from the definition of a multiple employer welfare arrangement, and thus exempt from state law. This is intended to address the problem of "bogus unions" and other illegitimate health insurance operators. The provision amends the definition of such an arrangement to exclude a plan or arrangement which is established or maintained under or pursuant to a collective bargaining arrangement (as described in the National Labor Relations Act, the Railway Labor Act, and similar state public employee relations laws). (Current law requires the Secretary to "find" that a collective bargaining agreement exists, but no such finding has ever been issued). It then specifies additional conditions which must be met for such a plan to be a statutorily excluded collectively bargained arrangement and thus not a multiple employer welfare arrangement. These include:

(1) The plan cannot utilize the services of any licensed insurance agent or broker to solicit or enroll employers or pay a commission or other form of compensation to certain persons that is related to the volume or number of employers or individuals solicited or enrolled in the plan.

(2) A maximum 15 percent rule applies to the number of covered individuals in the plan who are not employees (or their beneficiaries) within a bargaining unit covered by any of the collective bargaining agreements with a participating employer or who are not present or former employees (or their beneficiaries) of sponsoring employee organizations or employers who are or were a party to any of the collective bargaining agreements.

(3) The employee organization or other entity sponsoring the plan or arrangement must certify annually to the Secretary the plan has met the previous requirements.

(4) If the plan or arrangement is not fully insured, it must be a multiemployer plan meeting specific requirements of the Labor Management Relations Act (i.e., the requirement for joint labor-management trusteeship under section 302(c)(5)(B)).

(5) If the plan or arrangement is not in effect as of the date of enactment, the employee organization or other entity sponsoring the plan or arrangement must have existed for at least 3 years or have been affiliated with another employee organization in existence for at least 3 years, or demonstrate to the Secretary that certain of the above requirements have been met.

Section 1305. Enforcement Provisions Relating to Association Health Plans. This section amends ERISA to establish enforcement provisions relating to association health plans and multiple employer welfare ar-

rangements: (1) willful misrepresentation that an entity is an exempted AHP or collectively-bargained arrangement may result in criminal penalties; (2) the section provides for cease activity orders for arrangements found to be neither licensed, registered, or otherwise approved under State insurance law, or operating in accordance with the terms of a certification granted by the applicable authority under part 8; and (3) the section provides for the responsibility of the named fiduciary or board of trustees of an AHP to comply with the required claims procedure under ERISA.

Section 1306. Cooperation between Federal and State Authorities. This section amends section 506 of ERISA (relating to coordination and responsibility of agencies enforcing ERISA and related laws) to specify State responsibility with respect to Association Health Plans. In general, a state would be the applicable authority under Part 8 to the extent the state enters into an agreement with the Secretary for delegation to the state of some or all of the authority under Title I to certify AHPs and to enforce the provisions applicable to certified AHPs. The Secretary would be the applicable authority if a state did not assume such authority.

Section 1307. Effective Date; Transitional Rules. In general, the amendments made by the Act are effective January 1, 2000. Sections 3 and 4 are effective upon date of enactment. The provisions of section 801(a)(2) relating to health insurance coverage do not apply to group health plans existing on April 1, 1997 if they do not provide fully-insured health insurance coverage, but later qualify for certification. In certain cases existing state licensed plans would be eligible to become certified.

Pilot Program for Self-Insured Association Health Plans. During a 5-year pilot program period, association health plans may offer self-insured benefit options only if they consist of the following: (A) plans which offer such coverage on the date of enactment, (B) the sponsor of the plan does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or (C) plans whose eligible participating employers represent one or more trades, businesses, industries, which have been indicated as having average or above-average health insurance risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, and other demonstrated means, including (but not limited to) the following: agriculture; automobile dealerships; barbering and cosmetology; child care; construction; dance, theatrical, and orchestra productions; disinfecting and pest control; eating and drinking establishments; fishing; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; sanitary services; transportation (local and freight); and warehousing.

TITLE II—AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

Subtitle A—Patient Protections and Point of Service Coverage Requirements.

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

Subsection (a). In General. This section amends subpart 2 of part A of title XXVII of the Public Health Service Act by adding a new Section 2706, which follows.

Section 2706. Patient Access to Unrestricted Medical Advice, Emergency Medical

Care, Obstetric And Gynecological Care, Pediatric Care.

Subsection (a). Patient Access to Unrestricted Medical Advice. This subsection states that a group health plan or health insurance issuer may not prohibit or restrict health care professionals under contract from advising participants or beneficiaries about their health status or treatment, even if benefits for such care or treatment are not covered by the plan or health insurance. Health care professional is defined as a physician (section 1861(r) of the Social Security Act) or other health care professional whose services are provided under the group health plan. This includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Subsection (b). Patient Access to Emergency Medical Care. This subsection prohibits group health plans or health insurance issuers from requiring beneficiaries to get preauthorization before seeking emergency medical services and requires them to cover emergency medical screening examinations obtained at any emergency medical care facility, whether in or outside a plan's network of affiliated providers, if a prudent layperson with an average knowledge of health and medicine would judge the examination necessary in order to determine whether emergency medical care is needed. The plan or issuer must provide additional emergency medical services to the extent a prudent emergency medical professional determines necessary to avoid the consequences described in section 503(b)(8)(I) of ERISA as amended by this Act. These requirements apply to the extent the group health plan or health insurance issuer covers emergency medical care benefits (as defined in section 503(b)(8)(I) of ERISA as amended by this Act), except for items or services specifically excluded; and to items or services within the capability of the emergency facility, including routinely available ancillary services. This subsection does not prevent a group health plan or issuer from imposing any form of cost-sharing for emergency medical services so long as the cost-sharing is uniformly applied.

Subsection (c). Patient Access to Obstetric and Gynecological Care. If the group health plan or health insurance issuer covers routine gynecological or obstetric care by a participating physician specializing in such care, and the participant's designated primary care provider is not such a specialist, authorization or referral by a primary care provider must not be required for routine gynecological or obstetric care. Ordering of other similar routine gynecological or obstetric care by such a participating specialist is treated as authorized by the primary care provider. Plan requirements relating to medical necessity or appropriateness for obstetric and gynecological care will be allowed.

Subsection (d). Patient Access to Pediatric Care. This subsection states that if the group health plan or health insurance issuer covers routine pediatric care, and requires the designation of a primary care provider, the parent or guardian of any plan beneficiary under 18 years of age may designate a participating physician who specializes in pedi-

atrics, if available, as the primary care provider. Plan requirements relating to medical necessity or appropriateness for pediatric care will be allowed.

Subsection (e). Treatment of Multiple Coverage Options. This subsection requires plans that have two or more coverage options to provide patient access to obstetric and gynecological care and pediatric care as defined in subsections (c) and (d) under each option.

Subsection (b). Effective Date and Related Rules. In General. This subsection states that the amendments made by Subtitle A will apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of the Act. The Secretary is also required to issue all necessary regulations before the effective date.

Limitation on Enforcement Actions. If the group health plan or health insurance issuer has sought to comply in good faith with the amendments of Subtitle A, no enforcement action shall be taken against a plan or issuer for violating a requirement imposed by the amendments before implementing regulations are issued.

Special Rule for Collective Bargaining Agreements. If a group health plan is maintained pursuant to one or more collective bargaining agreements ratified before the date of enactment of this Act, the provisions relating to patient access (subsections (b), (c), and (d) of section 713 of ERISA as added by this subtitle) will not apply before the date of termination of the last collective bargaining agreement relating to the plan, or January 1, 2001, whichever is later. Any amendment in the plan made solely to conform to requirements of this subtitle must not be treated as a termination of the collective bargaining agreement.

Application to group health plans and health insurance issuers. As under current law, the application of Subpart 2, as amended by this section, applies with respect to group health plans that are nonfederal governmental plans and with respect to health insurance coverage offered by health insurance issuers in connection with all group health plans (private and governmental).

Section 2002. Requiring Health Maintenance Organizations to Offer Option of Point-of-Service Coverage.

Subsection (a). In General. This section amends Title XXVII of the Public Health Service Act by inserting after section 2713 the following new section:

Section 2714. Requiring Offering of Option of Point-of-Service Coverage.

Subsection (a). Requirement to Offer Coverage Option to Certain Employers. Except as provided in subsection (c), any health insurance issuer which (1) is a health maintenance organization (as defined in section 2791(b)(3)), and (2) which provides for coverage of services of one or more classes of health care professionals which are furnished exclusively through closed panels of health care professionals, shall make available to the plan sponsor in connection with such plan, a coverage option which provides for coverage of such services which are furnished through such class (or classes) of health care professionals regardless of whether or not the professionals are members of such panel.

Subsection (b). Requirement to Offer Supplemental Coverage to Participants in Certain Cases. If a health insurance issuer makes available a coverage option under and described in subsection (a) to a plan sponsor of a group health plan and the sponsor declines to contract for such coverage option,

then the issuer must make available in the individual insurance market to each participant in the group health plan optional separate supplemental health insurance coverage in the individual health insurance market which consists of services identical to those provided under such coverage provided through the closed panel under the group health plan but are furnished exclusively by health care professionals who are not members of such a closed panel. Exceptions are provided in subsection (c).

Subsection (c). Exceptions. (1) Offering of non-panel option. Subsections (a) and (b) shall not apply with respect to a group health plan if the plan offers a coverage option that provides coverage for services that may be furnished by a class or classes of health care professionals who are not in a closed panel. This paragraph shall be applied separately to distinguishable groups of employees under the plan.

(2) Availability of coverage through a HealthMart. Subsections (a) and (b) shall not apply to a group health plan if the health insurance coverage under the plan is made available through a HealthMart (as defined in section 2801) and if any health insurance coverage made available through the HealthMart provides for coverage of the services of any class of health care professionals other than through a closed panel of professionals.

(3) Relicensure exemption.—Subsections (a) and (b) shall not apply to a health maintenance organization in a State in any case in which—

(A) the organization demonstrates to the applicable authority that the organization has made a good faith effort to obtain (but has failed to obtain) a contract between the organization and any other health insurance issuer providing for the coverage option or supplemental coverage described in subsection (a) or (b), as the case may be, within the applicable service area of the organization, and

(B) the State requires the organization to receive or qualify for a separate license, as an indemnity insurer or otherwise, in order to offer such coverage option or supplemental coverage, respectively.

The applicable authority may require that the organization demonstrate that it meets the requirements of the previous sentence no more frequently than once every two years.

(4) Increased costs.—Subsections (a) and (b) shall not apply to a health maintenance organization if the organization demonstrates to the applicable authority, in accordance with generally accepted actuarial practice, that, on either a prospective or retroactive basis, the premium for the coverage option or supplemental coverage required to be made available under such respective subsection exceeds by more than 1 percent the premium for the coverage consisting of services which are furnished through a closed panel of health care professionals in the class or classes involved. The applicable authority may require that the organization demonstrate such an increase no more frequently than once every two years. This paragraph shall be applied on an average per enrollee or similar basis.

(5) Collective bargaining agreements.—Subsections (a) and (b) shall not apply in connection with a group health plan if the plan is established or maintained pursuant to one or more collective bargaining agreements.

Subsection (d). Definitions. For purposes of this section, the following definitions apply:

Coverage through closed panel. Health insurance coverage for a class of health care

professionals shall be treated as provided through a closed panel of such professionals only if such coverage consists of coverage of items or services consisting of professionals services which are reimbursed for or provided only within a limited network of such professionals.

Health care professional. The term 'health care professional' has the meaning given such term in section 2706(a)(2).

Subsection (b). Effective Date. This subsection states that the amendment made by subsection (a) applies to coverage offered on or after January 1 of the second calendar year following the date of enactment of this Act.

Subtitle B—Patient Access to Information

Section 2101. Patient Access to Information Regarding Plan Coverage, Managed Care Procedures, Health Care Providers, And Quality of Medical Care.

Subsection (a). In General. This subsection amends subpart 2 of part A of title XXVII of the Public Health Service Act (as amended by subtitle A of this title) by adding the following new Section 2707.

Section 2707. Patient Access to Information Regarding Plan Coverage, Managed Care Procedures, Health Care Providers, and Quality of Medical Care.

Subsection (a). Disclosure Requirement. This subsection requires the administrator of each group health plan to ensure that the summary plan descriptions required under ERISA section 102 contain the information described in subsections (b),(c),(d), and (e)(2)(A). Each health insurance issuer connected with a group health plan is also required to provide the necessary information to the administrator or to plan participants and beneficiaries on a timely basis.

Subsection (b). Plan Benefits. The information required under subsection (a) includes a description of: (A) covered benefits categorized by the types of items and services and the types of health care professionals providing the items and services; (B) plan coverage for emergency medical care, the extent of access to urgent care centers, and definitions of terminology referring to emergency medical care; (C) plan benefits for preventive services; (D) any use or application of a drug formulary, including a summary of the process for determining the formulary; (E) and COBRA benefits available under the plan. Information must also be provided on any limitations, exclusions, or restrictions on covered benefits, including: (A) benefits specifically excluded from coverage, categorized by types of items and services; (B) whether coverage for medical care can be limited or excluded based on utilization review or preauthorization requirements; (C) any lifetime, annual, or other period limitations on coverage, categorized by types of benefits; (D) any limitations or exclusions for custodial care; (E) experimental treatment or technology; or (F) failure to meet the plan's requirements for medical appropriateness or necessity; (G) coverage of second or subsequent opinions; (H) whether referral from a primary care provider is required for specialty care; (I) if continuity of care may be affected by the departure by the health care professional from a defined set of providers; restrictions on coverage of emergency services; and (J) any financial responsibility of participants or beneficiaries for emergency services.

Subsection (c). Participant's Financial Responsibilities. The summary plan description must also explain the participant's financial responsibility for payment of premiums, co-insurance, copayments, deductibles, and

whether this may vary if the health care provider is not one of a defined set of providers.

Subsection (d). Dispute Resolution Procedures. The summary plan description must describe the process for dispute resolution adopted by the plan pursuant to section 503(b) of ERISA as amended by this Act. This must explain the procedures and time frames for coverage decisions and internal and external review.

Subsection (e). Information Available on Request. Upon written request, a group health plan or health insurance issuer offering coverage in connection with a group health plan must provide access to plan benefit information in electronic form. This information, in electronic format, must include, in addition to information required by section 104(b)(4) of ERISA, the latest summary plan description, summary of material modifications, and the actual plan provisions with available benefits. This is required no more than once a year, and a reasonable charge is permitted which may be subject to a maximum amount set by the Secretary. Requirements may also be met by making the information generally available on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries. A summary description of the types of information available on request must be included in the summary plan description made available to participants and beneficiaries.

In addition to information described above, a group or health plan issuer must provide to participants or beneficiaries upon request information on: (i) any network characteristics with detailed lists of primary care providers and specialists and their geographic locations; (ii) any special disease management programs or programs for persons with disabilities, whether these programs are voluntary and if benefits would differ significantly for participants in care management; (iii) whether a specific drug or biological is included in the plan's formulary and procedures for waiver requests; (iv) the procedures and medically-based criteria used in an adverse coverage decision if the determination relates to medical necessity, an experimental treatment or technology; (v) the basis on which any preauthorization and utilization review requirement has resulted in an adverse coverage decision; (vi) the accreditation and licensing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licensing authority; (vii) the latest information on enrollee satisfaction maintained by the plan or health insurance issuer; (viii) the latest information on quality performance maintained by the plan or health insurance issuer; and (ix) information about the frequency and outcome of external review decisions requested by enrollees of the plan or health insurance issuer.

Upon request, any health care professional treating a participant or beneficiary under a group health plan must provide to the participant or beneficiary a description of his or her professional qualifications, privileges, experience and general description of the method of compensation for medical care according to categories that may be specified by the Secretary.

In addition, upon request, any health care facility from which a participant or beneficiary has sought treatment under a group health plan must provide to the participant or beneficiary a description of the facility's

corporate form or other organizational form and all forms of licensing and accreditation status, if any, with standard-setting organizations.

Subsection (f). Access to Information Relevant to the Coverage Options under which the Participant or Beneficiary is Eligible to Enroll. Upon written request, and in connection with a period of enrollment, the group health plan and health insurance issuer must make the summary plan description available for any coverage option in which the participant or prospective participant is eligible to enroll and any information described in clauses (i),(ii),(iii),(vi),(vii), and (viii) of subsection (e)(2)(B).

Subsection (g). Advance Notice of Changes in Drug Formularies. This subsection requires the plan to inform participants not later than 30 days before the effective date of any exclusion of a specific drug or biological from any drug formulary used by the plan in the treatment of a chronic illness or disease.

Section 2102. Effective Date.

Subsection (a). In General. Amendments made by Subtitle B—Patient Access to Information will apply to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The subsection also requires the Secretary to issue all necessary regulations before that date. As under current law, the application of Subpart 2, as amended by this section, applies with respect to group health plans that are nonfederal governmental plans and with respect to health insurance coverage offered in connection with all group health plans (private and governmental).

Subsection (b). Limitation on Enforcement Actions. If the group health plan or health insurance issuer has sought to comply in good faith with the amendments of Subtitle B, no enforcement actions shall be taken against a plan or issuer for violating a requirement imposed by the amendments before final regulations are issued.

Subtitle C—HealthMarts

Section 2201. Short Title of Subtitle. The short title of this subtitle is the "Health Care Consumer Empowerment Act of 1998."

Section 2202. Expansion of Consumer Choice through HealthMarts.

Subsection (a). In General. This section amends the Public Health Service Act by adding the following new title:

TITLE XXVIII—HEALTHMARTS

Section 2801. Definition of HealthMart.

Subsection (a). In General. This subsection defines the "HealthMart" as a legal entity that meets several requirements specified in the Act. In short, the HealthMart is an organization that offers health benefits within a defined geographic area (or areas), provides administrative services to purchasers, and disseminates and files information. Requirements are described below.

(1) Organization. The HealthMart is a private, nonprofit organization operated under the direction of a board of directors. The board is composed of representatives from: small employers, employees of small employers, health care providers (which may be physicians, other health care professionals, health care facilities, or any combination thereof), and entities that underwrite or administer health benefits coverage (such as insurance companies, health maintenance organizations, and licensed provider-sponsored organizations). There must be at least 2 board members from each group and there must be the same number from each group.

(2) Offering health benefits coverage. The HealthMart, in conjunction with health insurance issuers that offer health benefits

coverage through the HealthMart, must make available health benefits coverage at rates (including employer's and employee's share) that are established by the health insurance issuer on a policy or product specific basis and that may vary only as permissible under State law. A HealthMart is deemed to be a group health plan for purposes of applying section 702 of the Employee Retirement Income Security Act of 1974, section 2702 of this Act, and section 9802(b) of the Internal Revenue Code of 1986. (These provisions limit variation of required premiums for health benefits coverage, for similarly situated individuals, on the basis of health status-related factors.)

Nondiscrimination in coverage offered. The HealthMart may not offer health benefits coverage to an eligible employee in a geographic area (as specified in (3) below) unless the same coverage is offered to all such employees in the same geographic area. Section 2711(a)(1)(B) of this Act limits denial of enrollment of certain eligible individuals under health benefits coverage in the small group market. Nothing in this title shall be construed as requiring or permitting a health insurance issuer to provide coverage outside the service area of the issuer, as approved under State law.

No financial underwriting. The HealthMart provides health benefits coverage only through contracts with health insurance issuers and does not assume insurance risk with respect to such coverage.

Minimum coverage. Requires the HealthMart to maintain at least 10 purchasers and 100 members by the end of the first year of its operation and thereafter.

(3) **Geographic areas.** Requires the HealthMart to specify the geographic area (or areas) in which it makes available health benefits coverage offered by health insurance issuers to small employers. Such an area must encompass at least one entire county or equivalent area. In the case of a HealthMart that serves more than one State, such geographic areas may be areas that include portions of two or more contiguous States. Allows the establishment and operation of more than one HealthMart in a geographic area. Does not limit the number of HealthMarts that may operate in any area.

(4) **Provision of administrative services to purchasers.** The HealthMart provides administrative services for purchasers. Such services may include accounting, billing, enrollment information, and employee coverage status reports. Nothing in this subsection should be construed as preventing a HealthMart from serving as an administrative service organization to any entity.

(5) **Dissemination of information.** Requires the HealthMart to collect and disseminate (or arrange for the collection and dissemination of) consumer-oriented information on the scope, cost, and enrollee satisfaction of all coverage options offered through the HealthMart to its members and eligible individuals, in a manner defined by the Health Mart as appropriate to the type of coverage offered. To the extent practicable, this must include consumer-oriented information on provider performance, locations and hours of operation of providers, outcomes, and similar matters. Allows the dissemination of this information or other information by the HealthMart or by health insurance issuers through electronic or other means.

(6) **Filing information.** Requires the HealthMart to file information that demonstrates the HealthMart's compliance with the applicable requirements of this title with the applicable Federal authority; or in ac-

cordance with rules established under section 2803(a), to file with a State such information as the State may require to demonstrate such compliance.

Subsection (b). Health Benefits Coverage Requirements. This subsection specifies consumer protection requirements, an alternative process for approval of health benefits coverage in case of discrimination or delay, examples of types of coverage, and wellness bonuses for health promotion.

(1) **Compliance with consumer protection requirements.** Requires that any health benefits coverage offered through a HealthMart must be underwritten by a health insurance issuer that is licensed (or otherwise regulated) under State law, meets all applicable State standards relating to consumer protection (subject to section 2802(a)), and offers the coverage under a contract with the HealthMart. Subject to the provisions of (2) below, health benefit coverage offered through HealthMarts must be approved or otherwise permitted to be offered under State law. Finally, HealthMarts must provide full portability of creditable coverage for individuals who remain members of the same HealthMart notwithstanding that they change the employer through which they are members (in accordance with the provisions of the parts 6 and 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and titles XXII and XXVII of this Act), so long as both employers are purchasers in the HealthMart.

(2) **Alternative process for approval of health benefits coverage in case of discrimination or delay.** The requirement that health benefit coverage offered through HealthMarts be approved or otherwise permitted to be offered under State law does not apply to a policy or product of health benefits coverage offered in a State if the health insurance issuer seeking to offer such policy or product files an application to waive such requirement with the applicable Federal authority, and the authority determines, based on the application and other evidence presented to the authority, that:

—either (or both) of the grounds (described next) for approval of the application has been met; and

—the coverage meets the applicable State standards (other than those that have been preempted under section 2802).

Grounds. The grounds described above are:

—the State has failed to complete action on the policy or product (or rates for the policy or product) within 90 days of the date of the State's receipt of a substantially complete application. (No period before the date of the enactment of this section shall be included in determining such 90-day period.)

—the State has discriminatorily denied an application if:

(1) the standards or review process imposed by the State as a condition of approval of the policy or product imposes either any material requirements, procedures, or standards to such policy or product that are not generally applicable to other policies and products offered or any requirements that are preempted under section 2802; or

(2) the State requires the issuer, as a condition of approval of the policy or product, to offer any policy or product other than such policy or product.

Enforcement. In the case of a waiver granted to an issuer with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an issuer and its health insurance coverage

with the applicable State standards described above (and in (A)(ii) of subsection (b)). Requires that such monitoring and enforcement be conducted by the State in the same manner as the State enforces such standards with respect to other health insurance issuers and plans, without discrimination based on the type of issuer to which the standards apply. Requires that such an agreement must specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers.

(3) **Examples of types of coverage.** The health benefits coverage made available through a HealthMart may include, but is not limited to, any of the following (if it meets the other applicable requirements of this title): coverage through a health maintenance organization, coverage in connection with a preferred provider organization, coverage in connection with a licensed provider-sponsored organization, indemnity coverage through an insurance company, coverage offered in connection with a contribution into a medical savings account or flexible spending account, coverage that includes a point-of-service option, coverage offered in conjunction with community health centers (as defined in section 330B(e) of the PHS Act, as amended by this bill) or any combination of such types of coverage.

(4) **Wellness bonuses for health promotion.** Requires that nothing in this title be construed as precluding a health insurance issuer offering health benefits coverage through a HealthMart from establishing premium discounts or rebates for members or from modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention so long as such programs are agreed to in advance by the HealthMart and comply with all other provisions of this title and do not discriminate among similarly situated members.

Subsection (c). Purchasers, Membership, Health Insurance Issuers.

(1) **Purchasers.** Subject to the provisions of this title, a HealthMart must permit any small employer to contract with the HealthMart for the purchase of health benefits coverage for its employees and dependents of those employees and may not vary conditions of eligibility (including premium rates and membership fees) of a small employer to be a purchaser.

Role of Associations, brokers, and licensed health insurance agents. Nothing in this section should be construed as preventing an association, broker, licensed health insurance agent, or other entity from assisting or representing a HealthMart or small employers from entering into appropriate arrangements to carry out this title.

Period of Contract. The HealthMart may not require a contract between a HealthMart and a purchaser to be effective for a period of longer than 12 months. (However, this should not be construed as preventing such a contract from being extended for additional 12-month periods or preventing the purchaser from voluntarily electing a contract period of longer than 12 months.)

Exclusive nature of contract. Such a contract must provide that the purchaser agrees not to obtain or sponsor health benefits coverage, on behalf of any eligible employees (and their dependents), other than through the HealthMart. (However, this does not apply to an eligible individual who resides in an area for which no coverage is offered by any health insurance issuer through the HealthMart.)

(2) Members. Under rules established to carry out this title, with respect to a small employer that has a purchaser contract with a HealthMart, individuals who are employees of the employer may enroll for health benefits coverage (including coverage for dependents of such enrolling employees) offered by a health insurance issuer through the HealthMart.

Nondiscrimination in enrollment. A HealthMart may not deny enrollment as a member to an individual who is an employee (or dependent of such an employee) eligible to be so enrolled based on health status-related factors, except as may be permitted consistent with section 2742(b).

Annual open enrollment period. Requires the HealthMart to provide for an annual open enrollment period of 30 days during which members may change the coverage option in which they are enrolled.

Rules of eligibility. The HealthMart may establish rules of employee eligibility for enrollment and reenrollment of members during the annual open enrollment period (see above). Such rules must be applied consistently to all purchasers and members within the HealthMart and shall not be based in any manner on health status-related factors and may not conflict with sections 2701 and 2702 of this Act.

(3) Health insurance issuer.

Premium collection. Requires that the contract between a HealthMart and a health insurance issuer provide, with respect to a member enrolled with health benefits coverage offered by the issuer through the HealthMart, for the payment of the premiums collected by the HealthMart (or the issuer) for such coverage (less a pre-determined administrative charge negotiated by the HealthMart and the issuer) to the issuer.

Scope of service area. Nothing in this title should be construed as requiring the service area of a health insurance issuer with respect to health insurance coverage to cover the entire geographic area served by a HealthMart.

Availability of coverage options. A HealthMart must enter into contracts with one or more health insurance issuers in a manner that assures that at least 2 health insurance coverage options are made available in the geographic area specified under section (a)(3)(A) of this bill.

Subsection (d). Prevention of Conflicts of Interest.

For boards of directors. Provides that a member of a board of directors of a HealthMart may not serve as an employee or paid consultant to the HealthMart, but may receive reasonable reimbursement for travel expenses for purposes of attending meetings of the board or its committees.

For boards of directors or employees. An individual is not eligible to serve in a paid or unpaid capacity on the board of directors of a HealthMart, or as an employee of the HealthMart, if the individual is employed by, represents in any capacity, owns, or controls any ownership interest in a organization from whom the HealthMart receives contribution, grants, or other funds not connected with a contract for coverage through the HealthMart.

Employment and employee representatives. Requires that an individual who is serving on a board of directors of a HealthMart must not be employed by or affiliated with a health insurance issuer or be licensed as or employed by or affiliated with a health care provider. In the previous sentence, the term "affiliated" does not include membership in a health benefits plan or ob-

taining health benefits coverage offered by a health insurance issuer.

Subsection (e). Construction.

Network of Affiliated HealthMarts. Provides that nothing in this section should be construed as preventing one or more HealthMarts serving different areas (whether or not contiguous) from providing for some or all of the following (through a single administrative organization or otherwise):

(1) Coordinating the offering of the same or similar health benefits coverage in different areas served by the different HealthMarts;

(2) Providing for crediting of deductibles and other cost-sharing for individuals who are provided health benefits coverage through the HealthMarts (or affiliated HealthMarts) and who continue to receive such coverage through the same health insurance issuer after (a) a change of employers through which the coverage is provided, or (b) a change in place of employment to an area not served by the previous HealthMart.

Permitting HealthMarts to adjust distributions among issuers to reflect relative risk of enrollees. Does not preclude a HealthMart from providing for adjustments in amounts distributed among the health insurance issuers offering health benefits coverage through the HealthMart based on factors such as the relative health care risk of members enrolled under the coverage offered by the different issuers.

Uniform minimum participation and contribution rules. Does not preclude a HealthMart from establishing minimum participation and contribution rules (described in section 2711(e)(1)) for small employers that apply to become purchasers in the HealthMart, so long as such rules are applied uniformly for all health insurance issuers.

Section 2802. Application of Certain Laws and Requirements.

Subsection (a). Authority of States. Provides that nothing in this section should be construed as preempting State laws relating to the following:

—The regulation of underwriters of health coverage, including licensure and solvency requirements;

—The application of premium taxes and required payments for guaranty funds or for contributions to high-risk pools;

—The application of fair marketing requirements and other consumer protections (other than those specifically relating to an item described in subsection (a));

—The application of requirements relating to the adjustment of rates for health insurance coverage.

Subsection (b). Treatment of Benefit and Grouping Requirements. Provides that State laws are superseded and shall not apply to health benefits coverage made available through a HealthMart, insofar as they relate to any of the following:

—benefit requirements for health benefits coverage offered through a HealthMart, including (but not limited to) requirements relating to coverage of specific providers, specific services or conditions, or the amount, duration, or scope of benefits, but not including requirements to the extent required to implement title XXVII of the PHS Act or other Federal law and to the extent the requirement prohibits an exclusion of a specific disease from such coverage;

—requirements (commonly referred to as fictitious group laws) relating to grouping and similar requirements for such coverage;—any other requirements (including limitations on compensation arrangements) that, directly or indirectly, preclude (or have the effect of precluding) the offering of such

coverage through a HealthMart, if the HealthMart meets the requirements of this title.

Any State law or regulation relating to the composition or organization of a HealthMart is preempted to the extent the law or regulation is inconsistent with the provisions of this title.

Subsection (c). Application of ERISA Fiduciary and Disclosure Requirements. The board of directors of a HealthMart is deemed to be a plan administrator for purposes of applying parts 1 and 4 of subtitle B of title I of the Employee Retirement Income Security Act of 1974. The HealthMart shall be treated as such a plan and the enrollees shall be treated as participants and beneficiaries for purposes of applying such provisions pursuant to this subsection.

Subsection (d). Application of ERISA Renewability Protection.—A HealthMart is deemed to be a group health plan that is a multiple employer welfare arrangement for purposes of applying section 703 of the Employee Retirement Income Security Act of 1974.

Subsection (e). Application of Rules for Network Plans and Financial Capacity. The provisions of subsections (c) and (d) of section 2711 of ERISA apply to health benefits coverage offered by a health insurance issuer through a HealthMart.

Subsection (f). Construction Relating to Offering Requirement. Nothing in section 2711(a) of this Act (relating to guaranteed issuance) or section 703 of the Employee Retirement Income Security Act of 1974 (relating to guaranteed renewal) shall be construed as permitting the offering outside the HealthMart of health benefits coverage that is only made available through a HealthMart under this section because of the application of subsection (b).

Subsection (g). Application to Guaranteed Renewability Requirements in Case of Discontinuation of an Issuer. For purposes of applying section 2712 in the case of health insurance coverage offered by a health insurance issuer through a HealthMart, if the contract between the HealthMart and the issuer is terminated and the HealthMart continues to make available any health insurance coverage after the date of such termination, the following rules apply:

Renewability. The HealthMart shall fulfill the obligation under such section of the issuer renewing and continuing in force coverage by offering purchasers (and members and their dependents) all available health benefits coverage that would otherwise be available to similarly-situated purchasers and members from the remaining participating health insurance issuers in the same manner as would be required of issuers under section 2712(c).

Application of association rules. The HealthMart shall be considered an association for purposes of applying section 2712(e).

Subsection (h). Construction in Relation to Certain Other Laws. Nothing in this title shall be construed as modifying or affecting the applicability to HealthMarts or health benefits coverage offered by a health insurance issuer through a HealthMart of parts 6 (relating to continuation of coverage under group health plans) and 7 (relating to group health plan portability, access, and renewability) of subtitle B of title I of the Employee Retirement Income Security Act of 1974 or titles XXII (relating to requirements for certain group health plans for certain state and local employees) and XXVII (regarding requirements relating to health insurance coverage) of this Act.

Section 2803. Administration.

Subsection (a).

In General. Provides that the applicable federal authority must administer this title through the division established under subsection (b) of this section, and is authorized to issue such regulations as may be required to carry out this title. These regulations shall be subject to Congressional review under the provisions of chapter 8 of title 5, United States Code. Provides that the applicable Federal authority must incorporate the process of 'deemed file and use' with respect to the information filed under section 2801(a)(6)(A) of this title and shall determine whether information filed by a HealthMart demonstrates compliance with the applicable requirements of this title. Such authority shall exercise its authority under this title in a manner that fosters and promotes the development of HealthMarts in order to improve access to health care coverage and services.

Subsection (b). Administration Through Health Care Marketplace Division. Provides that the applicable federal authority carry out its duties under this title through a separate Health Care Marketplace Division, the sole duty of which (including the staff of which) shall be to administer this title. In addition to other responsibilities provided under this title, such Division is responsible for: oversight of the operations of HealthMarts under this title, and the periodic submission of reports to Congress on the performance of HealthMarts under this title under subsection (c), below.

Subsection (c). Periodic Reports. Requires that the applicable Federal authority submit to Congress a report every 30 months, during the 10-year period beginning on the effective date of the rules promulgated by the applicable Federal authority to carry out this title, on the effectiveness of this title in promoting coverage of uninsured individuals. Such authority may provide for the production of such reports through one or more contracts with appropriate private entities.

Section 2804. Definitions. Provides the following definitions for purposes of this title:

Applicable Federal authority. The term 'applicable Federal authority' means the Secretary of Health and Human Services.

Eligible employee or individual. The term 'eligible' means, with respect to an employee or other individual and a HealthMart, an employee or individual who is eligible under section 2801(c)(2), as provided in this Act, to enroll or be enrolled in health benefits coverage offered through the HealthMart.

Employer, employee, dependent. Except as the applicable Federal authority may otherwise provide, the terms "employer", "employee", and "dependent", as applied to health insurance coverage offered by a health insurance issuer licensed (or otherwise regulated) in a State, shall have the meanings applied to such terms with respect to such coverage under the laws of the State relating to such coverage and such an issuer.

Health benefits coverage. The term 'health benefits coverage' has the meaning given the term group health insurance coverage in section 2791(b)(4) of the PHS Act.

Health insurance issuer. The term 'health insurance issuer' has the meaning given the term in section 2791(b)(2).

Health status-related factor. The term 'health status-related factor' has the meaning given the term in section 2791(d)(9) of the PHS Act.

HealthMart. The term 'HealthMart' is defined above in section 2801(a)

Member. The term 'member' means, with respect to a HealthMart, an individual en-

rolled for health benefits coverage through the HealthMart under section 2801(c)(2).

Purchaser. The term 'purchaser' means, with respect to a HealthMart, a small employer that has contracted under section 2801(c)(1)(A) with the HealthMart for the purchase of health benefits coverage.

Small employer. The term 'small employer' has the meaning given such term in section 2791(e)(4).

Subsection (b). Effective Date. In general, the amendment made by subsection (a) shall take effect on January 1, 2000. The Secretary of Health and Human Services shall issue all regulations necessary to carry out the amendment made by subsection (a) before January 1, 2000.

Subtitle D—Community Health Organizations

Section 2301. Promotion of Provision of Insurance by Community Health Organizations. This section amends subpart I of part D of title III of the Public Health Service Act by authorizing the waiver of state licensure requirements by community health organizations. It adds the following new section 330B.

Section 330B. Waiver of state licensure requirement for community health organizations in certain cases.

Subsection (a). In General. A community health organization may offer health insurance coverage in a state in which it is not licensed if the organization files an application for waiver of the licensure requirement with the Secretary of Health and Human Services by November 1, 2003, and the Secretary determines that the grounds for approval of the application have been met. The grounds for approval of a waiver include: (1) the state failed to complete action on a licensing application within 90 days of the state's receipt of the application; (2) the waiver application denied by the state is discriminatory in that the standards or review process used by the state imposed requirements, procedures, or standards (other than solvency requirements) that are not generally applicable to other entities engaged in substantially similar business; or (3) the waiver application denied by the state is based on the organizations' failure to meet applicable state solvency requirements and such requirements are not the same as those established by the Secretary. A waiver granted under this subsection: is effective only in the state for which it is granted; is effective for a 36-month period and may be renewed for up to 36 additional months; may be continued on condition that the organization complies with state consumer protection and quality standards; and preempts state law. The Secretary is required to grant or deny a waiver application within 60 days after a substantially complete application is filed. The Secretary is required to report to the House Committee on Commerce and the Senate Committee on Labor and Human Resources, by December 31, 2002, on whether the waiver process should be continued after December 31, 2003.

Subsection (b). Assumption of full financial risk. The community health organization, in order to qualify for a waiver, must assume full financial risk on a prospective basis for the provision of covered health care services. The organization may obtain insurance or make other arrangements for: (1) the costs of providing services, the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time; (2) providing services other than through the organization because medical necessity required their provision before they could be secured through the organization; and (3) not

more than 90 percent of the amount by which its costs for any of its fiscal years exceed 105 percent of its income for such fiscal year. The organization may also make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions, to assume all or part of the financial risk on a prospective basis for the provision of health services.

Subsection (c). Certification of provision against risk of insolvency for unlicensed CHOs. Each community health organization that is not licensed by a state and which has an approved waiver application must meet the standards established by the Secretary relating to financial solvency and capital adequacy. The Secretary is required to establish a certification process for organizations to meet the solvency standards.

Subsection (d). Establishment of solvency standards for community health organizations. The Secretary is required to establish on an expedited basis, using a negotiated rulemaking process and through the Health Resources and Services Administration, standards relating to financial solvency and capital adequacy for entities to meet in order to obtain an approved waiver. The Secretary, in establishing such standards, must consult with interested organizations, including the National Association of Insurance Commissioners, the Academy of Actuaries, and organizations representing federally qualified health centers. The Secretary must take into account the following factors for such standards: (1) the delivery system assets of an organization; (2) alternative means of protecting against insolvency; and (3) any standards developed by the National Association of Insurance Commissioners specifically for risk-based health care delivery organizations. The standards must include provisions to prevent enrollees from being held liable to any person or entity for the organization's debts in the event of the organization's insolvency.

The Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of Medicare beneficiaries, and other interested parties, must: (1) publish a notice in the Federal Register of the rulemaking process within 45 days of enactment of this Act; (2) establish a target date for publication of the rule of April 1, 1999; (3) allow 15 days, instead of 30 days, for a comment period; and (4) appoint a negotiated rulemaking committee not later than 30 days after the comment period and nominate a facilitator not later than ten days after appointment of the committee. The Secretary must provide for publication of a rule and terminate the process if, by January 1, 1999, the committee reports that it is unlikely that it will reach consensus within one month of the target date. If the committee is not terminated, then it must report a proposed rule not later than one month before the target date of publication. The Secretary must publish a rule not later than the target date of publication that will be effective on an interim basis and include at least a 60-day public comment period. The Secretary must provide for consideration of comments and republish such rule not later than one year after the target date.

Subsection (e). Definitions. A community health organization is an organization that is a federally-qualified health center or is controlled by one or more federally-qualified health centers. A federally-qualified health center is as defined under Medicaid law and generally is a health center that meet statutory requirements but does not receive grant

funding. "Health insurance coverage" has the meaning given in section 2701 (b) (1) of the Public Health Service Act. "Control" means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.

TITLE III—AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986

Subtitle A—Patient Protections

Section 3001. Patient Access to Unrestricted Medical Advice, Emergency Medical Care, Obstetric and Gynecological Care, Pediatric Care. Subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) is amended by adding at the end the following new section:

Section 9813. Patient Access to Unrestricted Medical Advice, Emergency Medical Care, Obstetric And Gynecological Care, Pediatric Care.

Subsection (a). Patient Access to Unrestricted Medical Advice. This subsection states that a group health plan may not prohibit or restrict health care professionals under contract from advising participants or beneficiaries about their health status or treatment, even if benefits for such care or treatment are not covered by the plan. Health care professional is defined as a physician (section 1861(r) of the Social Security Act) or other health care professional whose services are provided under the group health plan. This includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Subsection (b). Patient Access to Emergency Medical Care. This subsection prohibits group health plans or health insurance issuers from requiring beneficiaries to get preauthorization before seeking emergency medical services and requires them to cover emergency medical screening examinations obtained at any emergency medical care facility, whether in or outside a plan's network of affiliated providers, if a prudent layperson with an average knowledge of health and medicine would judge the examination necessary in order to determine whether emergency medical care is needed. The plan or issuer must provide additional emergency medical services to the extent a prudent emergency medical professional determines necessary to avoid the consequences described in section 503(b)(8)(I) of ERISA as amended by this Act. These requirements apply to the extent the group health plan or health insurance issuer covers emergency medical care benefits (as defined in section 503(b)(8)(I) of ERISA as amended by this Act), except for items or services specifically excluded; and to items or services within the capability of the emergency facility, including routinely available ancillary services. This subsection does not prevent a group health plan or issuer from imposing any form of cost-sharing for emergency medical services so long as the cost-sharing is uniformly applied.

Subsection (c). Patient Access to Obstetric and Gynecological Care. If the group health plan or health insurance issuer covers routine gynecological or obstetric care by a participating physician specializing in such

care, and the participant's designated primary care provider is not such a specialist, authorization or referral by a primary care provider must not be required for routine gynecological or obstetric care. Ordering of other similar routine gynecological or obstetric care by such a participating specialist is treated as authorized by the primary care provider. Plan requirements relating to medical necessity or appropriateness for obstetric and gynecological care will be allowed.

Subsection (d). Patient Access to Pediatric Care. This subsection states that if the group health plan or health insurance issuer covers routine pediatric care, and requires the designation of a primary care provider, the parent or guardian of any plan beneficiary under 18 years of age may designate a participating physician who specializes in pediatrics, if available, as the primary care provider. Plan requirements relating to medical necessity or appropriateness for pediatric care will be allowed.

Subsection (e). Treatment of Multiple Coverage Options. This subsection requires plans that have two or more coverage options to provide patient access to obstetric and gynecological care and pediatric care as defined in subsections (c) and (d) under each option.

Subsection (b). Clerical Amendment. This subsection adds a clerical amendment to the table of sections.

Section 3002. Effective Date and Related Rules.

Subsection (a). In General. This subsection states that the amendments made by Subtitle A will apply with respect to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of the Act. The Secretary is also required to issue all necessary regulations before the effective date.

Subsection (b). Limitation on Enforcement Actions. No penalty shall be imposed on any failure to comply with any requirement imposed by the amendments made by section 3101 to the extent such failure occurs before the date of issuance of regulations issued in connection with such requirement if the plan has sought to comply in good faith with such requirement.

Subsection (c). Special Rule for Collective Bargaining Agreements. If a group health plan is maintained pursuant to one or more collective bargaining agreements ratified before the date of enactment of this Act, the provisions relating to patient access (subsections (b), (c), and (d) of section 9813 of the Internal Revenue Code of 1986 (as added by this subtitle) will not apply before the date of termination of the last collective bargaining agreement relating to the plan, or January 1, 2001, whichever is later. Any amendment in the plan made solely to conform to requirements of this subtitle must not be treated as a termination of the collective bargaining agreement.

Subtitle B—Patient Access to Information

Section 3101. Patient Access to Information Regarding Plan Coverage, Managed Care Procedures, Health Care Providers, And Quality of Medical Care. Subsection (a). In General. This subsection amends subchapter B of chapter 100 of the Internal Revenue Code of 1986 (relating to other requirements) by adding the following new Section 9814.

Section 9814. Disclosure by Group Health Plans.

Subsection (a). Disclosure Requirement. This subsection requires the administrator of each group health plan to ensure that the summary plan descriptions required under ERISA section 102 contain the information

described in subsections (b), (c), (d), and (e)(2)(A).

Each health insurance issuer connected with a group health plan is also required to provide the necessary information to the administrator or to plan participants and beneficiaries on a timely basis.

Subsection (b). Plan Benefits. The information required under subsection (a) includes a description of: (A) covered benefits categorized by the types of items and services and the types of health care professionals providing the items and services; (B) plan coverage for emergency medical care, the extent of access to urgent care centers, and definitions of terminology referring to emergency medical care; (C) plan benefits for preventive services; (D) any use or application of a drug formulary, including a summary of the process for determining the formulary; (E) and COBRA benefits available under the plan.

Information must also be provided on any limitations, exclusions, or restrictions on covered benefits, including: (A) benefits specifically excluded from coverage, categorized by types of items and services; (B) whether coverage for medical care can be limited or excluded based on utilization review or preauthorization requirements; (C) any lifetime, annual, or other period limitations on coverage, categorized by types of benefits; (D) any limitations or exclusions for custodial care; (E) experimental treatment or technology; or (F) failure to meet the plan's requirements for medical appropriateness or necessity; (G) coverage of second or subsequent opinions; (H) whether referral from a primary care provider is required for specialty care; (I) if continuity of care may be affected by the departure by the health care professional from a defined set of providers; restrictions on coverage of emergency services; and (J) any financial responsibility of participants or beneficiaries for emergency services.

Subsection (c). Participant's Financial Responsibilities. The summary plan description must also explain the participant's financial responsibility for payment of premiums, co-insurance, copayments, deductibles, and whether this may vary if the health care provider is not one of a defined set of providers.

Subsection (d). Dispute Resolution Procedures. The summary plan description must describe the process for dispute resolution adopted by the plan pursuant to section 503(b) of ERISA as amended by this Act. This must explain the procedures and time frames for coverage decisions and internal and external review.

Subsection (e). Information Available on Request. Upon written request, a group health plan offering coverage in connection with a group health plan must provide access to plan benefit information in electronic form. This information, in electronic format, must include, in addition to information required by section 104(b)(4) of ERISA, the latest summary plan description, summary of material modifications, and the actual plan provisions with available benefits. This is required no more than once a year, and a reasonable charge is permitted which may be subject to a maximum amount set by the Secretary. Requirements may also be met by making the information generally available on the Internet or on a proprietary computer network in a format which is readily accessible to participants and beneficiaries. A summary description of the types of information available on request must be included in the summary plan description made available to participants and beneficiaries.

In addition to information described above, a group or health plan issuer must provide to participants or beneficiaries upon request information on: (i) any network characteristics with detailed lists of primary care providers and specialists and their geographic locations; (ii) any special disease management programs or programs for persons with disabilities, whether these programs are voluntary and if benefits would differ significantly for participants in care management; (iii) whether a specific drug or biological is included in the plan's formulary and procedures for waiver requests; (iv) the procedures and medically-based criteria used in an adverse coverage decision if the determination relates to medical necessity, an experimental treatment or technology; (v) the basis on which any preauthorization and utilization review requirement has resulted in an adverse coverage decision; (vi) the accreditation and licensing status (if any) of each health insurance issuer offering health insurance coverage in connection with the plan and of any utilization review organization utilized by the issuer or the plan, together with the name and address of the accrediting or licensing authority; (vii) the latest information, if any, on enrollee satisfaction maintained by the plan; (viii) the latest information on quality performance maintained by the plan; and (ix) information about the frequency and outcome of external review decisions requested by enrollees of the plan or health insurance issuer.

Upon request, any health care professional treating a participant or beneficiary under a group health plan must provide to the participant or beneficiary a description of his or her professional qualifications, privileges, experience and general description of the method of compensation for medical care according to categories that may be specified by the Secretary.

In addition, upon request, any health care facility from which a participant or beneficiary has sought treatment under a group health plan must provide to the participant or beneficiary a description of the facility's corporate form or other organizational form and all forms of licensing and accreditation status, if any, with standard-setting organizations.

Subsection (f). Access to Information Relevant to the Coverage Options under which the Participant or Beneficiary is Eligible to Enroll. Upon written request, and in connection with a period of enrollment, the group health plan must make the summary plan description available for any coverage option in which the participant or prospective participant is eligible to enroll and any information described in clauses (i), (ii), (iii), (vi), (vii), and (viii) of subsection (e)(2)(B).

Subsection (g). Advance Notice of Changes in Drug Formularies. Plans must inform participants not later than 30 days before the effective date of any exclusion of a specific drug or biological from any drug formulary used by the plan in the treatment of a chronic illness or disease.

Subsection (b). Clerical Amendment. This subsection amends the table of sections.

Section 3102. Effective Date.

Subsection (a). In General. Amendments made by Subtitle B—Patient Access to Information will apply to plan years beginning on or after January 1 of the second calendar year following the date of the enactment of this Act. The subsection also requires the Secretary to issue all necessary regulations before that date.

Subsection (b). Limitation on Enforcement Actions. If the group health plan has sought

to comply in good faith with the amendments of Subtitle B, no enforcement actions shall be taken against a plan or issuer for violating a requirement imposed by the amendments before final regulations are issued.

Subtitle C—Medical Savings Accounts

Section 3201. Expansion of Availability of Medical Savings Accounts (MSAs)

Subsection (a). Repeal of Limitations on Number of Medical Savings Accounts. The current limitation on the number of taxpayers that may have MSAs and the rules for applying this limitation are repealed.

Subsection (b). All Employers May Offer MSAs. The legislation removes the current restriction that only small employers may offer MSAs.

Subsection (c). Increase in Amount of Deduction Allowed for Contributions to MSAs. The legislation allows monthly contributions of up to 1/12th the annual deductible for the taxpayer's coverage under the high deductible plan. The current percentage limitations are repealed.

Subsection (d). Both Employers and Employees May Contribute to MSAs. The legislation allows both employers and employees to contribute to an MSA. Currently, if an employer makes a contribution the employee may not contribute.

Subsection (e). Reduction in Permitted Deductibles under High Deductible Health Plans. The legislation lowers the allowable deductible for high deductible plans from \$1,500 to \$1,000 in the case of single coverage and \$3,000 to \$2,000 in the case of family coverage. It also postpones from 1998 to 1999 the first year for which cost-of-living adjustments are applied to the minimum allowable deductible, the maximum allowable deductible, and the maximum out-of-pocket requirements.

Subsection (f). MSAs May Be Offered under Cafeteria Plans. The current restriction against funding MSAs through cafeteria plans is repealed.

Subsection (g). Special Rules for Certain Federal Annuities. Individuals receiving immediate Federal annuities may also have MSAs.

Subsection (h). Effective Date. The amendments made by this section apply to taxable years ending after the date of enactment of this legislation.

Section 3202. Exception from Insurance Limitation in Case of Medical Savings Accounts (MSAs).

Subsection (a). Insurance Offered by Community Health Centers. Qualified medical expenses (with respect to an account holder) includes coverage under insurance offered by a community health center if the coverage consists solely of required primary health benefits provided on a capitated basis. This exception applies only to individuals who in the taxable year involved have income that is less than 200% of the official poverty line. The exception applies only to the first 15,000 individuals enrolled in this insurance in a taxable year.

Subsection (b). Reports on Enrollment. Centers offering insurance coverage to individuals with MSAs shall provide reports as may be required by the Secretary of Health and Human Services and the Secretary of the Treasury to carry out the restriction on the number of individuals to whom the exception applies.

Section 3203. Sense of the House of Representatives. This section expresses the Sense of the House of Representatives that patients are best served when they are empowered to make informed choices about

their own health care. The same is true regarding an individual's choice of health insurance. A system that gives people the power to choose the coverage that best meets their needs, combined with insurance market reforms, offers great promise of increased choices and greater access to health insurance for Americans.

Subtitle D—Revenue Offsets

See attached Joint Committee on Taxation Report No. JCX-56-98.

TITLE IV—HEALTH CARE LAWSUIT REFORM

Subtitle A—General Provisions

Section 4001. Federal Reform of Health Care Liability Actions. Title IV provides for Federal reform of health care liability actions.

Subsection (a). Applicability. This subsection specifies that reform provisions apply to any health care liability action brought in any State or Federal court. The provisions do not apply to any action for damages arising from a vaccine-related injury or death to the extent that the provisions of the National Vaccine Injury Compensation Program apply. The provisions also do not apply to actions under the Employment Retirement Income Security Act.

Subsection (b). Preemption. This subsection specifies that the provisions preempt State law to the extent State law provisions are inconsistent with the new requirements. However, they do not preempt State law to the extent State law provisions are more stringent.

Subsection (c). Effect on Sovereign Immunity and Choice of Law or Venue. This subsection provides that the new provisions do not waive or affect the defense of sovereign immunity asserted by any State or the U.S., affect the applicability of the Foreign Sovereign Immunities Act of 1976, preempt State choice-of-law rules with respect to claims brought by a foreign nation or citizen, or affect the right of any court to transfer venue.

Subsection (d). Amount in Controversy. This subsection specifies that in the case of any action under which the new provisions apply, and which is brought in federal court, the amount of economic damages, punitive damages, and attorneys fees or costs, are not included in the determination of whether the amount in controversy exceeds the minimum limit.

Subsection (e). Federal Court Jurisdiction Not Established on Federal Question Grounds. This subsection specifies that nothing in the new provisions is to be construed as establishing any new jurisdiction in the federal courts over health care liability actions.

Section 4002. Definitions. This section defines a number of terms.

Actual damages means damages awarded to pay for economic loss.

Alternative dispute resolution system or ADR means a system established under federal or state law that provides for resolution of health care liability claims other than through liability actions.

Claimant means any person who brings a health care liability action and any person on whose behalf the action is brought.

Clear and convincing evidence is that measure or degree of proof that produces in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations. It is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

Collateral source payments means any amount paid or reasonably likely to be paid

in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant as a result of injury or wrongful death pursuant to various laws, insurance policies, contracts, or other programs.

Drug has the meaning given the term under the Federal Food, Drug and Cosmetic Act.

Economic loss means any pecuniary loss resulting from injury to the extent recovery for such loss is allowed under state law. The term includes loss of earnings or other employment benefits, medical expense loss, replacement service loss, loss due to death, burial costs, and loss of business or employment opportunities.

Harm means any legally cognizable wrong or injury for which punitive damages may be imposed.

Health benefit plan means any of the following that provides benefits with respect to health care services: a hospital or medical expense incurred policy or certificate; a hospital or medical service plan contract; a health maintenance subscriber contract; or a Medicare+Choice plan offered under Medicare.

Health care liability action means a civil action brought in a state or federal court in which the claimant alleges a claim based on the provision of (or the failure to provide or pay for) health care services or the use of a medical product. The action may be brought against: a health care provider; an entity which is obligated to pay for health benefits under any health benefit plan (including persons or entities acting under a contract or arrangements); or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product. The term applies regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

Health care liability claim means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

Health care provider means any person that is engaged in the delivery of health care services in a state and is required by the state to be licensed or certified in order to engage in the delivery of services in the state.

Health care service means any service eligible for payment under a health benefit plan, including services related to the delivery or administration of such service.

Medical device has the meaning given the term under the Federal Food, Drug and Cosmetic Act.

Non-economic damages means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

Person means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including governmental entity.

Product seller means a person who (in the course of a business conducted for that purpose) sells, distributes, rents, leases, prepares, blends, packages, labels, or is otherwise involved in placing a product in the stream of commerce. The term also includes a person who installs, repairs, or maintains the harm-causing aspect of a product. The term does not include: (i) a seller or lessor of real property; (ii) a provider of professional services in any case where the sale or use of a product is incidental to the furnishing of

judgment, skill, or services; or (iii) any person who acts only in a financial capacity with respect to sale of the product or who leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

Punitive damages means damages awarded against any person to punish or deter such person or others from engaging in similar behavior in the future. The term does not include damages awarded to compensate for actual injury suffered.

State includes the 50 states, the District of Columbia, and all territories and possessions of the U.S.

Section 4003. Effective Date. The section specifies that the provisions of title IV of the bill apply to any health care liability action brought in any State or Federal court, and any health care liability claim subject to an ADR system, that is initiated on or after the date of enactment. Any health care liability claim or action arising from an injury occurring prior to enactment would be governed by the statute of limitations in effect at the time the injury occurred.

Subtitle B—Uniform Standards for Health Care Liability Actions

Section 4011. Statute of Limitations. This section establishes a uniform statute of limitations. Actions may not be brought more than two years after the injury is discovered or reasonably should be discovered. In no event may the action be brought more than five years after the date of the alleged injury.

Section 4012. Calculation and Payment of Damages

Subsection (a) Treatment of Non-Economic Damages. This subsection limits non-economic damages for losses resulting from an injury to \$250,000. The limit applies regardless of the number of persons against whom the health care liability action is brought or the number of actions brought. The limitation does not apply to an action for damages based solely on intentional denial of medical treatment (necessary to preserve a patient's life that the patient is otherwise qualified to receive), against the wishes of the patient (or if the patient is incompetent, against the wishes of the patient's guardian), on the basis of the patient's present or predicted age, disability, degree of medical dependency or quality of life.

The subsection specifies that, if after enactment, a state enacts a law which prescribes the amount of non-economic damages that may be awarded, the state limit will apply. Similarly, if after enactment, a state limits the amount of recovery in a health care liability action, but doesn't delineate between economic and non-economic damages, the state limit will apply.

The subsection specifies that a defendant is only liable for the amount of non-economic damages attributable to that defendant's proportionate share of the fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all cases, the liability of a defendant for non-economic damages is several and not joint. A separate judgment is to be rendered against each defendant for the amount allocated to such defendant.

Subsection (b) Treatment of Punitive Damages. The subsection permits the award of punitive damages (to the extent allowed under State law) only if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct that was either specifically intended to cause harm or that manifested a conscious

flagrant indifference to the rights or safety of others.

The subsection applies to any health care liability action brought in any federal or state court on any theory where punitive damages are sought. It does not create a cause of action for punitive damages. Further, it does not preempt or supersede any State or Federal law to the extent that such law would further limit punitive damage awards.

The subsection permits either party to request a separate proceeding (bifurcation) on the issue of whether punitive damages should be awarded and in what amount. If a separate proceeding is requested, evidence related only to the claim of punitive damages (as determined under state law) is inadmissible in any proceeding to determine whether actual damages should be awarded.

The subsection generally prohibits the award of punitive damages against a manufacturer or product seller of a drug or medical device. The prohibition applies in a case where the drug or device, or the adequacy of its packaging or labeling, was subject to pre-market approval by the Food and Drug Administration (FDA) and had received such pre-market approval. The prohibition also applies where the drug is generally recognized as safe and effective according to conditions established by the FDA. The prohibition against punitive damage awards does not apply in any case where the defendant, before or after pre-market approval of the drug or device, intentionally and wrongfully withheld information or made misrepresentations to the FDA or to the Secretary (with respect to biological products) that is material and relevant to the harm suffered by the claimant. The prohibition against damage awards also does not apply if the defendant made an illegal payment to an FDA official or employee for the purpose of securing or maintaining approval of the drug or device.

The subsection provides that a manufacturer or product seller shall not be held liable for punitive damages related to adequacy of required tamper resistant packaging unless the packaging or labeling was found by clear and convincing evidence to be substantially out of compliance with the regulations.

Subsection (c) Periodic Payments for Future Losses. The subsection permits periodic (rather than lump sum) payment in any case in which damages awarded for future economic and non-economic loss exceeds \$50,000. The judgment of a court awarding periodic payments may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of payments. The provision does not preclude a single lump sum settlement.

Subsection (d) Treatment of Collateral Source Payments. The subsection permits a defendant to introduce evidence of collateral source payments. If such evidence is introduced, the claimant may introduce evidence of any amount paid or reasonably likely to be paid to secure the right to such collateral source payments. No provider of collateral source payments is permitted to recover any amount against the claimant or against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care liability action. This subsection applies to actions that are settled as well as actions that are resolved by a fact finder.

Section 4013. Alternative Dispute Resolution. The subsection requires that any system used to resolve health care liability actions or claims must include provisions consistent with those specified in the bill relating to statute of limitations, non-economic

damages, joint and several liability, punitive damages, collateral source rule, and periodic payments.

Section 4014. Reporting on Fraud and Abuse Enforcement Activities. This subsection requires the General Accounting Office to:

(1) monitor the compliance of the Department of Justice and all United States Attorneys with the guideline entitled "Guidance on the Use of the False Claims Act in Civil Health Care Matters" issued by the Department on June 3, 1998, including any revisions to that guideline; and

(2) monitor the compliance of the Office of the Inspector General of the Department of Health and Human Services with the protocols and guidelines entitled "National Project Protocols—Best Practice Guidelines" issued by the Inspector General on June 3, 1998, including any revisions to such protocols and guidelines; and

(3) submit a report on such compliance to the Committee on the Judiciary, the Committee on Commerce, and the Committee on Ways and Means of the House of Representatives and the Committee on the Judiciary and the Committee on Finance of the Senate not later than February 1, 1999, and every year thereafter for a period of four years ending February 1, 2002.

TITLE V—CONFIDENTIALITY OF HEALTH INFORMATION

Section 5001. Confidentiality of Protected Health Information.

Subsection (a). In General. The section amends Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) by adding the following text:

Part D—Confidentiality of Protected Health Information—Inspection and Copying of Protected Health Information

Section 1181. Inspection And Copying of Protected Health Information.

Subsection (a). In General. The section generally authorizes, subject to the succeeding provisions of the section, a health care provider, health plan employer, health or life insurer, or educational institution to make available to a requesting individual (or a health care provider designated by the individual) his or her protected health information for inspection and copying.

Subsection (b). Access Through Originating Provider. Protected health information created by an originating provider and subsequently received by another health care provider or health plan as part of treatment or payment activities shall be made available for inspection and copying as provided in this section through the originating provider, rather than the receiving health care provider or health plan, unless the originating provider does not maintain the information.

Subsection (c). Investigational Information. Health information created as part of the requesting individual's participation in a clinical trial monitored by an institutional review board established pursuant to federal regulations adopted under the Public Health Service Act (42 U.S.C. 300v-1(b)) and Common Rule notice (56 Fed. Reg. 28003) shall be provided in response to a subsection (a) request only to the extent and in a manner consistent with such regulations.

Subsection (d). Other Exceptions. Unless ordered by a court of competent jurisdiction, the recipient of a subsection 1181(a) request is not required to grant the request if disclosure could reasonably be expected to endanger the life or physical safety, or cause substantial harm to any individual, or if the information has been compiled principally in

anticipation of or for use in a civil, criminal, or administrative action or proceeding.

Subsection (e). Denial of Request For Inspection or Copying. If the recipient of a subsection 1181(a) request denies the request, the requesting individual shall be informed in writing of the reasons for the denial, the availability of procedures for further review of the denial, and the individual's right to file a concise statement setting forth the request.

Subsection (f). Statement Regarding Request. If a requesting individual has filed a concise statement pursuant to subsection 1181(e), any subsequent disclosure of that individual's protected health information shall include a notation concerning the statement and may include a concise statement of the reasons for the denial of the request for inspection and copying.

Subsection (g). Procedures. A health care provider, health plan employer, health or life insurer, or educational institution providing access to protected health information for inspection or copying under this section, may prescribe appropriate procedures and may require a requesting individual to pay reasonable costs associated with such inspection and copying.

Subsection (h). Inspection and Copying of Segregable Portion. A health care provider, health plan employer, health or life insurer, or educational institution receiving a subsection 1181(a) request shall permit the inspection and copying of any segregable portion of a record after the deletion of any portion that is not required to be disclosed under this section.

Subsection (i). Deadline. A health care provider, health plan employer, health or life insurer, or educational institution shall comply with or deny a subsection 1181(a) request not later than 30 days after the date of receiving such request.

Subsection (j). Rules Governing Agents. An agent of a health care provider, health plan employer, health or life insurer, or educational institution shall not be required to provide for the inspection and copying of protected health information, except where the information is retained by the agent and the agent has been asked by the health care provider, health plan employer, health or life insurer, or educational institution to fulfill the requirements of this section.

Section 1182. Supplementation of Protected Health Information.

Subsection (a). In General. Subject to subsection 1182(b), not later than 45 days after receiving a written request from an individual to amend his or her protected health information by adding a concise written statement, a health care provider, health plan employer, health or life insurer, or educational institution shall make the requested amendment, inform the individual of the amendment action, and make reasonable efforts to inform recipients of the unamended health information during the previous year of the addition of a supplement.

Subsection (b). Refusal to Amend. If a health care provider, health plan employer, health or life insurer, or educational institution refuses to make a requested subsection 1182(a) amendment, the requesting individual shall be informed of the reasons for the refusal, any procedures for further review of the refusal, and the individual's right to file a concise statement setting forth the requested amendment, and the individual's reasons for disagreeing with the refusal.

Subsection (c). Statement of Disagreement. If a requesting individual has filed a

concise statement pursuant to subsection 1182(b), any subsequent disclosure of the disputed portion of the information shall include a notation concerning the statement and may include a concise statement of the reasons for the denial of the amendment request.

Subsection (d). Rules Governing Agents. An agent of a health care provider, health plan employer, health or life insurer, or educational institution shall not be required to make amendments to individually identifiable health information, except where the information is retained by the agent and the agent has been asked by the health care provider, health plan employer, health or life insurer, or educational institution to fulfill the requirements of this section.

Subsection (e). Duplicative Requests For Amendments. If a health care provider, health plan employer, health or life insurer, or educational institution receives a duplicative request for an amendment of health information and a statement of disagreement with respect to the request that has been filed, the requesting individual shall be informed of such filing and there shall be no further requirement to carry out the procedures under this section.

Subsection (f). Rule of Construction. This section shall not be construed to permit an individual to modify statements in his or her record that document the factual observations of another individual or state the results of diagnostic tests, or to permit an individual to amend his or her record as to the type, duration, or quality of treatment the individual believes he or she should have been provided.

Section 1183. Notice of Confidentiality Practices.

Subsection (a). Preparation of Written Notice. A health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall post or provide, in writing and in a clear and conspicuous manner, notice of their protected health information confidentiality practices. Such notice shall include a description of an individual's rights with respect to protected health information, the intended uses and disclosures of such information, the procedures established for the exercise of an individual's rights with respect to such information, and the procedures established for obtaining copies of the notice.

Subsection (b). Model Notice. The Secretary of Health and Human Services, after notice and opportunity for public comment, and based on the advice of the National Committee on Vital and Health Statistics, shall develop and disseminate, not later than 6 months after the date of the enactment of the Accessibility, Affordability, and Accountability Patient Protection Act of 1998, model notices of confidentiality practices for use under this section. Use of a model notice developed by the Secretary shall serve as a complete defense in any civil action to an allegation that a violation of this section has occurred.

Section 1184. Establishment of Safeguards.

Subsection (a). In General. A health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution shall establish, maintain, and enforce reasonable and appropriate administrative, technical, and physical safeguards to protect the confidentiality, security, accuracy, and integrity of protected health information created, received, obtained, maintained, used, transmitted, or disposed of by them.

Subsection (b). Factors to Be Considered. A health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution subject to subsection 1184(a) shall consider the following factors in establishing safeguards under such subsection: the need for protected health information; the categories of personnel who will have access to such information; the feasibility of limiting access to individual identifiers; the appropriateness of the policy or procedure to the person and the medium in which protected health information is stored and transmitted; and the value of audit trails in computerized records.

Subsection (c). Relationship to Part C Requirement. Any safeguard established under this section shall be consistent with the requirement in section 1173(d)(2).

Subsection (d). Conversion to Nonidentifiable Health Information. A health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, health researcher, or educational institution subject to subsection 1184(a) shall, to the extent practicable and consistent with the purpose for which protected health information is maintained, convert such information into nonidentifiable health information.

Section 1185. Availability of Protected Health Information For Purposes of Health Care Operations

Subsection (a). Disclosure. The bill allows any person who maintains protected health information to disclose the information to a health care provider or a health plan in order to permit the provider or plan to conduct health care operations.

Subsection (b). Use. A health care provider or a health plan that maintains protected health information may use it to conduct health care operations.

Subsection (c). Limitation on Sale or Barter. Notwithstanding subsection (b), this subsection prohibits health care providers or health plans from selling or bartering protected health information as part of conducting health care operations.

Section 1186. Relationship to Other Laws.

Subsection (a). State Law. Part D, as established by the bill, preempts State law provisions that: (A) would be preempted as inconsistent with this title under the Supremacy Clause of the U.S. Constitution; (B) relate to authorization for the use or disclosure of protected health information for health care operations, or nonidentifiable health information; or (C) relate to the inspection, copying, or amendment of protected health information by the information-subject, to the notice of confidentiality practices, or to the establishment of safeguards for protected health information. Nothing in this part shall be construed to preempt or modify State privileges. There are exceptions to federal preemption for the following purposes of protected health information: (A) confidentiality of medical records maintained by a licensed mental health professional; (B) provision of health care or disclosure of information about a minor; (C) condition-specific limitations on disclosure as identified by the Secretary as posing a public health threat; (D) use or disclosure of information for use in public health reporting; (E) situations where the individual is unconscious, incompetent, or otherwise incapable of deciding whether to authorize disclosure of protected health information; or, (F) situations where the individual has a valid and applicable power of attorney.

Subsection (b). Federal Law. Part D shall not be construed to preempt, modify, or repeal any provision of Federal law relating to protected health information, or relating to an individual's access to protected health information or health care services. This part shall not be construed to preempt or modify Federal privileges.

Section 1187. Civil Penalties.

Subsection (a). Violation. A person determined by the Secretary to have substantially and materially failed to comply with this part shall be subject to, in addition to any other penalties that may be imposed: (1) in the case of a violation related to section 1181 or 1182, a civil penalty up to \$500 for each violation but not more than \$5,000 for all violations of an identical requirement or prohibition during a calendar year; (2) for violations of sections 1183, 1184, or 1185, to a civil penalty not more than \$10,000 for each violation, but not to exceed \$50,000 for all violations of an identical requirement or prohibition during the calendar year; or (3) in a case where the Secretary finds that violations occur with such frequency as to constitute a general business practice, to a civil penalty of not more than \$100,000.

Subsection (b). Procedures For Imposition of Penalties. Section 1128A, other than subsections (a) and (b) and the second sentence of subsection (f) of that section, shall apply to the imposition of a civil or monetary penalty under this section in the same manner as such provisions apply with respect to the imposition of a penalty under section 1128A.

Section 1188. Definitions. The bill defines the following terms:

Agent means a person, including a contractor, who represents and acts for another under the contract or relation of an agency, or whose function is to bring about, modify, affect, accept performance of, or terminate contractual obligations between the principle and a third person.

Disclose means to release, transfer, provide access to, or otherwise divulge protected health information to any person other than an individual who is the subject of such information.

Educational institution means an institution or place accredited or licensed for purposes of providing for instruction or education, including an elementary school, secondary school, or institution of higher learning, a college, or an assemblage of colleges united under one corporate organization or government.

Employer means the definition used under ERISA, except that such term is required to include only employers of two or more employees.

Health care means: (a) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, including appropriate assistance with disease or symptom management and maintenance, counseling, services or procedures with respect to the physical or mental condition of an individual or affecting the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs, or any other tissue; or (b) any sale or dispensing, pursuant to a prescription or medical order, of a drug, device, equipment, or other health care related item to an individual, or for the use of an individual.

Health care operations means services, provided directly by or on behalf of a health plan or health care provider or by its agent, for any of the following purposes: (a) coordinating health care, including health care management of the individual through risk assessment, case management, and disease

management; (b) conducting quality assessment and improvement activities, including outcomes evaluation, clinical guideline development and improvement, and health promotion; (c) carrying out utilization review activities, including precertification and preauthorization of services, and health plan rating activities, including underwriting and experience rating; or (d) conducting or arranging for auditing services.

Health care provider means a person, who with respect to a specific item of protected health information, receives, creates, uses, maintains, or discloses the information while acting in whole or in part in the capacity of (a) a person who is licensed, certified, registered, or otherwise authorized by federal or state law to provide an item or service that constitutes health care in the ordinary course of business, or practice of a profession; (b) a federal, state, employer-sponsored or any other privately-sponsored program that directly provides items or services that constitute health care to beneficiaries; or (c) an officer or employee of a person described in subparagraphs (a) or (b).

Health or life insurer means a health insurance issuer, as defined in section 9805(b)(2) of the Internal Revenue Code of 1986, or a life insurance company, as defined in section 816 of such Code.

Health plan means any health insurance plan, including any hospital or medical service plan, dental or other health service plan, health maintenance organization plan, plan offered by a provider-sponsored organization (as defined in section 1855(d) of the Social Security Act, the Medicare+Choice program), or other program providing or arranging for the provision of health benefits.

Health researcher means a person (or officer, employee, or agent of a person) who is engaged in systematic investigation, including research development, testing, data analysis, and evaluation, designed to develop or contribute to generalizable knowledge relating to basic biomedical processes, health, health care, health care delivery, or health care cost.

Nonidentifiable health information means protected health information from which personal identifiers that reveal the identity of the individual who is the subject of such information or provide direct means of identifying the individual (such as name, address, and social security number) have been removed, encrypted, or replaced with a code, so that the identity of the individual is not evident without (in the case of encrypted or coded information) the use of a key.

Originating provider means, when used with respect to protected health information, the health care provider who takes an action that initiates the treatment episode to which that information relates, such as prescribing a drug, ordering a diagnostic test, or admitting an individual to a health care facility. A hospital or nursing facility is the originating provider with respect to protected health information created or received as part of inpatient or outpatient treatment provided in the hospital or facility.

Payment activities means (a) activities undertaken (i) by, or on behalf of, a health plan to determine its responsibility for coverage under the plan; or (ii) by a health care provider to obtain payment for items or services provided to an individual, provided under a health plan, or provided based on a determination by the health plan or responsibility for coverage under the plan; and (b) includes the following activities: (i) billing,

claims management, medical data processing, other administrative services, and actual payment; (ii) determinations of coverage or adjudication of health benefit or subrogation claims; or (iii) review of health care services with respect to coverage under a health plan or justification of charges.

Person means a natural person; a government or governmental subdivision, agency, or authority; a company, corporation, estate, firm, trust, partnership, association, joint venture, society, or joint stock company; or any other legal entity.

Protected health information when used with respect to an individual who is the subject of information, means any information (including genetic information) that identifies the individual, whether oral or recorded in any form or medium, and that (a) is created or received by a health care provider, health plan, health oversight agency, public health authority, employer, health or life insurer, or educational institution; (b) relates to the past, present, or future physical or mental health or condition of an individual (including individual cells and their components); (c) is derived from the provision of health care to an individual or payment for the provision of health care to an individual; and (d) is not nonidentifiable health information.

State includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Treatment means the provision of health care by a health care provider.

Writing means writing either in a paper-based, computer-based, or electronic form, including electronic signatures.

Subsection (b). Enforcement of Provisions Through Conditions of Participation. This subsection amends section 1842(h) of the Social Security Act to permit the Secretary to refuse to enter into an agreement with a physician or supplier, or to terminate or refuse to renew an agreement, if the physician or supplier is found to have violated the confidentiality of protected health information as established by the bill. This subsection also amends sections 1852(h), 1866(a)(1), and 1876(k)(4) of the Social Security Act to require that Medicare+Choice organizations, Medicare providers, and Health

Maintenance Organizations with risk-sharing contracts under Medicare comply with the confidentiality of protected health information provisions established by the bill.

Subsection (c). Conforming Amendments. This subsection provides conforming amendments modifying the title heading of Title XI of the Social Security Act to read as follows: "Title XI — General Provisions, Peer Review, Administrative Simplification, and Confidentiality of Protected Health Information". This subsection also amends section 306(k)(5) of the Public Health Service Act to require the National Committee on Vital and Health Statistics to study the issues relating to section 1184 of the bill regarding the establishment of safeguards to protect health information. The National Committee is required to report the results of the study to the Congress by not later than one year after enactment of the bill.

Subsection (d). Effective Date. This subsection provides an effective date for the provisions of this section that is one year after enactment of the bill, with some exceptions; (1) the provisions in subsection (c)(2), the study on safeguards required of the National Committee on Vital and Health Statistics, and (2) section 1183(b) related to the development of a model notice of confidentiality practices.

Section 5002. Study and Report on Effect of State Law on Health-Related Research. The bill requires that one year after enactment of the bill, the Comptroller General of the U.S. prepare and submit to the Congress a report containing the results of a study on the effect of state laws on health-related research that is subject to review by an institutional review board or institutional review committee with respect to the protection of human subjects.

Section 5003. Study and Report on State Law on Protected Health Information.

Subsection (a). In General. The bill requires that not later than 9 months after the date of the enactment of this Act, the Comptroller General of the United States shall prepare and submit to the Congress a report containing the results of a study that (1) compiles State laws on the confidentiality of protected health information (as defined in section 1188 of the Social Security Act, as added by section 5001 of this Act); and (2)

analyzing the effect of such laws on the provision of health care and securing payment for such care.

Subsection (b). Modification of Deadline. Section 264(c)(1) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191; 110 Stat. 2033) is amended by striking "36 months after the date of the enactment of this Act," (August 1999), and inserting "6 months after the date on which the Comptroller General of the United States submits to the Congress a report under section 5003(a) of the Patient Protection Act of 1998."

Section 5004. Protection for Certain Information Developed to Reduce Mortality or Morbidity or for Improving Patient Care and Safety

Subsection (a). Protection of Certain Information. Health care response information shall be exempt from any disclosure requirement in connection with a civil or administrative proceeding to the same extent as information developed by a health care provider with respect to any of the following: (1) peer review; (2) utilization review; (3) quality management or improvement; (4) quality control; (5) risk management; (6) internal review for purposes of reducing mortality, morbidity, or for improving patient care or safety.

Subsection (b). No Waiver of Protection Through Interaction with Accrediting Body. The protection of health care response information from disclosure shall not be deemed to be modified or in any way waived by the development or transfer of such information to an accrediting body.

Section 5005. Effective Date for Standards Governing Unique Health Identifiers for Individuals. Amends Section 1174 of the Social Security Act (42 U.S.C. 1320d-3) to preclude the Secretary of Health and Human Services from promulgating or adopting a final standard to be effective under section 1173(b) of the Social Security Act providing for a unique health identifier for an individual (except in an individual's capacity as an employer or a health care provider), until legislation is enacted specifically approving the standard or containing provisions consistent with the standard.