

***In the Senate of the United States,***

*June 30, 2000.*

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

**AMENDMENT:**

Strike out all after the enacting clause and insert:

1 *DIVISION A—DEPARTMENTS OF LABOR, HEALTH*  
2 *AND HUMAN SERVICES, AND EDUCATION,*  
3 *AND RELATED AGENCIES*

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

1            *TITLE I—DEPARTMENT OF LABOR*2            *EMPLOYMENT AND TRAINING ADMINISTRATION*3            *TRAINING AND EMPLOYMENT SERVICES*

4            *For necessary expenses of the Workforce Investment*  
5 *Act, including the purchase and hire of passenger motor*  
6 *vehicles, the construction, alteration, and repair of build-*  
7 *ings and other facilities, and the purchase of real property*  
8 *for training centers as authorized by the Workforce Invest-*  
9 *ment Act and the National Skill Standards Act of 1994;*  
10 *\$2,990,141,000 plus reimbursements, of which*  
11 *\$1,718,801,000 is available for obligation for the period*  
12 *July 1, 2001 through June 30, 2002, of which*  
13 *\$1,250,965,000 is available for obligation for the period*  
14 *April 1, 2001 through June 30, 2002, including*  
15 *\$1,000,965,000 to carry out chapter 4 of the Workforce In-*  
16 *vestment Act and \$250,000,000 to carry out section 169 of*  
17 *such Act; and of which \$20,375,000 is available for the pe-*  
18 *riod July 1, 2001 through June 30, 2004 for necessary ex-*  
19 *penses of construction, rehabilitation, and acquisition of*  
20 *Job Corps centers: Provided, That \$9,098,000 shall be for*  
21 *carrying out section 172 of the Workforce Investment Act,*  
22 *and \$3,500,000 shall be for carrying out the National Skills*  
23 *Standards Act of 1994: Provided further, That no funds*  
24 *from any other appropriation shall be used to provide meal*  
25 *services at or for Job Corps centers: Provided further, That*

1 *funds provided to carry out section 171(d) of such Act may*  
2 *be used for demonstration projects that provide assistance*  
3 *to new entrants in the workforce and incumbent workers:*  
4 *Provided further, That funding provided to carry out*  
5 *projects under section 171 of the Workforce Investment Act*  
6 *of 1998 that are identified in the Conference Agreement,*  
7 *shall not be subject to the requirements of section*  
8 *171(b)(2)(B) of such Act, the requirements of section*  
9 *171(c)(4)(D) of such Act, or the joint funding requirements*  
10 *of sections 171(b)(2)(A) and 171(c)(4)(A) of such Act: Pro-*  
11 *vided further, That funding appropriated herein for Dis-*  
12 *located Worker Employment and Training Activities under*  
13 *section 132(a)(2)(A) of the Workforce Investment Act of*  
14 *1998 may be distributed for Dislocated Worker Projects*  
15 *under section 171(d) of the Act without regard to the 10*  
16 *percent limitation contained in section 171(d) of the Act.*

17 *For necessary expenses of the Workforce Investment*  
18 *Act, including the purchase and hire of passenger motor*  
19 *vehicles, the construction, alteration, and repair of build-*  
20 *ings and other facilities, and the purchase of real property*  
21 *for training centers as authorized by the Workforce Invest-*  
22 *ment Act; \$2,463,000,000 plus reimbursements, of which*  
23 *\$2,363,000,000 is available for obligation for the period Oc-*  
24 *tober 1, 2001 through June 30, 2002, and of which*  
25 *\$100,000,000 is available for the period October 1, 2001*

1 *through June 30, 2004, for necessary expenses of construc-*  
2 *tion, rehabilitation, and acquisition of Job Corps centers.*

3 *COMMUNITY SERVICE EMPLOYMENT FOR OLDER AMERICANS*

4 *To carry out the activities for national grants or con-*  
5 *tracts with public agencies and public or private nonprofit*  
6 *organizations under paragraph (1)(A) of section 506(a) of*  
7 *title V of the Older Americans Act of 1965, as amended,*  
8 *or to carry out older worker activities as subsequently au-*  
9 *thorized, \$343,356,000.*

10 *To carry out the activities for grants to States under*  
11 *paragraph (3) of section 506(a) of title V of the Older Amer-*  
12 *icans Act of 1965, as amended, or to carry out older worker*  
13 *activities as subsequently authorized, \$96,844,000.*

14 *FEDERAL UNEMPLOYMENT BENEFITS AND ALLOWANCES*

15 *For payments during the current fiscal year of trade*  
16 *adjustment benefit payments and allowances under part I;*  
17 *and for training, allowances for job search and relocation,*  
18 *and related State administrative expenses under part II,*  
19 *subchapters B and D, chapter 2, title II of the Trade Act*  
20 *of 1974, as amended, \$406,550,000, together with such*  
21 *amounts as may be necessary to be charged to the subse-*  
22 *quent appropriation for payments for any period subse-*  
23 *quent to September 15 of the current year.*

1     *STATE UNEMPLOYMENT INSURANCE AND EMPLOYMENT*2                     *SERVICE OPERATIONS*

3             *For authorized administrative expenses, \$153,452,000,*  
4 *together with not to exceed \$3,095,978,000 (including not*  
5 *to exceed \$1,228,000 which may be used for amortization*  
6 *payments to States which had independent retirement plans*  
7 *in their State employment service agencies prior to 1980),*  
8 *which may be expended from the Employment Security Ad-*  
9 *ministration account in the Unemployment Trust Fund in-*  
10 *cluding the cost of administering section 51 of the Internal*  
11 *Revenue Code of 1986, as amended, section 7(d) of the Wag-*  
12 *ner-Peyser Act, as amended, the Trade Act of 1974, as*  
13 *amended, the Immigration Act of 1990, and the Immigra-*  
14 *tion and Nationality Act, as amended, and of which the*  
15 *sums available in the allocation for activities authorized by*  
16 *title III of the Social Security Act, as amended (42 U.S.C.*  
17 *502–504), and the sums available in the allocation for nec-*  
18 *essary administrative expenses for carrying out 5 U.S.C.*  
19 *8501–8523, shall be available for obligation by the States*  
20 *through December 31, 2001, except that funds used for auto-*  
21 *mation acquisitions shall be available for obligation by the*  
22 *States through September 30, 2003; and of which*  
23 *\$153,452,000, together with not to exceed \$763,283,000 of*  
24 *the amount which may be expended from said trust fund,*  
25 *shall be available for obligation for the period July 1, 2001*

1 *through June 30, 2002, to fund activities under the Act of*  
2 *June 6, 1933, as amended, including the cost of penalty*  
3 *mail authorized under 39 U.S.C. 3202(a)(1)(E) made*  
4 *available to States in lieu of allotments for such purpose:*  
5 *Provided, That to the extent that the Average Weekly In-*  
6 *sured Unemployment (AWIU) for fiscal year 2001 is pro-*  
7 *jected by the Department of Labor to exceed 2,396,000, an*  
8 *additional \$28,600,000 shall be available for obligation for*  
9 *every 100,000 increase in the AWIU level (including a pro*  
10 *rata amount for any increment less than 100,000) from the*  
11 *Employment Security Administration Account of the Un-*  
12 *employment Trust Fund: Provided further, That funds ap-*  
13 *propriated in this Act which are used to establish a na-*  
14 *tional one-stop career center system, or which are used to*  
15 *support the national activities of the Federal-State unem-*  
16 *ployment insurance programs, may be obligated in con-*  
17 *tracts, grants or agreements with non-State entities: Pro-*  
18 *vided further, That funds appropriated under this Act for*  
19 *activities authorized under the Wagner-Peyser Act, as*  
20 *amended, and title III of the Social Security Act, may be*  
21 *used by the States to fund integrated Employment Service*  
22 *and Unemployment Insurance automation efforts, notwith-*  
23 *standing cost allocation principles prescribed under Office*  
24 *of Management and Budget Circular A-87.*

1     *ADVANCES TO THE UNEMPLOYMENT TRUST FUND AND*  
2                                     *OTHER FUNDS*

3             *For repayable advances to the Unemployment Trust*  
4 *Fund as authorized by sections 905(d) and 1203 of the So-*  
5 *cial Security Act, as amended, and to the Black Lung Dis-*  
6 *ability Trust Fund as authorized by section 9501(c)(1) of*  
7 *the Internal Revenue Code of 1954, as amended; and for*  
8 *nonrepayable advances to the Unemployment Trust Fund*  
9 *as authorized by section 8509 of title 5, United States Code,*  
10 *and to the "Federal unemployment benefits and allow-*  
11 *ances" account, to remain available until September 30,*  
12 *2002, \$435,000,000.*

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

18                                     *PROGRAM ADMINISTRATION*

19             *For expenses of administering employment and train-*  
20 *ing programs, \$107,651,000, including \$6,431,000 to sup-*  
21 *port up to 75 full-time equivalent staff, the majority of*  
22 *which will be term Federal appointments lasting no more*  
23 *than 1 year, to administer welfare-to-work grants, together*  
24 *with not to exceed \$48,507,000, which may be expended*  
25 *from the Employment Security Administration account in*  
26 *the Unemployment Trust Fund.*

1     *PENSION AND WELFARE BENEFITS ADMINISTRATION*

2                     *SALARIES AND EXPENSES*

3         *For necessary expenses for the Pension and Welfare*  
4 *Benefits Administration, \$103,342,000.*

5                     *PENSION BENEFIT GUARANTY CORPORATION*

6                     *PENSION BENEFIT GUARANTY CORPORATION FUND*

7         *The Pension Benefit Guaranty Corporation is author-*  
8 *ized to make such expenditures, including financial assist-*  
9 *ance authorized by section 104 of Public Law 96-364, with-*  
10 *in limits of funds and borrowing authority available to*  
11 *such Corporation, and in accord with law, and to make*  
12 *such contracts and commitments without regard to fiscal*  
13 *year limitations as provided by section 104 of the Govern-*  
14 *ment Corporation Control Act, as amended (31 U.S.C.*  
15 *9104), as may be necessary in carrying out the program*  
16 *through September 30, 2001, for such Corporation: Pro-*  
17 *vided, That not to exceed \$11,652,000 shall be available for*  
18 *administrative expenses of the Corporation: Provided fur-*  
19 *ther, That expenses of such Corporation in connection with*  
20 *the termination of pension plans, for the acquisition, pro-*  
21 *tection or management, and investment of trust assets, and*  
22 *for benefits administration services shall be considered as*  
23 *non-administrative expenses for the purposes hereof, and ex-*  
24 *cluded from the above limitation.*

1            *EMPLOYMENT STANDARDS ADMINISTRATION*2                            *SALARIES AND EXPENSES*

3            *For necessary expenses for the Employment Standards*  
4 *Administration, including reimbursement to State, Federal,*  
5 *and local agencies and their employees for inspection serv-*  
6 *ices rendered, \$350,779,000, together with \$1,985,000 which*  
7 *may be expended from the Special Fund in accordance with*  
8 *sections 39(c), 44(d) and 44(j) of the Longshore and Harbor*  
9 *Workers' Compensation Act: Provided, That \$2,000,000*  
10 *shall be for the development of an alternative system for*  
11 *the electronic submission of reports required to be filed*  
12 *under the Labor-Management Reporting and Disclosure Act*  
13 *of 1959, as amended, and for a computer database of the*  
14 *information for each submission by whatever means, that*  
15 *is indexed and easily searchable by the public via the Inter-*  
16 *net: Provided further, That the Secretary of Labor is au-*  
17 *thorized to accept, retain, and spend, until expended, in*  
18 *the name of the Department of Labor, all sums of money*  
19 *ordered to be paid to the Secretary of Labor, in accordance*  
20 *with the terms of the Consent Judgment in Civil Action*  
21 *No. 91-0027 of the United States District Court for the Dis-*  
22 *trict of the Northern Mariana Islands (May 21, 1992): Pro-*  
23 *vided further, That the Secretary of Labor is authorized to*  
24 *establish and, in accordance with 31 U.S.C. 3302, collect*  
25 *and deposit in the Treasury fees for processing applications*

1 *and issuing certificates under sections 11(d) and 14 of the*  
2 *Fair Labor Standards Act of 1938, as amended (29 U.S.C.*  
3 *211(d) and 214) and for processing applications and*  
4 *issuing registrations under title I of the Migrant and Sea-*  
5 *sonal Agricultural Worker Protection Act (29 U.S.C. 1801*  
6 *et seq.).*

7 *SPECIAL BENEFITS*

8 *(INCLUDING TRANSFER OF FUNDS)*

9 *For the payment of compensation, benefits, and ex-*  
10 *penses (except administrative expenses) accruing during the*  
11 *current or any prior fiscal year authorized by title 5, chap-*  
12 *ter 81 of the United States Code; continuation of benefits*  
13 *as provided for under the heading “Civilian War Benefits”*  
14 *in the Federal Security Agency Appropriation Act, 1947;*  
15 *the Employees’ Compensation Commission Appropriation*  
16 *Act, 1944; sections 4(c) and 5(f) of the War Claims Act*  
17 *of 1948 (50 U.S.C. App. 2012); and 50 percent of the addi-*  
18 *tional compensation and benefits required by section 10(h)*  
19 *of the Longshore and Harbor Workers’ Compensation Act,*  
20 *as amended, \$56,000,000 together with such amounts as*  
21 *may be necessary to be charged to the subsequent year ap-*  
22 *propriation for the payment of compensation and other ben-*  
23 *efits for any period subsequent to August 15 of the current*  
24 *year: Provided, That amounts appropriated may be used*  
25 *under section 8104 of title 5, United States Code, by the*  
26 *Secretary of Labor to reimburse an employer, who is not*

1 *the employer at the time of injury, for portions of the salary*  
2 *of a reemployed, disabled beneficiary: Provided further,*  
3 *That balances of reimbursements unobligated on September*  
4 *30, 2000, shall remain available until expended for the pay-*  
5 *ment of compensation, benefits, and expenses: Provided fur-*  
6 *ther, That in addition there shall be transferred to this ap-*  
7 *propriation from the Postal Service and from any other cor-*  
8 *poration or instrumentality required under section 8147(c)*  
9 *of title 5, United States Code, to pay an amount for its*  
10 *fair share of the cost of administration, such sums as the*  
11 *Secretary determines to be the cost of administration for*  
12 *employees of such fair share entities through September 30,*  
13 *2001: Provided further, That of those funds transferred to*  
14 *this account from the fair share entities to pay the cost of*  
15 *administration, \$30,510,000 shall be made available to the*  
16 *Secretary as follows: (1) for the operation of and enhance-*  
17 *ment to the automated data processing systems, including*  
18 *document imaging, medical bill review, and periodic roll*  
19 *management, in support of Federal Employees' Compensa-*  
20 *tion Act administration, \$19,971,000; (2) for conversion to*  
21 *a paperless office, \$7,005,000; (3) for communications rede-*  
22 *sign, \$750,000; (4) for information technology maintenance*  
23 *and support, \$2,784,000; and (5) the remaining funds shall*  
24 *be paid into the Treasury as miscellaneous receipts: Pro-*  
25 *vided further, That the Secretary may require that any per-*

1 *son filing a notice of injury or a claim for benefits under*  
2 *chapter 81 of title 5, United States Code, or 33 U.S.C. 901*  
3 *et seq., provide as part of such notice and claim, such iden-*  
4 *tifying information (including Social Security account*  
5 *number) as such regulations may prescribe.*

6 *BLACK LUNG DISABILITY TRUST FUND*  
7 *(INCLUDING TRANSFER OF FUNDS)*

8 *Beginning in fiscal year 2001 and thereafter, such*  
9 *sums as may be necessary from the Black Lung Disability*  
10 *Trust Fund, to remain available until expended, for pay-*  
11 *ment of all benefits authorized by section 9501(d)(1) (2) (4)*  
12 *and (7) of the Internal Revenue Code of 1954, as amended;*  
13 *and interest on advances as authorized by section*  
14 *9501(c)(2) of that Act. In addition, the following amounts*  
15 *shall be available from the Fund for fiscal year 2001 for*  
16 *expenses of operation and administration of the Black Lung*  
17 *Benefits program as authorized by section 9501(d)(5) of*  
18 *that Act: \$30,393,000 for transfer to the Employment*  
19 *Standards Administration, “Salaries and Expenses”;*  
20 *\$21,590,000 for transfer to Departmental Management,*  
21 *“Salaries and Expenses”; \$318,000 for transfer to Depart-*  
22 *mental Management, “Office of Inspector General”; and*  
23 *\$356,000 for payments into Miscellaneous Receipts for the*  
24 *expenses of the Department of Treasury.*

1    *OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION*  
2                                    *SALARIES AND EXPENSES*

3       *For necessary expenses for the Occupational Safety*  
4 *and Health Administration, \$425,983,000, including not to*  
5 *exceed \$88,493,000 which shall be the maximum amount*  
6 *available for grants to States under section 23(g) of the Oc-*  
7 *cupational Safety and Health Act, which grants shall be*  
8 *no less than 50 percent of the costs of State occupational*  
9 *safety and health programs required to be incurred under*  
10 *plans approved by the Secretary under section 18 of the*  
11 *Occupational Safety and Health Act of 1970; and, in addi-*  
12 *tion, notwithstanding 31 U.S.C. 3302, the Occupational*  
13 *Safety and Health Administration may retain up to*  
14 *\$750,000 per fiscal year of training institute course tuition*  
15 *fees, otherwise authorized by law to be collected, and may*  
16 *utilize such sums for occupational safety and health train-*  
17 *ing and education grants: Provided, That of the amount*  
18 *appropriated under this heading that is in excess of the*  
19 *amount appropriated for such purposes for fiscal year 2000,*  
20 *at least \$22,200,000 shall be used to carry out education,*  
21 *training, and consultation activities as described in sub-*  
22 *sections (c) and (d) of section 21 of the Occupational Safety*  
23 *and Health Act of 1970 (29 U.S.C. 670(c) and (d)): Pro-*  
24 *vided further, That, notwithstanding 31 U.S.C. 3302, the*  
25 *Secretary of Labor is authorized, during the fiscal year end-*

1 *ing September 30, 2001, to collect and retain fees for serv-*  
2 *ices provided to Nationally Recognized Testing Labora-*  
3 *tories, and may utilize such sums, in accordance with the*  
4 *provisions of 29 U.S.C. 9a, to administer national and*  
5 *international laboratory recognition programs that ensure*  
6 *the safety of equipment and products used by workers in*  
7 *the workplace: Provided further, That none of the funds ap-*  
8 *propriated under this paragraph shall be obligated or ex-*  
9 *pended to prescribe, issue, administer, or enforce any stand-*  
10 *ard, rule, regulation, or order under the Occupational Safe-*  
11 *ty and Health Act of 1970 which is applicable to any per-*  
12 *son who is engaged in a farming operation which does not*  
13 *maintain a temporary labor camp and employs 10 or fewer*  
14 *employees: Provided further, That no funds appropriated*  
15 *under this paragraph shall be obligated or expended to ad-*  
16 *minister or enforce any standard, rule, regulation, or order*  
17 *under the Occupational Safety and Health Act of 1970 with*  
18 *respect to any employer of 10 or fewer employees who is*  
19 *included within a category having an occupational injury*  
20 *lost workday case rate, at the most precise Standard Indus-*  
21 *trial Classification Code for which such data are published,*  
22 *less than the national average rate as such rates are most*  
23 *recently published by the Secretary, acting through the Bu-*  
24 *reau of Labor Statistics, in accordance with section 24 of*  
25 *that Act (29 U.S.C. 673), except—*

1           (1) to provide, as authorized by such Act, con-  
2           sultation, technical assistance, educational and train-  
3           ing services, and to conduct surveys and studies;

4           (2) to conduct an inspection or investigation in  
5           response to an employee complaint, to issue a citation  
6           for violations found during such inspection, and to  
7           assess a penalty for violations which are not corrected  
8           within a reasonable abatement period and for any  
9           willful violations found;

10          (3) to take any action authorized by such Act  
11          with respect to imminent dangers;

12          (4) to take any action authorized by such Act  
13          with respect to health hazards;

14          (5) to take any action authorized by such Act  
15          with respect to a report of an employment accident  
16          which is fatal to one or more employees or which re-  
17          sults in hospitalization of two or more employees, and  
18          to take any action pursuant to such investigation au-  
19          thorized by such Act; and

20          (6) to take any action authorized by such Act  
21          with respect to complaints of discrimination against  
22          employees for exercising rights under such Act:

23          *Provided further, That the foregoing proviso shall not apply*  
24          *to any person who is engaged in a farming operation which*

1 *does not maintain a temporary labor camp and employs*  
2 *10 or fewer employees.*

3 *MINE SAFETY AND HEALTH ADMINISTRATION*

4 *SALARIES AND EXPENSES*

5 *For necessary expenses for the Mine Safety and Health*  
6 *Administration, \$244,747,000, including purchase and be-*  
7 *stowal of certificates and trophies in connection with mine*  
8 *rescue and first-aid work, and the hire of passenger motor*  
9 *vehicles; including up to \$1,000,000 for mine rescue and*  
10 *recovery activities, which shall be available only to the ex-*  
11 *tent that fiscal year 2001 obligations for these activities ex-*  
12 *ceed \$1,000,000; in addition, not to exceed \$750,000 may*  
13 *be collected by the National Mine Health and Safety Acad-*  
14 *emy for room, board, tuition, and the sale of training mate-*  
15 *rials, otherwise authorized by law to be collected, to be*  
16 *available for mine safety and health education and training*  
17 *activities, notwithstanding 31 U.S.C. 3302; and, in addi-*  
18 *tion, the Administration may retain up to \$1,000,000 from*  
19 *fees collected for the approval and certification of equip-*  
20 *ment, materials, and explosives for use in mines, and may*  
21 *utilize such sums for such activities; the Secretary is au-*  
22 *thorized to accept lands, buildings, equipment, and other*  
23 *contributions from public and private sources and to pros-*  
24 *ecute projects in cooperation with other agencies, Federal,*  
25 *State, or private; the Mine Safety and Health Administra-*

1 *tion is authorized to promote health and safety education*  
2 *and training in the mining community through cooperative*  
3 *programs with States, industry, and safety associations;*  
4 *and any funds available to the department may be used,*  
5 *with the approval of the Secretary, to provide for the costs*  
6 *of mine rescue and survival operations in the event of a*  
7 *major disaster.*

8 *BUREAU OF LABOR STATISTICS*

9 *SALARIES AND EXPENSES*

10 *For necessary expenses for the Bureau of Labor Statis-*  
11 *tics, including advances or reimbursements to State, Fed-*  
12 *eral, and local agencies and their employees for services ren-*  
13 *dered, \$369,327,000, together with not to exceed*  
14 *\$67,257,000, which may be expended from the Employment*  
15 *Security Administration account in the Unemployment*  
16 *Trust Fund; and \$10,000,000 which shall be available for*  
17 *obligation for the period July 1, 2001 through June 30,*  
18 *2002, for Occupational Employment Statistics.*

19 *DEPARTMENTAL MANAGEMENT*

20 *SALARIES AND EXPENSES*

21 *For necessary expenses for Departmental Management,*  
22 *including the hire of three sedans, and including the man-*  
23 *agement or operation, through contracts, grants or other ar-*  
24 *rangements, of Departmental bilateral and multilateral for-*  
25 *eign technical assistance, of which the funds designated to*

1 carry out bilateral assistance under the international child  
2 labor initiative shall be available for obligation through  
3 September 30, 2002, \$30,000,000 for the acquisition of De-  
4 partmental information technology, architecture, infra-  
5 structure, equipment, software and related needs which will  
6 be allocated by the Department's Chief Information Officer  
7 in accordance with the Department's capital investment  
8 management process to assure a sound investment strategy;  
9 \$337,964,000: Provided, That no funds made available by  
10 this Act may be used by the Solicitor of Labor to participate  
11 in a review in any United States court of appeals of any  
12 decision made by the Benefits Review Board under section  
13 21 of the Longshore and Harbor Workers' Compensation Act  
14 (33 U.S.C. 921) where such participation is precluded by  
15 the decision of the United States Supreme Court in Direc-  
16 tor, Office of Workers' Compensation Programs v. Newport  
17 News Shipbuilding, 115 S. Ct. 1278 (1995), notwith-  
18 standing any provisions to the contrary contained in Rule  
19 15 of the Federal Rules of Appellate Procedure: Provided  
20 further, That no funds made available by this Act may be  
21 used by the Secretary of Labor to review a decision under  
22 the Longshore and Harbor Workers' Compensation Act (33  
23 U.S.C. 901 et seq.) that has been appealed and that has  
24 been pending before the Benefits Review Board for more  
25 than 12 months: Provided further, That any such decision

1 *pending a review by the Benefits Review Board for more*  
2 *than 1 year shall be considered affirmed by the Benefits*  
3 *Review Board on the 1-year anniversary of the filing of*  
4 *the appeal, and shall be considered the final order of the*  
5 *Board for purposes of obtaining a review in the United*  
6 *States courts of appeals: Provided further, That these provi-*  
7 *sions shall not be applicable to the review or appeal of any*  
8 *decision issued under the Black Lung Benefits Act (30*  
9 *U.S.C. 901 et seq.): Provided further, That beginning in*  
10 *fiscal year 2001, there is established in the Department of*  
11 *Labor an office of disability employment policy which shall,*  
12 *under the overall direction of the Secretary, provide leader-*  
13 *ship, develop policy and initiatives, and award grants fur-*  
14 *thering the objective of eliminating barriers to the training*  
15 *and employment of people with disabilities. Such office*  
16 *shall be headed by an assistant secretary: Provided further,*  
17 *That of amounts provided under this head, not more than*  
18 *\$23,002,000 is for this purpose.*

19 *VETERANS EMPLOYMENT AND TRAINING*

20 *Not to exceed \$186,913,000 may be derived from the*  
21 *Employment Security Administration account in the Un-*  
22 *employment Trust Fund to carry out the provisions of 38*  
23 *U.S.C. 4100–4110A, 4212, 4214, and 4321–4327, and Pub-*  
24 *lic Law 103–353, and which shall be available for obliga-*  
25 *tion by the States through December 31, 2001. To carry*  
26 *out the Stewart B. McKinney Homeless Assistance Act and*

1 *section 168 of the Workforce Investment Act of 1998,*  
2 *\$19,800,000, of which \$7,300,000 shall be available for obli-*  
3 *gation for the period July 1, 2001, through June 30, 2002.*

4 *OFFICE OF INSPECTOR GENERAL*

5 *For salaries and expenses of the Office of Inspector*  
6 *General in carrying out the provisions of the Inspector Gen-*  
7 *eral Act of 1978, as amended, \$50,015,000, together with*  
8 *not to exceed \$4,770,000, which may be expended from the*  
9 *Employment Security Administration account in the Un-*  
10 *employment Trust Fund.*

11 *GENERAL PROVISIONS*

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

17 *(TRANSFER OF FUNDS)*

18 *SEC. 102. Not to exceed 1 percent of any discretionary*  
19 *funds (pursuant to the Balanced Budget and Emergency*  
20 *Deficit Control Act of 1985, as amended) which are appro-*  
21 *priated for the current fiscal year for the Department of*  
22 *Labor in this Act may be transferred between appropria-*  
23 *tions, but no such appropriation shall be increased by more*  
24 *than 3 percent by any such transfer: Provided, That the*  
25 *Appropriations Committees of both Houses of Congress are*  
26 *notified at least 15 days in advance of any transfer.*

1        *SEC. 103. EXTENDED DEADLINE FOR EXPENDITURE.*  
2        *Section 403(a)(5)(C)(viii) of the Social Security Act (42*  
3        *U.S.C. 603(a)(5)(C)(viii)) (as amended by section 806(b)*  
4        *of the Departments of Labor, Health and Human Services,*  
5        *and Education, and Related Agencies Appropriations Act,*  
6        *2000 (as enacted into law by section 1000(a)(4) of Public*  
7        *Law 106–113)) is amended by striking “3 years” and in-*  
8        *serting “5 years”.*

9        *SEC. 104. ELIMINATION OF SET-ASIDE OF PORTION OF*  
10        *WELFARE-TO-WORK FUNDS FOR PERFORMANCE BONUSES.*

11        *(a) IN GENERAL.—Section 403(a)(5) of the Social Security*  
12        *Act (as amended by section 806(b) of the Departments of*  
13        *Labor, Health and Human Services, and Education, and*  
14        *Related Agencies Appropriations Act, 2000 (as enacted into*  
15        *law by section 1000(a)(4) of Public Law 106–113)) is*  
16        *amended by striking subparagraph (E) and redesignating*  
17        *subparagraphs (F) through (K) as subparagraphs (E)*  
18        *through (J), respectively.*

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

1           (1) Section 403(a)(5)(A)(i) (42 U.S.C.  
2           603(a)(5)(A)(i)) is amended by striking “subpara-  
3           graph (I)” and inserting “subparagraph (H)”.

4           (2) Subclause (I) of each of subparagraphs  
5           (A)(iv) and (B)(v) of section 403(a)(5) (42 U.S.C.  
6           603(a)(5)(A)(iv)(I) and (B)(v)(I)) is amended—

7                   (A) in item (aa)—

8                           (i) by striking “(I)” and inserting  
9                           “(H)”; and

10                           (ii) by striking “(G), and (H)” and  
11                           inserting “and (G)”; and

12                   (B) in item (bb), by striking “(F)” and in-  
13                   serting “(E)”.

14           (3) Section 403(a)(5)(B)(v) (42 U.S.C.  
15           603(a)(5)(B)(v)) is amended in the matter preceding  
16           subclause (I) by striking “(I)” and inserting “(H)”.

17           (4) Subparagraphs (E), (F), and (G)(i) of sec-  
18           tion 403(a)(5) (42 U.S.C. 603(a)(5)), as so redesign-  
19           ated by subsection (a) of this section, are each  
20           amended by striking “(I)” and inserting “(H)”.

21           (5) Section 412(a)(3)(A) (42 U.S.C.  
22           612(a)(3)(A)) is amended by striking “403(a)(5)(I)”  
23           and inserting “403(a)(5)(H)”.

24           (c)           FUNDING           AMENDMENT.—Section  
25           403(a)(5)(H)(i)(II) of such Act (42 U.S.C.

1 603(a)(5)(H)(i)(II) (as redesignated by subsection (a) of  
 2 this section and as amended by section 806(b) of the De-  
 3 partments of Labor, Health and Human Services, and Edu-  
 4 cation, and Related Agencies Appropriations Act, 2000 (as  
 5 enacted into law by section 1000(a)(4) of Public Law 106-  
 6 113)) is further amended by striking “\$1,450,000,000” and  
 7 inserting “\$1,400,000,000”.

8 (d) *EFFECTIVE DATE.*—The amendments made by  
 9 subsections (a), (b), and (c) of this section shall take effect  
 10 on October 1, 2000.

11 *SEC. 105.* None of the funds made available in this  
 12 Act may be used by the Occupational Safety and Health  
 13 Administration to promulgate, issue, implement, admin-  
 14 ister, or enforce any proposed, temporary, or final standard  
 15 on ergonomic protection.

16 *TITLE II—DEPARTMENT OF HEALTH AND*  
 17 *HUMAN SERVICES*

18 *HEALTH RESOURCES AND SERVICES ADMINISTRATION*

19 *HEALTH RESOURCES AND SERVICES*

20 *For carrying out titles II, III, VII, VIII, X, XII, XIX,*  
 21 *and XXVI of the Public Health Service Act, section 427(a)*  
 22 *of the Federal Coal Mine Health and Safety Act, title V*  
 23 *and section 1820 of the Social Security Act, the Health Care*  
 24 *Quality Improvement Act of 1986, as amended, and the Na-*  
 25 *tive Hawaiian Health Care Act of 1988, as amended,*

1 \$4,572,424,000, of which \$150,000 shall remain available  
2 until expended for interest subsidies on loan guarantees  
3 made prior to fiscal year 1981 under part B of title VII  
4 of the Public Health Service Act, of which \$10,000,000 shall  
5 be available for the construction and renovation of health  
6 care and other facilities, of which \$25,000,000 from general  
7 revenues, notwithstanding section 1820(j) of the Social Se-  
8 curity Act, shall be available for carrying out the Medicare  
9 rural hospital flexibility grants program under section 1820  
10 of such Act, and of which \$4,000,000 shall be provided to  
11 the Rural Health Outreach Office of the Health Resources  
12 and Services Administration for the awarding of grants to  
13 community partnerships in rural areas for the purchase of  
14 automated external defibrillators and the training of indi-  
15 viduals in basic cardiac life support: Provided, That the  
16 Division of Federal Occupational Health may utilize per-  
17 sonal services contracting to employ professional manage-  
18 ment/administrative and occupational health professionals:  
19 Provided further, That of the funds made available under  
20 this heading, \$250,000 shall be available until expended for  
21 facilities renovations at the Gillis W. Long Hansen's Dis-  
22 ease Center: Provided further, That in addition to fees au-  
23 thorized by section 427(b) of the Health Care Quality Im-  
24 provement Act of 1986, fees shall be collected for the full  
25 disclosure of information under the Act sufficient to recover

1 *the full costs of operating the National Practitioner Data*  
2 *Bank, and shall remain available until expended to carry*  
3 *out that Act: Provided further, That fees collected for the*  
4 *full disclosure of information under the “Health Care*  
5 *Fraud and Abuse Data Collection Program”, authorized by*  
6 *section 221 of the Health Insurance Portability and Ac-*  
7 *countability Act of 1996, shall be sufficient to recover the*  
8 *full costs of operating the Program, and shall remain avail-*  
9 *able to carry out that Act until expended: Provided further,*  
10 *That no more than \$5,000,000 is available for carrying out*  
11 *the provisions of Public Law 104–73: Provided further,*  
12 *That of the funds made available under this heading,*  
13 *\$253,932,000 shall be for the program under title X of the*  
14 *Public Health Service Act to provide for voluntary family*  
15 *planning projects: Provided further, That amounts provided*  
16 *to said projects under such title shall not be expended for*  
17 *abortions, that all pregnancy counseling shall be nondirec-*  
18 *tive, and that such amounts shall not be expended for any*  
19 *activity (including the publication or distribution of lit-*  
20 *erature) that in any way tends to promote public support*  
21 *or opposition to any legislative proposal or candidate for*  
22 *public office: Provided further, That \$538,000,000 shall be*  
23 *for State AIDS Drug Assistance Programs authorized by*  
24 *section 2616 of the Public Health Service Act.*



1 *Safety and Health Act of 1977, sections 20, 21, and 22 of*  
2 *the Occupational Safety and Health Act of 1970, title IV*  
3 *of the Immigration and Nationality Act and section 501*  
4 *of the Refugee Education Assistance Act of 1980; including*  
5 *insurance of official motor vehicles in foreign countries; and*  
6 *hire, maintenance, and operation of aircraft,*  
7 *\$3,204,496,000, of which \$20,000,000 shall be made avail-*  
8 *able to carry out children's asthma programs and*  
9 *\$4,000,000 of such \$20,000,000 shall be utilized to carry*  
10 *out improved asthma surveillance and tracking systems and*  
11 *the remainder shall be used to carry out diverse community-*  
12 *based childhood asthma programs including both school-*  
13 *and community-based grant programs, except that not to*  
14 *exceed 5 percent of such funds may be used by the Centers*  
15 *for Disease Control and Prevention for administrative costs*  
16 *or reprogramming, and of which \$175,000,000 shall remain*  
17 *available until expended for the facilities master plan for*  
18 *equipment and construction and renovation of facilities,*  
19 *and in addition, such sums as may be derived from author-*  
20 *ized user fees, which shall be credited to this account, and*  
21 *of which \$25,000,000 shall be made available through such*  
22 *Centers for the establishment of partnerships between the*  
23 *Federal Government and academic institutions and State*  
24 *and local public health departments to carry out pilot pro-*  
25 *grams for antimicrobial resistance detection, surveillance,*

1 *education and prevention and to conduct research on resist-*  
2 *ance mechanisms and new or more effective antimicrobial*  
3 *compounds, and of which \$10,000,000 shall remain avail-*  
4 *able until expended to carry out the Fetal Alcohol Syn-*  
5 *drome prevention and services program: Provided, That in*  
6 *addition to amounts provided herein, up to \$91,129,000*  
7 *shall be available from amounts available under section 241*  
8 *of the Public Health Service Act: Provided further, That*  
9 *none of the funds made available for injury prevention and*  
10 *control at the Centers for Disease Control and Prevention*  
11 *may be used to advocate or promote gun control: Provided*  
12 *further, That the Director may redirect the total amount*  
13 *made available under authority of Public Law 101–502,*  
14 *section 3, dated November 3, 1990, to activities the Director*  
15 *may so designate: Provided further, That the Congress is*  
16 *to be notified promptly of any such transfer: Provided fur-*  
17 *ther, That not to exceed \$10,000,000 may be available for*  
18 *making grants under section 1509 of the Public Health*  
19 *Service Act to not more than 15 States: Provided further,*  
20 *That notwithstanding any other provision of law, a single*  
21 *contract or related contracts for development and construc-*  
22 *tion of facilities may be employed which collectively include*  
23 *the full scope of the project: Provided further, That the solici-*  
24 *tation and contract shall contain the clause “availability*  
25 *of funds” found at 48 CFR 52.232–18: Provided further,*

1 *That in addition to amounts made available under this*  
2 *heading for the National Program of Cancer Registries, an*  
3 *additional \$15,000,000 shall be made available for such*  
4 *Program and special emphasis in carrying out such Pro-*  
5 *gram shall be given to States with the highest number of*  
6 *the leading causes of cancer mortality: Provided further,*  
7 *That amounts made available under this Act for the admin-*  
8 *istrative and related expenses of the Centers for Disease*  
9 *Control and Prevention shall be reduced by \$15,000,000:*  
10 *Provided further, That the funds made available under this*  
11 *heading for section 317A of the Public Health Service Act*  
12 *may be made available for programs operated in accordance*  
13 *with a strategy (developed and implemented by the Director*  
14 *for the Centers for Disease Control and Prevention) to iden-*  
15 *tify and target resources for childhood lead poisoning pre-*  
16 *vention to high-risk populations, including ensuring that*  
17 *any individual or entity that receives a grant under that*  
18 *section to carry out activities relating to childhood lead poi-*  
19 *soning prevention may use a portion of the grant funds*  
20 *awarded for the purpose of funding screening assessments*  
21 *and referrals at sites of operation of the Early Head Start*  
22 *programs under the Head Start Act.*

1                    *NATIONAL INSTITUTES OF HEALTH*

2                    *NATIONAL CANCER INSTITUTE*

3            *For carrying out section 301 and title IV of the Public*  
4 *Health Service Act with respect to cancer, \$3,804,084,000.*

5                    *NATIONAL HEART, LUNG, AND BLOOD INSTITUTE*

6            *For carrying out section 301 and title IV of the Public*  
7 *Health Service Act with respect to cardiovascular, lung,*  
8 *and blood diseases, and blood and blood products,*  
9 *\$2,328,102,000.*

10                  *NATIONAL INSTITUTE OF DENTAL AND CRANIOFACIAL*

11                                  *RESEARCH*

12            *For carrying out section 301 and title IV of the Public*  
13 *Health Service Act with respect to dental disease,*  
14 *\$309,923,000.*

15                  *NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND*

16                                  *KIDNEY DISEASES*

17            *For carrying out section 301 and title IV of the Public*  
18 *Health Service Act with respect to diabetes and digestive*  
19 *and kidney disease, \$1,318,106,000.*

20                  *NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND*

21                                  *STROKE*

22            *For carrying out section 301 and title IV of the Public*  
23 *Health Service Act with respect to neurological disorders*  
24 *and stroke, \$1,189,425,000.*



1            *NATIONAL INSTITUTE OF ARTHRITIS AND*  
2            *MUSCULOSKELETAL AND SKIN DISEASES*

3            *For carrying out section 301 and title IV of the Public*  
4 *Health Service Act with respect to arthritis and musculo-*  
5 *skeletal and skin diseases, \$401,161,000.*

6            *NATIONAL INSTITUTE ON DEAFNESS AND OTHER*  
7            *COMMUNICATION DISORDERS*

8            *For carrying out section 301 and title IV of the Public*  
9 *Health Service Act with respect to deafness and other com-*  
10 *munication disorders, \$303,541,000.*

11           *NATIONAL INSTITUTE OF NURSING RESEARCH*

12           *For carrying out section 301 and title IV of the Public*  
13 *Health Service Act with respect to nursing research,*  
14 *\$106,848,000.*

15           *NATIONAL INSTITUTE ON ALCOHOL ABUSE AND*  
16           *ALCOHOLISM*

17           *For carrying out section 301 and title IV of the Public*  
18 *Health Service Act with respect to alcohol abuse and alco-*  
19 *holism, \$336,848,000.*

20           *NATIONAL INSTITUTE ON DRUG ABUSE*

21           *For carrying out section 301 and title IV of the Public*  
22 *Health Service Act with respect to drug abuse,*  
23 *\$790,038,000.*



1                    *NATIONAL LIBRARY OF MEDICINE*

2            *For carrying out section 301 and title IV of the Public*  
3 *Health Service Act with respect to health information com-*  
4 *munications, \$256,953,000, of which \$4,000,000 shall be*  
5 *available until expended for improvement of information*  
6 *systems: Provided, That in fiscal year 2001, the Library*  
7 *may enter into personal services contracts for the provision*  
8 *of services in facilities owned, operated, or constructed*  
9 *under the jurisdiction of the National Institutes of Health.*

10                    *OFFICE OF THE DIRECTOR*

11                    *(INCLUDING TRANSFER OF FUNDS)*

12            *For carrying out the responsibilities of the Office of*  
13 *the Director, National Institutes of Health, \$352,165,000,*  
14 *of which \$48,271,000 shall be for the Office of AIDS Re-*  
15 *search: Provided, That funding shall be available for the*  
16 *purchase of not to exceed 20 passenger motor vehicles for*  
17 *replacement only: Provided further, That the Director may*  
18 *direct up to 1 percent of the total amount made available*  
19 *in this or any other Act to all National Institutes of Health*  
20 *appropriations to activities the Director may so designate:*  
21 *Provided further, That no such appropriation shall be de-*  
22 *creased by more than 1 percent by any such transfers and*  
23 *that the Congress is promptly notified of the transfer: Pro-*  
24 *vided further, That the National Institutes of Health is au-*  
25 *thorized to collect third party payments for the cost of clin-*  
26 *ical services that are incurred in National Institutes of*

1 *Health research facilities and that such payments shall be*  
2 *credited to the National Institutes of Health Management*  
3 *Fund: Provided further, That all funds credited to the Na-*  
4 *tional Institutes of Health Management Fund shall remain*  
5 *available for one fiscal year after the fiscal year in which*  
6 *they are deposited: Provided further, That up to \$500,000*  
7 *shall be available to carry out section 499 of the Public*  
8 *Health Service Act: Provided further, That, notwith-*  
9 *standing section 499(k)(10) of the Public Health Service*  
10 *Act, funds from the Foundation for the National Institutes*  
11 *of Health may be transferred to the National Institutes of*  
12 *Health.*

13 *BUILDINGS AND FACILITIES*

14 *For the study of, construction of, and acquisition of*  
15 *equipment for, facilities of or used by the National Insti-*  
16 *tutes of Health, including the acquisition of real property,*  
17 *\$148,900,000, to remain available until expended, of which*  
18 *\$47,300,000 shall be for the neuroscience research center:*  
19 *Provided, That notwithstanding any other provision of law,*  
20 *a single contract or related contracts for the development*  
21 *and construction of the first phase of the National Neuro-*  
22 *science Research Center may be employed which collectively*  
23 *include the full scope of the project: Provided further, That*  
24 *the solicitation and contract shall contain the clause “avail-*  
25 *ability of funds” found at 48 CFR 52.232–18.*

1     *SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES*

2                             *ADMINISTRATION*

3     *SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES*

4         *For carrying out titles V and XIX of the Public Health*  
5 *Service Act with respect to substance abuse and mental*  
6 *health services, the Protection and Advocacy for Mentally*  
7 *Ill Individuals Act of 1986, and section 301 of the Public*  
8 *Health Service Act with respect to program management,*  
9 *\$2,730,757,000, of which \$15,000,000 shall remain avail-*  
10 *able until expended to carry out the Fetal Alcohol Syn-*  
11 *drome prevention and services program, of which*  
12 *\$10,000,000 shall be used to provide grants to local non-*  
13 *profit private and public entities to enable such entities to*  
14 *develop and expand activities to provide substance abuse*  
15 *services to homeless individuals: Provided, That in addition*  
16 *to amounts provided herein, \$12,000,000 shall be available*  
17 *from amounts available under section 241 of the Public*  
18 *Health Services Act, to carry out the National Household*  
19 *Survey on Drug Abuse: Provided further, That within the*  
20 *amounts provided herein, \$3,000,000 shall be available for*  
21 *the Center for Mental Health Services to support through*  
22 *grants a certification program to improve and evaluate the*  
23 *effectiveness and responsiveness of suicide hotlines and cri-*  
24 *sis centers in the United States and to help support and*  
25 *evaluate a national hotline and crisis center network.*

1     *AGENCY FOR HEALTHCARE RESEARCH AND QUALITY*

2             *HEALTHCARE RESEARCH AND QUALITY*

3             *For carrying out titles III and IX of the Public Health*  
4 *Service Act, amounts received from Freedom of Information*  
5 *Act fees, reimbursable and interagency agreements, and the*  
6 *sale of data shall be credited to this appropriation and shall*  
7 *remain available until expended: Provided, That the*  
8 *amount made available pursuant to section 926(b) of the*  
9 *Public Health Service Act shall not exceed \$269,943,000.*

10            *HEALTH CARE FINANCING ADMINISTRATION*

11                    *GRANTS TO STATES FOR MEDICAID*

12            *For carrying out, except as otherwise provided, titles*  
13 *XI and XIX of the Social Security Act, \$93,586,251,000,*  
14 *to remain available until expended.*

15            *For making, after May 31, 2001, payments to States*  
16 *under title XIX of the Social Security Act for the last quar-*  
17 *ter of fiscal year 2001 for unanticipated costs, incurred for*  
18 *the current fiscal year, such sums as may be necessary.*

19            *For making payments to States or in the case of sec-*  
20 *tion 1928 on behalf of States under title XIX of the Social*  
21 *Security Act for the first quarter of fiscal year 2002,*  
22 *\$36,207,551,000, to remain available until expended.*

23            *Payment under title XIX may be made for any quarter*  
24 *with respect to a State plan or plan amendment in effect*

1 *during such quarter, if submitted in or prior to such quar-*  
2 *ter and approved in that or any subsequent quarter.*

3 *PAYMENTS TO HEALTH CARE TRUST FUNDS*

4 *For payment to the Federal Hospital Insurance and*  
5 *the Federal Supplementary Medical Insurance Trust*  
6 *Funds, as provided under sections 217(g) and 1844 of the*  
7 *Social Security Act, sections 103(c) and 111(d) of the So-*  
8 *cial Security Amendments of 1965, section 278(d) of Public*  
9 *Law 97–248, and for administrative expenses incurred pur-*  
10 *suant to section 201(g) of the Social Security Act,*  
11 *\$70,381,600,000.*

12 *PROGRAM MANAGEMENT*

13 *For carrying out, except as otherwise provided, titles*  
14 *XI, XVIII, XIX, and XXI of the Social Security Act, titles*  
15 *XIII and XXVII of the Public Health Service Act, and the*  
16 *Clinical Laboratory Improvement Amendments of 1988, not*  
17 *to exceed \$2,018,500,000, to be transferred from the Federal*  
18 *Hospital Insurance and the Federal Supplementary Med-*  
19 *ical Insurance Trust Funds, as authorized by section 201(g)*  
20 *of the Social Security Act; together with all funds collected*  
21 *in accordance with section 353 of the Public Health Service*  
22 *Act and such sums as may be collected from authorized user*  
23 *fees and the sale of data, which shall remain available until*  
24 *expended, and together with administrative fees collected*  
25 *relative to Medicare overpayment recovery activities, which*  
26 *shall remain available until expended: Provided, That all*

1 *funds derived in accordance with 31 U.S.C. 9701 from or-*  
2 *ganizations established under title XIII of the Public Health*  
3 *Service Act shall be credited to and available for carrying*  
4 *out the purposes of this appropriation: Provided further,*  
5 *That \$18,000,000 appropriated under this heading for the*  
6 *managed care system redesign shall remain available until*  
7 *expended: Provided further, That \$3,000,000 of the amount*  
8 *available for research, demonstration, and evaluation ac-*  
9 *tivities shall be available to continue carrying out dem-*  
10 *onstration projects on Medicaid coverage of community-*  
11 *based attendant care services for people with disabilities*  
12 *which ensures maximum control by the consumer to select*  
13 *and manage their attendant care services: Provided further,*  
14 *That the Secretary of Health and Human Services is di-*  
15 *rected to collect fees in fiscal year 2001 from Medi-*  
16 *care + Choice organizations pursuant to section 1857(e)(2)*  
17 *of the Social Security Act and from eligible organizations*  
18 *with risk-sharing contracts under section 1876 of that Act*  
19 *pursuant to section 1876(k)(4)(D) of that Act: Provided fur-*  
20 *ther, That administrative fees collected relative to Medicare*  
21 *overpayment recovery activities shall be transferred to the*  
22 *Health Care Fraud and Abuse Control (HCFAC) account,*  
23 *to be used for Medicare Integrity Program (MIP) activities*  
24 *in addition to the amounts already specified, and shall re-*  
25 *main available until expended.*

1        *ADMINISTRATION FOR CHILDREN AND FAMILIES*2                    *LOW INCOME HOME ENERGY ASSISTANCE*

3        *For making payments under title XXVI of the Omni-*  
4 *bus Reconciliation Act of 1981, \$300,000,000: Provided,*  
5 *That these funds are hereby designated by the Congress to*  
6 *be emergency requirements pursuant to section 251(b)(2)(A)*  
7 *of the Balanced Budget and Emergency Deficit Control Act*  
8 *of 1985: Provided further, That these funds shall be made*  
9 *available only after submission to the Congress of a formal*  
10 *budget request by the President that includes designation*  
11 *of the entire amount of the request as an emergency require-*  
12 *ment as defined in such Act.*

13                    *REFUGEE AND ENTRANT ASSISTANCE*

14        *For making payments for refugee and entrant assist-*  
15 *ance activities authorized by title IV of the Immigration*  
16 *and Nationality Act and section 501 of the Refugee Edu-*  
17 *cation Assistance Act of 1980 (Public Law 96-422),*  
18 *\$418,321,000, to remain available through September 30,*  
19 *2003.*

20        *For carrying out section 5 of the Torture Victims Re-*  
21 *lief Act of 1998 (Public Law 105-320), \$7,265,000.*

22        *PAYMENTS TO STATES FOR CHILD SUPPORT ENFORCEMENT*23                    *AND FAMILY SUPPORT PROGRAMS*

24        *For making payments to States or other non-Federal*  
25 *entities under titles I, IV-D, X, XI, XIV, and XVI of the*  
26 *Social Security Act and the Act of July 5, 1960 (24 U.S.C.*

1 *ch. 9), \$2,473,880,000, to remain available until expended;*  
2 *and for such purposes for the first quarter of fiscal year*  
3 *2002, \$1,000,000,000, to remain available until expended.*

4 *For making payments to each State for carrying out*  
5 *the program of Aid to Families with Dependent Children*  
6 *under title IV–A of the Social Security Act before the effec-*  
7 *tive date of the program of Temporary Assistance to Needy*  
8 *Families (TANF) with respect to such State, such sums as*  
9 *may be necessary: Provided, That the sum of the amounts*  
10 *available to a State with respect to expenditures under such*  
11 *title IV–A in fiscal year 1997 under this appropriation and*  
12 *under such title IV–A as amended by the Personal Respon-*  
13 *sibility and Work Opportunity Reconciliation Act of 1996*  
14 *shall not exceed the limitations under section 116(b) of such*  
15 *Act.*

16 *For making, after May 31 of the current fiscal year,*  
17 *payments to States or other non-Federal entities under ti-*  
18 *ties I, IV–D, X, XI, XIV, and XVI of the Social Security*  
19 *Act and the Act of July 5, 1960 (24 U.S.C. ch. 9), for the*  
20 *last 3 months of the current year for unanticipated costs,*  
21 *incurred for the current fiscal year, such sums as may be*  
22 *necessary.*

23 *PAYMENTS TO STATES FOR THE CHILD CARE AND*  
24 *DEVELOPMENT BLOCK GRANT*

25 *For carrying out sections 658A through 658R of the*  
26 *Omnibus Budget Reconciliation Act of 1981 (The Child*

1 *Care and Development Block Grant Act of 1990), in addi-*  
2 *tion to amounts already appropriated for fiscal year 2001,*  
3 *\$817,328,000: Provided, That of the funds appropriated for*  
4 *fiscal year 2001, \$19,120,000 shall be available for child*  
5 *care resource and referral and school-aged child care activi-*  
6 *ties: Provided further, That of the funds appropriated for*  
7 *fiscal year 2001, in addition to the amounts required to*  
8 *be reserved by the States under section 658G, \$222,672,000*  
9 *shall be reserved by the States for activities authorized*  
10 *under section 658G, of which \$100,000,000 shall be for ac-*  
11 *tivities that improve the quality of infant and toddler child*  
12 *care.*

13 *SOCIAL SERVICES BLOCK GRANT*

14 *For making grants to States pursuant to section 2002*  
15 *of the Social Security Act, \$600,000,000: Provided, That*  
16 *notwithstanding section 2003(c) of such Act, as amended,*  
17 *the amount specified for allocation under such section for*  
18 *fiscal year 2001 shall be \$600,000,000.*

19 *CHILDREN AND FAMILIES SERVICES PROGRAMS*

20 *(INCLUDING RESCISSIONS)*

21 *For carrying out, except as otherwise provided, the*  
22 *Runaway and Homeless Youth Act, the Developmental Dis-*  
23 *abilities Assistance and Bill of Rights Act, the Head Start*  
24 *Act, the Child Abuse Prevention and Treatment Act, the Na-*  
25 *tive American Programs Act of 1974, title II of Public Law*  
26 *95-266 (adoption opportunities), the Adoption and Safe*

1 *Families Act of 1997 (Public Law 105–89), the Abandoned*  
2 *Infants Assistance Act of 1988, part B(1) of title IV and*  
3 *sections 413, 429A, 1110, and 1115 of the Social Security*  
4 *Act; for making payments under the Community Services*  
5 *Block Grant Act, section 473A of the Social Security Act,*  
6 *and title IV of Public Law 105–285; and for necessary ad-*  
7 *ministrative expenses to carry out said Acts and titles I,*  
8 *IV, X, XI, XIV, XVI, and XX of the Social Security Act,*  
9 *the Act of July 5, 1960 (24 U.S.C. ch. 9), the Omnibus*  
10 *Budget Reconciliation Act of 1981, title IV of the Immigra-*  
11 *tion and Nationality Act, section 501 of the Refugee Edu-*  
12 *cation Assistance Act of 1980, section 5 of the Torture Vic-*  
13 *tims Relief Act of 1998 (Public Law 105–320), sections*  
14 *40155, 40211, and 40241 of Public Law 103–322 and sec-*  
15 *tion 126 and titles IV and V of Public Law 100–485,*  
16 *\$7,895,723,000, of which \$5,000,000 shall be made available*  
17 *to provide grants for early childhood learning for young*  
18 *children, of which \$55,928,000, to remain available until*  
19 *September 30, 2002, shall be for grants to States for adop-*  
20 *tion incentive payments, as authorized by section 473A of*  
21 *title IV of the Social Security Act (42 U.S.C. 670–679);*  
22 *of which \$134,074,000, to remain available until expended,*  
23 *shall be for activities authorized by sections 40155, 40211,*  
24 *and 40241 of Public Law 103–322; of which \$606,676,000*  
25 *shall be for making payments under the Community Serv-*

1 *ices Block Grant Act; and of which \$6,267,000,000 shall be*  
2 *for making payments under the Head Start Act, of which*  
3 *\$1,400,000,000 shall become available October 1, 2001 and*  
4 *remain available through September 30, 2002: Provided,*  
5 *That to the extent Community Services Block Grant funds*  
6 *are distributed as grant funds by a State to an eligible enti-*  
7 *ty as provided under the Act, and have not been expended*  
8 *by such entity, they shall remain with such entity for carry-*  
9 *over into the next fiscal year for expenditure by such entity*  
10 *consistent with program purposes: Provided further, That*  
11 *the Secretary shall establish procedures regarding the dis-*  
12 *position of intangible property which permits grant funds,*  
13 *or intangible assets acquired with funds authorized under*  
14 *section 680 of the Community Services Block Grant Act,*  
15 *as amended, to become the sole property of such grantees*  
16 *after a period of not more than 12 years after the end of*  
17 *the grant for purposes and uses consistent with the original*  
18 *grant: Provided further, That amounts made available*  
19 *under this Act for the administrative and related expenses*  
20 *of the Department of Health and Human Services, the De-*  
21 *partment of Labor, and the Department of Education shall*  
22 *be further reduced on a pro rata basis by \$14,137,000.*

23 *Funds appropriated for fiscal year 2000 under section*  
24 *429A(e), part B of title IV of the Social Security Act shall*  
25 *be reduced by \$6,000,000.*

1        *Funds appropriated for fiscal year 2000 under section*  
2 *413(h)(1) of the Social Security Act shall be reduced by*  
3 *\$15,000,000.*

4                    *PROMOTING SAFE AND STABLE FAMILIES*

5        *For carrying out section 430 of the Social Security*  
6 *Act, \$305,000,000.*

7                    *PAYMENTS TO STATES FOR FOSTER CARE AND ADOPTION*

8                                    *ASSISTANCE*

9        *For making payments to States or other non-Federal*  
10 *entities under title IV–E of the Social Security Act,*  
11 *\$4,868,100,000.*

12        *For making payments to States or other non-Federal*  
13 *entities under title IV–E of the Social Security Act, for the*  
14 *first quarter of fiscal year 2002, \$1,735,900,000.*

15                    *ADMINISTRATION ON AGING*

16                                    *AGING SERVICES PROGRAMS*

17        *For carrying out, to the extent not otherwise provided,*  
18 *the Older Americans Act of 1965, as amended, and section*  
19 *398 of the Public Health Service Act, \$954,619,000, of*  
20 *which \$5,000,000 shall be available for activities regarding*  
21 *medication management, screening, and education to pre-*  
22 *vent incorrect medication and adverse drug reactions: Pro-*  
23 *vided, That notwithstanding section 308(b)(1) of the Older*  
24 *Americans Act of 1965, as amended, the amounts available*  
25 *to each State for administration of the State plan under*  
26 *title III of such Act shall be reduced not more than 5 percent*

1 *below the amount that was available to such State for such*  
2 *purpose for fiscal year 1995: Provided further, That in con-*  
3 *sidering grant applications for nutrition services for elder*  
4 *Indian recipients, the Assistant Secretary shall provide*  
5 *maximum flexibility to applicants who seek to take into ac-*  
6 *count subsistence, local customs, and other characteristics*  
7 *that are appropriate to the unique cultural, regional, and*  
8 *geographic needs of the American Indian, Alaska and Ha-*  
9 *waiian Native communities to be served.*

10 *OFFICE OF THE SECRETARY*

11 *GENERAL DEPARTMENTAL MANAGEMENT*

12 *For necessary expenses, not otherwise provided, for*  
13 *general departmental management, including hire of six se-*  
14 *dans, and for carrying out titles III, XVII, and XX of the*  
15 *Public Health Service Act, and the United States-Mexico*  
16 *Border Health Commission Act, \$206,766,000, together*  
17 *with \$5,851,000, to be transferred and expended as author-*  
18 *ized by section 201(g)(1) of the Social Security Act from*  
19 *the Hospital Insurance Trust Fund and the Supplemental*  
20 *Medical Insurance Trust Fund: Provided further, That of*  
21 *the funds made available under this heading for carrying*  
22 *out title XX of the Public Health Service Act, \$10,569,000*  
23 *shall be for activities specified under section 2003(b)(2), of*  
24 *which \$9,131,000 shall be for prevention service demonstra-*  
25 *tion grants under section 510(b)(2) of title V of the Social*

1 *Security Act, as amended, without application of the limi-*  
2 *tation of section 2010(c) of said title XX.*

3 *OFFICE OF INSPECTOR GENERAL*

4 *For expenses necessary for the Office of Inspector Gen-*  
5 *eral in carrying out the provisions of the Inspector General*  
6 *Act of 1978, as amended, \$33,849,000.*

7 *OFFICE FOR CIVIL RIGHTS*

8 *For expenses necessary for the Office for Civil Rights,*  
9 *\$20,742,000, together with not to exceed \$3,314,000, to be*  
10 *transferred and expended as authorized by section 201(g)(1)*  
11 *of the Social Security Act from the Hospital Insurance*  
12 *Trust Fund and the Supplemental Medical Insurance Trust*  
13 *Fund: Provided, That an additional \$2,500,000 shall be*  
14 *made available for the Office for Civil Rights: Provided fur-*  
15 *ther, That amounts made available under this title for the*  
16 *administrative and related expenses of the Department of*  
17 *Health and Human Services shall be reduced by*  
18 *\$2,500,000”.*

19 *POLICY RESEARCH*

20 *For carrying out, to the extent not otherwise provided,*  
21 *research studies under section 1110 of the Social Security*  
22 *Act, \$16,738,000.*

23 *RETIREMENT PAY AND MEDICAL BENEFITS FOR*

24 *COMMISSIONED OFFICERS*

25 *For retirement pay and medical benefits of Public*  
26 *Health Service Commissioned Officers as authorized by law,*

1 *for payments under the Retired Serviceman's Family Pro-*  
2 *tection Plan and Survivor Benefit Plan, for medical care*  
3 *of dependents and retired personnel under the Dependents'*  
4 *Medical Care Act (10 U.S.C. ch. 55), and for payments pur-*  
5 *suant to section 229(b) of the Social Security Act (42*  
6 *U.S.C. 429(b)), such amounts as may be required during*  
7 *the current fiscal year.*

8 *PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY*  
9 *FUND*

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

11 *GENERAL PROVISIONS*

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

16 *SEC. 202. The Secretary shall make available through*  
17 *assignment not more than 60 employees of the Public*  
18 *Health Service to assist in child survival activities and to*  
19 *work in AIDS programs through and with funds provided*  
20 *by the Agency for International Development, the United*  
21 *Nations International Children's Emergency Fund or the*  
22 *World Health Organization.*

23 *SEC. 203. None of the funds appropriated under this*  
24 *Act may be used to implement section 399L(b) of the Public*  
25 *Health Service Act or section 1503 of the National Insti-*

1 *tutes of Health Revitalization Act of 1993, Public Law 103–*  
2 *43.*

3 *SEC. 204. None of the funds appropriated in this Act*  
4 *for the National Institutes of Health and the Substance*  
5 *Abuse and Mental Health Services Administration shall be*  
6 *used to pay the salary of an individual, through a grant*  
7 *or other extramural mechanism, at a rate in excess of Exec-*  
8 *utive Level II.*

9 *SEC. 205. Notwithstanding section 241(a) of the Public*  
10 *Health Service Act, such portion as the Secretary shall de-*  
11 *termine, but not more than 1.6 percent, of any amounts*  
12 *appropriated for programs authorized under the PHS Act*  
13 *shall be made available for the evaluation (directly or by*  
14 *grants or contracts) of the implementation and effectiveness*  
15 *of such programs.*

16 *(TRANSFER OF FUNDS)*

17 *SEC. 206. Not to exceed 1 percent of any discretionary*  
18 *funds (pursuant to the Balanced Budget and Emergency*  
19 *Deficit Control Act of 1985, as amended) which are appro-*  
20 *priated for the current fiscal year for the Department of*  
21 *Health and Human Services in this Act may be transferred*  
22 *between appropriations, but no such appropriation shall be*  
23 *increased by more than 3 percent by any such transfer: Pro-*  
24 *vided, That the Appropriations Committees of both Houses*  
25 *of Congress are notified at least 15 days in advance of any*  
26 *transfer.*

1        *SEC. 207. The Director of the National Institutes of*  
2 *Health, jointly with the Director of the Office of AIDS Re-*  
3 *search, may transfer up to 3 percent among institutes, cen-*  
4 *ters, and divisions from the total amounts identified by*  
5 *these two Directors as funding for research pertaining to*  
6 *the human immunodeficiency virus: Provided, That the*  
7 *Congress is promptly notified of the transfer.*

8        *SEC. 208. Of the amounts made available in this Act*  
9 *for the National Institutes of Health, the amount for re-*  
10 *search related to the human immunodeficiency virus, as*  
11 *jointly determined by the Director of the National Institutes*  
12 *of Health and the Director of the Office of AIDS Research,*  
13 *shall be made available to the “Office of AIDS Research”*  
14 *account. The Director of the Office of AIDS Research shall*  
15 *transfer from such account amounts necessary to carry out*  
16 *section 2353(d)(3) of the Public Health Service Act.*

17        *SEC. 209. None of the funds appropriated in this Act*  
18 *may be made available to any entity under title X of the*  
19 *Public Health Service Act unless the applicant for the*  
20 *award certifies to the Secretary that it encourages family*  
21 *participation in the decision of minors to seek family plan-*  
22 *ning services and that it provides counseling to minors on*  
23 *how to resist attempts to coerce minors into engaging in*  
24 *sexual activities.*

1        *SEC. 210. None of the funds appropriated by this Act*  
2 *(including funds appropriated to any trust fund) may be*  
3 *used to carry out the Medicare+Choice program if the Sec-*  
4 *retary denies participation in such program to an other-*  
5 *wise eligible entity (including a Provider Sponsored Orga-*  
6 *nization) because the entity informs the Secretary that it*  
7 *will not provide, pay for, provide coverage of, or provide*  
8 *referrals for abortions: Provided, That the Secretary shall*  
9 *make appropriate prospective adjustments to the capitation*  
10 *payment to such an entity (based on an actuarially sound*  
11 *estimate of the expected costs of providing the service to such*  
12 *entity's enrollees): Provided further, That nothing in this*  
13 *section shall be construed to change the Medicare program's*  
14 *coverage for such services and a Medicare+Choice organiza-*  
15 *tion described in this section shall be responsible for inform-*  
16 *ing enrollees where to obtain information about all Medi-*  
17 *care covered services.*

18        *SEC. 211. (a) MENTAL HEALTH.—Section 1918(b) of*  
19 *the Public Health Service Act (42 U.S.C. 300x-7(b)) is*  
20 *amended to read as follows:*

21        *“(b) MINIMUM ALLOTMENTS FOR STATES.—Each*  
22 *State's allotment for fiscal year 2001 for programs under*  
23 *this subpart shall not be less than such State's allotment*  
24 *for such programs for fiscal year 2000.”.*

1           (b) *SUBSTANCE ABUSE.*—*Section 1933(b) of the Public*  
2 *Health Service Act (42 U.S.C. 300x–33(b)) is amended to*  
3 *read as follows:*

4           “(b) *MINIMUM ALLOTMENTS FOR STATES.*—*Each*  
5 *State’s allotment for fiscal year 2001 for programs under*  
6 *this subpart shall not be less than such State’s allotment*  
7 *for such programs for fiscal year 2000.”.*

8           *SEC. 212. Notwithstanding any other provision of law,*  
9 *no provider of services under title X of the Public Health*  
10 *Service Act shall be exempt from any State law requiring*  
11 *notification or the reporting of child abuse, child molesta-*  
12 *tion, sexual abuse, rape, or incest.*

13           *SEC. 213. EXTENSION OF CERTAIN ADJUDICATION*  
14 *PROVISIONS.*—*The Foreign Operations, Export Financing,*  
15 *and Related Programs Appropriations Act, 1990 (Public*  
16 *Law 101–167) is amended—*

17                   (1) *in section 599D (8 U.S.C. 1157 note)—*

18                           (A) *in subsection (b)(3), by striking “1997,*  
19                           *1998, 1999, and 2000” and inserting “1997,*  
20                           *1998, 1999, 2000 and 2001”;* and

21                           (B) *in subsection (e), by striking “October*  
22                           *1, 2000” each place it appears and inserting*  
23                           *“October 1, 2001”;* and

1           (2) in section 599E (8 U.S.C. 1255 note) in sub-  
2           section (b)(2), by striking “September 30, 2000” and  
3           inserting “September 30, 2001”.

4           SEC. 214. None of the funds provided in this Act or  
5           in any other Act making appropriations for fiscal year  
6           2001 may be used to administer or implement in Arizona  
7           or in the Kansas City, Missouri or in the Kansas City,  
8           Kansas area the Medicare Competitive Pricing Demonstra-  
9           tion Project (operated by the Secretary of Health and  
10          Human Services).

11          SEC. 215. WITHHOLDING OF SUBSTANCE ABUSE  
12          FUNDS. (a) IN GENERAL.—Except as provided by sub-  
13          section (e) none of the funds appropriated by this Act may  
14          be used to withhold substance abuse funding from a State  
15          pursuant to section 1926 of the Public Health Service Act  
16          (42 U.S.C. 300x–26) if such State certifies to the Secretary  
17          of Health and Human Services by March 1, 2001 that the  
18          State will commit additional State funds, in accordance  
19          with subsection (b), to ensure compliance with State laws  
20          prohibiting the sale of tobacco products to individuals  
21          under 18 years of age.

22          (b) AMOUNT OF STATE FUNDS.—The amount of funds  
23          to be committed by a State under subsection (a) shall be  
24          equal to 1 percent of such State’s substance abuse block  
25          grant allocation for each percentage point by which the

1 *State misses the retailer compliance rate goal established*  
2 *by the Secretary of Health and Human Services under sec-*  
3 *tion 1926 of such Act.*

4       (c) *ADDITIONAL STATE FUNDS.—The State is to main-*  
5 *tain State expenditures in fiscal year 2001 for tobacco pre-*  
6 *vention programs and for compliance activities at a level*  
7 *that is not less than the level of such expenditures main-*  
8 *tained by the State for fiscal year 2000, and adding to that*  
9 *level the additional funds for tobacco compliance activities*  
10 *required under subsection (a). The State is to submit a re-*  
11 *port to the Secretary on all fiscal year 2000 State expendi-*  
12 *tures and all fiscal year 2001 obligations for tobacco pre-*  
13 *vention and compliance activities by program activity by*  
14 *July 31, 2001.*

15       (d) *ENFORCEMENT OF STATE OBLIGATIONS.—The*  
16 *Secretary shall exercise discretion in enforcing the timing*  
17 *of the State obligation of the additional funds required by*  
18 *the certification described in subsection (a) as late as July*  
19 *31, 2001.*

20       (e) *TERRITORIES.—None of the funds appropriated by*  
21 *this Act may be used to withhold substance abuse funding*  
22 *pursuant to section 1926 from a territory that receives less*  
23 *than \$1,000,000.*

24       *SEC. 216. Section 403(a)(3) of the Social Security Act*  
25 *(42 U.S.C. 603(a)(3)) is amended—*

1           (1) *in subparagraph (A)—*

2                   (A) *in clause (i), by striking “and” at the*  
3           *end;*

4                   (B) *in clause (ii)—*

5                           (i) *by striking “1999, 2000, and 2001”*  
6                   *and inserting “1999 and 2000”; and*

7                           (ii) *by striking the period at the end*  
8                   *and inserting “; and”; and*

9                   (C) *by adding at the end the following new*  
10          *clause:*

11                           “(iii) *for fiscal year 2001, a grant in*  
12                   *an amount equal to the amount of the grant*  
13                   *to the State under clause (i) for fiscal year*  
14                   *1998.” and*

15          (2) *in subparagraph (G), by inserting at the*  
16          *end, “Upon enactment, the provisions of this Act that*  
17          *would have been estimated by the Director of the Of-*  
18          *fice of Management and Budget as changing direct*  
19          *spending and receipts for fiscal year 2001 under sec-*  
20          *tion 252 of the Balanced Budget and Emergency Def-*  
21          *icit Control Act of 1985 (Public Law 99–177), to the*  
22          *extent such changes would have been estimated to re-*  
23          *sult in savings in fiscal year 2001 of \$240,000,000 in*  
24          *budget authority and \$122,000,000 in outlays, shall*  
25          *be treated as if enacted in an appropriations act pur-*

1        *suant to Rule 3 of the Budget Scorekeeping Guide-*  
2        *lines set forth in the Joint Explanatory Statement of*  
3        *the Committee of Conference accompanying Con-*  
4        *ference Report No. 105–217, thereby changing discre-*  
5        *tionary spending under section 251 of that Act.”.*

6        *SEC. 217. (a) Notwithstanding Section 2104(f) of the*  
7        *Social Security Act (the Act), the Secretary of Health and*  
8        *Human Services shall reduce the amounts allotted to a*  
9        *State under subsection (b) of the Act for fiscal year 1998*  
10       *by the applicable amount with respect to the State; and*

11       *(b) Notwithstanding Section 2104(a) of the Act, the*  
12       *Secretary shall increase the amount otherwise payable to*  
13       *each State under such subsection for fiscal year 2003 by*  
14       *the amount of the reduction made under paragraph (a) of*  
15       *this section. Funds made available under this subsection*  
16       *shall remain available through September 30, 2004.*

17       *(c) APPLICABLE AMOUNT DEFINED.—In subsection*  
18       *(a), with respect to a State, the term “applicable amount”*  
19       *means, with respect to a State, an amount bearing the same*  
20       *proportion to \$1,900,000,000 as the unexpended balance of*  
21       *its fiscal year 1998 allotment as of September 30, 2000,*  
22       *which would otherwise be redistributed to States in fiscal*  
23       *year 2001 under Section 2104(f) of the Act, bears to the*  
24       *sum of the unexpended balances of fiscal year 1998 allot-*  
25       *ments for all States as of September 30, 2000: Provided,*

1 *That, the applicable amount for a State shall not exceed*  
2 *the unexpended balance of its fiscal year 1998 allotment*  
3 *as of September 30, 2000.*

4 *SEC. 218. SENSE OF THE SENATE ON PREVENTION OF*  
5 *NEEDLESTICK INJURIES. (a) FINDINGS.—The Senate finds*  
6 *that—*

7 *(1) the Centers for Disease Control and Preven-*  
8 *tion reports that American health care workers report*  
9 *600,000 to 800,000 needlestick and sharps injuries*  
10 *each year;*

11 *(2) the occurrence of needlestick injuries is be-*  
12 *lieved to be widely under-reported;*

13 *(3) needlestick and sharps injuries result in at*  
14 *least 1,000 new cases of health care workers with*  
15 *HIV, hepatitis C or hepatitis B every year;*

16 *(4) more than 80 percent of needlestick injuries*  
17 *can be prevented through the use of safer devices; and*

18 *(5) the Occupational Safety and Health Admin-*  
19 *istration's November 1999 Compliance Directive has*  
20 *helped clarify the duty of employers to use safer nee-*  
21 *dle devices to protect their workers. However, millions*  
22 *of State and local government employees are not cov-*  
23 *ered by OSHA's bloodborne pathogen standards and*  
24 *are not protected against the hazards of needlesticks.*

1           **(b) SENSE OF THE SENATE.**—*It is the sense of the Sen-*  
2 *ate that the Senate should pass legislation that would elimi-*  
3 *nate or minimize the significant risk of needlestick injury*  
4 *to health care workers.*

5           **SEC. 219. (a) IN GENERAL.**—*There is appropriated*  
6 *\$10,000,000 that may be used by the Director of the Na-*  
7 *tional Institute for Occupational Safety and Health to—*

8                   (1) *establish and maintain a national database*  
9 *on existing needleless systems and sharps with engi-*  
10 *neered sharps injury protections;*

11                   (2) *develop a set of evaluation criteria for use by*  
12 *employers, employees, and other persons when they*  
13 *are evaluating and selecting needleless systems and*  
14 *sharps with engineered sharps injury protections;*

15                   (3) *develop a model training curriculum to train*  
16 *employers, employees, and other persons on the proc-*  
17 *ess of evaluating needleless systems and sharps with*  
18 *engineered sharps injury protections and to the extent*  
19 *feasible to provide technical assistance to persons who*  
20 *request such assistance; and*

21                   (4) *establish a national system to collect com-*  
22 *prehensive data on needlestick injuries to health care*  
23 *workers, including data on mechanisms to analyze*  
24 *and evaluate prevention interventions in relation to*  
25 *needlestick injury occurrence.*

1       (b) *DEFINITIONS.—In this section:*

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

6           (2) *ENGINEERED SHARPS INJURY PROTEC-*  
7 *TIONS.—The term “engineered sharps injury protec-*  
8 *tions” means—*

9                   (A) *a physical attribute built into a needle*  
10 *device used for withdrawing body fluids, access-*  
11 *ing a vein or artery, or administering medica-*  
12 *tions or other fluids, that effectively reduces the*  
13 *risk of an exposure incident by a mechanism*  
14 *such as barrier creation, blunting, encapsulation,*  
15 *withdrawal, retraction, destruction, or other ef-*  
16 *fective mechanisms; or*

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

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

24                   (A) *the withdrawal of body fluids after ini-*  
25 *tial venous or arterial access is established;*

1                   (B) *the administration of medication or*  
2                   *fluids; and*

3                   (C) *any other procedure involving the po-*  
4                   *tential for an exposure incident.*

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

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

16                  (c) *OFFSET.—Amounts made available under this Act*  
17                  *for the travel, consulting, and printing services for the De-*  
18                  *partment of Labor, the Department of Health and Human*  
19                  *Services, and the Department of Education shall be reduced*  
20                  *on a pro rata basis by \$10,000,000.*

21                  *SEC. 220. None of the funds made available under this*  
22                  *Act may be made available to any entity under the Public*  
23                  *Health Service Act after September 1, 2001, unless the Di-*  
24                  *rector of the National Institutes of Health has provided to*  
25                  *the Chairman and Ranking Member of the Senate Commit-*

1 *tees on Appropriations, and Health, Education, Labor, and*  
2 *Pensions a proposal to require a reasonable rate of return*  
3 *on both intramural and extramural research by March 31,*  
4 *2001.*

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

7 *(1) the experiences of hospitals in the United*  
8 *States in obtaining reimbursement from foreign*  
9 *health insurance companies whose enrollees receive*  
10 *medical treatment in the United States;*

11 *(2) the identity of the foreign health insurance*  
12 *companies that do not cooperate with or reimburse*  
13 *(in whole or in part) United States health care pro-*  
14 *viders for medical services rendered in the United*  
15 *States to enrollees who are foreign nationals;*

16 *(3) the amount of unreimbursed services that*  
17 *hospitals in the United States provide to foreign na-*  
18 *tionals described in paragraph (2); and*

19 *(4) solutions to the problems identified in the*  
20 *study.*

21 *(b) REPORT.—Not later than March 31, 2001, the Sec-*  
22 *retary of Health and Human Services shall prepare and*  
23 *submit to the Committee on Health, Education, Labor, and*  
24 *Pensions of the Senate and the Committee on Appropria-*  
25 *tions, a report concerning the results of the study conducted*

1 *under subsection (a), including the recommendations de-*  
2 *scribed in paragraph (4) of such subsection.*

3 *SEC. 222. NATIONAL INSTITUTE OF CHILD HEALTH*  
4 *AND HUMAN DEVELOPMENT. Section 448 of the Public*  
5 *Health Service Act (42 U.S.C. 285g) is amended by insert-*  
6 *ing “gynecologic health,” after “with respect to”.*

7 *SEC. 223. In addition to amounts otherwise appro-*  
8 *priated under this title for the Centers for Disease Control*  
9 *and Prevention, \$37,500,000, to be utilized to provide*  
10 *grants to States and political subdivisions of States under*  
11 *section 317 of the Public Health Service Act to enable such*  
12 *States and political subdivisions to carry out immuniza-*  
13 *tion infrastructure and operations activities: Provided,*  
14 *That of the total amount made available in this Act for*  
15 *infrastructure funding for the Centers for Disease Control*  
16 *and Prevention, not less than 10 percent shall be used for*  
17 *immunization projects in areas with low or declining im-*  
18 *munization rates or areas that are particularly susceptible*  
19 *to disease outbreaks, and not more than 14 percent shall*  
20 *be used to carry out the incentive bonus program: Provided*  
21 *further, That amounts made available under this Act for*  
22 *the administrative and related expenses of the Department*  
23 *of Health and Human Services, the Department of Labor,*  
24 *and the Department of Education shall be further reduced*  
25 *on a pro rata basis by \$37,500,000.*

1        *SEC. 224. None of the funds appropriated under this*  
2 *Act shall be expended by the National Institutes of Health*  
3 *on a contract for the care of the 288 chimpanzees acquired*  
4 *by the National Institutes of Health from the Coulston*  
5 *Foundation, unless the contractor is accredited by the Asso-*  
6 *ciation for the Assessment and Accreditation of Laboratory*  
7 *Animal Care International or has a Public Health Services*  
8 *assurance, and has not been charged multiple times with*  
9 *egregious violations of the Animal Welfare Act.*

10        *SEC. 225. (a) In addition to amounts made available*  
11 *under the heading “Health Resources and Services Admin-*  
12 *istration-Health Resources and Services” for poison preven-*  
13 *tion and poison control center activities, there shall be*  
14 *available an additional \$20,000,000 to provide assistance*  
15 *for such activities and to stabilize the funding of regional*  
16 *poison control centers as provided for pursuant to the Poi-*  
17 *son Control Center Enhancement and Awareness Act (Pub-*  
18 *lic Law 106–174).*

19        *(b) Amounts made available under this Act for the ad-*  
20 *ministrative and related expenses of the Department of*  
21 *Health and Human Services, the Department of Labor, and*  
22 *the Department of Education shall be further reduced on*  
23 *a pro rata basis by \$20,000,000.*

1        *SEC. 226. SENSE OF THE SENATE REGARDING THE*  
2 *DELIVERY OF EMERGENCY MEDICAL SERVICES. (a) FIND-*  
3 *INGS.—The Senate finds the following:*

4            (1) *Several States have developed and imple-*  
5 *mented a unique 2-tiered emergency medical services*  
6 *system that effectively provides services to the resi-*  
7 *dents of those States.*

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

12           (3) *These 2-tiered systems have provided uni-*  
13 *versal access for residents of those States to affordable*  
14 *emergency services, while simultaneously ensuring*  
15 *that those persons in need of the most advanced care*  
16 *receive such care from the proper authorities.*

17           (4) *One State's 2-tiered system currently has an*  
18 *estimated 20,000 emergency medical technicians pro-*  
19 *viding ambulance transportation for basic life sup-*  
20 *port and advanced life support emergencies, over 80*  
21 *percent of which are handled by volunteers who are*  
22 *not reimbursed under the medicare program under*  
23 *title XVIII of the Social Security Act.*

24           (5) *The hospital-based paramedics, also known*  
25 *as mobile intensive care units, are reimbursed under*

1        *the medicare program when they respond to advanced*  
2        *life support emergencies.*

3            (6) *These 2-tiered State health systems save the*  
4        *lives of thousands of residents of those States each*  
5        *year, while saving the medicare program, in some in-*  
6        *stances, as much as \$39,000,000 in reimbursement*  
7        *fees.*

8            (7) *When Congress requested that the Health*  
9        *Care Financing Administration enact changes to the*  
10       *emergency medical services fee schedule as a result of*  
11       *the Balanced Budget Act of 1997, including a general*  
12       *overhaul of reimbursement rates and administrative*  
13       *costs, it was in the spirit of streamlining the agency,*  
14       *controlling skyrocketing health care costs, and length-*  
15       *ening the solvency of the medicare program.*

16           (8) *The Health Care Financing Administration*  
17       *is considering implementing new emergency medical*  
18       *services reimbursement guidelines that may desta-*  
19       *bilize the 2-tier system that has developed in these*  
20       *States.*

21        (b) *SENSE OF THE SENATE.—It is the sense of the Sen-*  
22       *ate that the Health Care Financing Administration*  
23       *should—*

24            (1) *consider the unique nature of 2-tiered emer-*  
25       *gency medical services delivery systems when imple-*

1 *menting new reimbursement guidelines for para-*  
2 *medics and hospitals under the medicare program*  
3 *under title XVIII of the Social Security Act; and*

4 *(2) promote innovative emergency medical serv-*  
5 *ice systems enacted by States that reduce reimburse-*  
6 *ment costs to the medicare program while ensuring*  
7 *that all residents receive quick and appropriate emer-*  
8 *gency care when needed.*

9 *SEC. 227. SENSE OF THE SENATE REGARDING IM-*  
10 *PACTS OF THE BALANCED BUDGET ACT OF 1997. (a) FIND-*  
11 *INGS.—The Senate makes the following findings:*

12 *(1) Since its passage in 1997, the Balanced*  
13 *Budget Act of 1997 has drastically cut payments*  
14 *under the medicare program under title XVIII of the*  
15 *Social Security Act in the areas of hospital, home*  
16 *health, and skilled nursing care, among others. While*  
17 *Congress intended to cut approximately*  
18 *\$100,000,000,000 from the medicare program over 5*  
19 *years, recent estimates put the actual cut at over*  
20 *\$200,000,000,000.*

21 *(2) A recent study on home health care found*  
22 *that nearly 70 percent of hospital discharge planners*  
23 *surveyed reported a greater difficulty obtaining home*  
24 *health services for medicare beneficiaries as a result*  
25 *of the Balanced Budget Act of 1997.*

1           (3) *According to the Medicare Payment Advisory*  
2           *Commission, rural hospitals were disproportionately*  
3           *affected by the Balanced Budget Act of 1997, drop-*  
4           *ping the inpatient margins of such hospitals over 4*  
5           *percentage points in 1998.*

6           (b) *SENSE OF SENATE.—It is the sense of the Senate*  
7           *that Congress and the President should act expeditiously*  
8           *to alleviate the adverse impacts of the Balanced Budget Act*  
9           *of 1997 on beneficiaries under the medicare program under*  
10          *title XVIII of the Social Security Act and health care pro-*  
11          *viders participating in such program.*

12           *TITLE III—DEPARTMENT OF EDUCATION*

13           *OFFICE OF ELEMENTARY AND SECONDARY EDUCATION*

14                           *EDUCATION REFORM*

15           *For carrying out activities authorized by title IV of*  
16           *the Goals 2000: Educate America Act as in effect prior to*  
17           *September 30, 2000, and sections 3122, 3132, 3136, and*  
18           *3141, parts B, C, and D of title III, and part I of title*  
19           *X of the Elementary and Secondary Education Act of 1965,*  
20           *\$1,434,500,000, of which \$40,000,000 shall be for the Goals*  
21           *2000: Educate America Act, and of which \$192,000,000*  
22           *shall be for section 3122: Provided, That up to one-half of*  
23           *1 percent of the amount available under section 3132 shall*  
24           *be set aside for the outlying areas, to be distributed on the*  
25           *basis of their relative need as determined by the Secretary*

1 *in accordance with the purposes of the program: Provided*  
2 *further, That if any State educational agency does not*  
3 *apply for a grant under section 3132, that State's allotment*  
4 *under section 3131 shall be reserved by the Secretary for*  
5 *grants to local educational agencies in that State that apply*  
6 *directly to the Secretary according to the terms and condi-*  
7 *tions published by the Secretary in the Federal Register:*  
8 *Provided further, That, notwithstanding part I of title X*  
9 *of the Elementary and Secondary Education Act of 1965*  
10 *or any other provision of law, a community-based organiza-*  
11 *tion that has experience in providing before- and after-*  
12 *school services shall be eligible to receive a grant under that*  
13 *part, on the same basis as a school or consortium described*  
14 *in section 10904 of that Act, and the Secretary shall give*  
15 *priority to any application for such a grant that is sub-*  
16 *mitted jointly by such a community-based organization and*  
17 *such a school or consortium.*

18 *EDUCATION FOR THE DISADVANTAGED*

19 *For carrying out title I of the Elementary and Sec-*  
20 *ondary Education Act of 1965, and section 418A of the*  
21 *Higher Education Act of 1965, \$8,986,800,000, of which*  
22 *\$2,729,958,000 shall become available on July 1, 2001, and*  
23 *shall remain available through September 30, 2002, and of*  
24 *which \$6,223,342,000 shall become available on October 1,*  
25 *2001 and shall remain available through September 30,*  
26 *2002, for academic year 2000–2001: Provided, That*

1 \$7,113,403,000 shall be available for basic grants under sec-  
2 tion 1124: Provided further, That up to \$3,500,000 of these  
3 funds shall be available to the Secretary on October 1, 2000,  
4 to obtain updated local educational agency level census pov-  
5 erty data from the Bureau of the Census: Provided further,  
6 That \$1,222,397,000 shall be available for concentration  
7 grants under section 1124A: Provided further, That grant  
8 awards under sections 1124 and 1124A of title I of the Ele-  
9 mentary and Secondary Education Act of 1965 shall be  
10 made to each State and local educational agency at no less  
11 than 100 percent of the amount such State or local edu-  
12 cational agency received under this authority for fiscal year  
13 2000: Provided further, That notwithstanding any other  
14 provision of law, grant awards under section 1124A of title  
15 I of the Elementary and Secondary Education Act of 1965  
16 shall be made to those local educational agencies that re-  
17 ceived a Concentration Grant under the Department of  
18 Education Appropriations Act, 2000, but are not eligible  
19 to receive such a grant for fiscal year 2001: Provided fur-  
20 ther, That each such local educational agency shall receive  
21 an amount equal to the Concentration Grant the agency  
22 received in fiscal year 2000, ratably reduced, if necessary,  
23 to ensure that these local educational agencies receive no  
24 greater share of their hold-harmless amounts than other  
25 local educational agencies: Provided further, That notwith-

1 *standing any other provision of law, in calculating the*  
2 *amount of Federal assistance awarded to a State or local*  
3 *educational agency under any program under title I of the*  
4 *Elementary and Secondary Education Act of 1965 (20*  
5 *U.S.C. 6301 et seq.) on the basis of a formula described in*  
6 *section 1124 or 1124A of such Act (20 U.S.C. 6333, 6334),*  
7 *any funds appropriated for the program in excess of the*  
8 *amount appropriated for the program for fiscal year 2000*  
9 *shall be awarded according to the formula, except that, for*  
10 *such purposes, the formula shall be applied only to States*  
11 *or local educational agencies that experience a reduction*  
12 *under the program for fiscal year 2001 as a result of the*  
13 *application of the 100 percent hold harmless provisions*  
14 *under the heading “Education for the Disadvantaged”: Pro-*  
15 *vided further, That the Secretary shall not take into account*  
16 *the hold harmless provisions in this section in determining*  
17 *State allocations under any other program administered by*  
18 *the Secretary in any fiscal year.*

19 *IMPACT AID*

20 *For carrying out programs of financial assistance to*  
21 *federally affected schools authorized by title VIII of the Ele-*  
22 *mentary and Secondary Education Act of 1965,*  
23 *\$1,030,000,000, of which \$818,000,000 shall be for basic*  
24 *support payments under section 8003(b), \$50,000,000 shall*  
25 *be for payments for children with disabilities under section*  
26 *8003(d), \$82,000,000, to remain available until expended,*

1 shall be for payments under section 8003(f), \$35,000,000  
2 shall be for construction under section 8007, \$47,000,000  
3 shall be for Federal property payments under section 8002  
4 and \$8,000,000 to remain available until expended shall  
5 be for facilities maintenance under section 8008: Provided,  
6 That amounts made available under this Act for the admin-  
7 istrative and related expenses of the Department of Health  
8 and Human Services, the Department of Labor, and the  
9 Department of Education shall be further reduced on a pro  
10 rata basis by \$10,000,000.

11 *SCHOOL IMPROVEMENT PROGRAMS*

12 *For carrying out school improvement activities author-*  
13 *ized by titles II, IV, V–A and B, VI, IX, X, and XIII of*  
14 *the Elementary and Secondary Education Act of 1965*  
15 *(“ESEA”); the Stewart B. McKinney Homeless Assistance*  
16 *Act; and the Civil Rights Act of 1964 and part B of title*  
17 *VIII of the Higher Education Act of 1965; \$4,672,534,000,*  
18 *of which \$1,100,200,000 shall become available on July 1,*  
19 *2001, and remain available through September 30, 2002,*  
20 *and of which \$2,915,000,000 shall become available on Oc-*  
21 *tober 1, 2001 and shall remain available through September*  
22 *30, 2002 for academic year 2001–2002: Provided, That of*  
23 *the amount appropriated, \$435,000,000 shall be for Eisen-*  
24 *hower professional development State grants under title II–*  
25 *B and \$3,100,000,000 shall be for title VI and up to*  
26 *\$750,000 shall be for an evaluation of comprehensive re-*

1 gional assistance centers under title XIII of ESEA: Pro-  
2 vided further, That of the amount made available for Title  
3 VI, \$2,700,000,000 shall be available, notwithstanding any  
4 other provision of law, for purposes consistent with title VI  
5 to be determined by the local education agency as part of  
6 a local strategy for improving academic achievement: Pro-  
7 vided further, That these funds may also be used to address  
8 the shortage of highly qualified teachers to reduce class size,  
9 particularly in early grades, using highly qualified teachers  
10 to improve educational achievement for regular and special  
11 needs children; to support efforts to recruit, train and re-  
12 train highly qualified teachers; to carry out part B of the  
13 Individuals with Disabilities Education Act (20 U.S.C.  
14 1411 et seq.); or for school construction and renovation of  
15 facilities, at the sole discretion of the local educational agen-  
16 cy: Provided further, That funds made available under this  
17 heading to carry out section 6301(b) of the Elementary and  
18 Secondary Education Act of 1965 shall be available for edu-  
19 cation reform projects that provide same gender schools and  
20 classrooms, consistent with applicable law: Provided fur-  
21 ther, That of the amount made available under this heading  
22 for activities carried out through the Fund for the Improve-  
23 ment of Education under part A of title X, \$10,000,000  
24 shall be made available to enable the Secretary of Education

1 *to award grants to develop and implement school dropout*  
2 *prevention programs.*

3 *READING EXCELLENCE*

4 *For necessary expenses to carry out the Reading Excel-*  
5 *lence Act, \$91,000,000, which shall become available on*  
6 *July 1, 2001 and shall remain available through September*  
7 *30, 2002 and \$195,000,000 which shall become available on*  
8 *October 1, 2001 and remain available through September*  
9 *30, 2002.*

10 *INDIAN EDUCATION*

11 *For expenses necessary to carry out, to the extent not*  
12 *otherwise provided, title IX, part A of the Elementary and*  
13 *Secondary Education Act of 1965, as amended,*  
14 *\$115,500,000.*

15 *OFFICE OF BILINGUAL EDUCATION AND MINORITY*

16 *LANGUAGES AFFAIRS*

17 *BILINGUAL AND IMMIGRANT EDUCATION*

18 *For carrying out, to the extent not otherwise provided,*  
19 *bilingual, foreign language and immigrant education ac-*  
20 *tivities authorized by parts A and C and section 7203 of*  
21 *title VII of the Elementary and Secondary Education Act*  
22 *of 1965, without regard to section 7103(b), \$443,000,000:*  
23 *Provided, That State educational agencies may use all, or*  
24 *any part of, their part C allocation for competitive grants*  
25 *to local educational agencies.*

1     *OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE*  
2                                     *SERVICES*  
3                                     *SPECIAL EDUCATION*

4         *For carrying out the Individuals with Disabilities*  
5 *Education Act, \$7,352,341,000, of which \$2,464,452,000*  
6 *shall become available for obligation on July 1, 2001, and*  
7 *shall remain available through September 30, 2002, and of*  
8 *which \$4,624,000,000 shall become available on October 1,*  
9 *2001 and shall remain available through September 30,*  
10 *2002, for academic year 2001–2002: Provided, That*  
11 *\$1,500,000 shall be for the recipient of funds provided by*  
12 *Public Law 105–78 under section 687(b)(2)(G) of the Act*  
13 *to provide information on diagnosis, intervention, and*  
14 *teaching strategies for children with disabilities: Provided*  
15 *further, That the amount for section 611(c) of the Act shall*  
16 *be equal to the amount available for that section under Pub-*  
17 *lic Law 106–113, increased by the rate of inflation as speci-*  
18 *fied in section 611(f)(1)(B)(i) of the Act.*

19     *REHABILITATION SERVICES AND DISABILITY RESEARCH*

20         *For carrying out, to the extent not otherwise provided,*  
21 *the Rehabilitation Act of 1973, the Assistive Technology Act*  
22 *of 1998, and the Helen Keller National Center Act,*  
23 *\$2,799,519,000: Provided, That notwithstanding section*  
24 *105(b)(1) of the Assistive Technology Act of 1998 (“the AT*  
25 *Act”), each State shall be provided \$50,000 for activities*  
26 *under section 102 of the AT Act: Provided further, That*

1 *notwithstanding section 105(b)(1) and section 101(f)(2)*  
2 *and (3) of the Assistive Technology Act of 1998, each State*  
3 *shall be provided a minimum of \$500,000 for activities*  
4 *under section 101: Provided further, That \$7,000,000 shall*  
5 *be used to support grants for up to three years to states*  
6 *under title III of the AT Act, of which the Federal share*  
7 *shall not exceed 75 percent in the first year, 50 percent in*  
8 *the second year, and 25 percent in the third year, and that*  
9 *the requirements in section 301(c)(2) and section 302 of*  
10 *that Act shall not apply to such grants.*

11 *SPECIAL INSTITUTIONS FOR PERSONS WITH DISABILITIES*

12 *AMERICAN PRINTING HOUSE FOR THE BLIND*

13 *For carrying out the Act of March 3, 1879, as amended*  
14 *(20 U.S.C. 101 et seq.), \$12,500,000.*

15 *NATIONAL TECHNICAL INSTITUTE FOR THE DEAF*

16 *For the National Technical Institute for the Deaf*  
17 *under titles I and II of the Education of the Deaf Act of*  
18 *1986 (20 U.S.C. 4301 et seq.), \$54,366,000, of which*  
19 *\$7,176,000 shall be for construction and shall remain avail-*  
20 *able until expended: Provided, That from the total amount*  
21 *available, the Institute may at its discretion use funds for*  
22 *the endowment program as authorized under section 207.*

23 *GALLAUDET UNIVERSITY*

24 *For the Kendall Demonstration Elementary School,*  
25 *the Model Secondary School for the Deaf, and the partial*  
26 *support of Gallaudet University under titles I and II of*

1 *the Education of the Deaf Act of 1986 (20 U.S.C. 4301 et*  
2 *seq.), \$87,650,000: Provided, That from the total amount*  
3 *available, the University may at its discretion use funds*  
4 *for the endowment program as authorized under section*  
5 *207.*

6 *OFFICE OF VOCATIONAL AND ADULT EDUCATION*

7 *VOCATIONAL AND ADULT EDUCATION*

8 *For carrying out, to the extent not otherwise provided,*  
9 *the Carl D. Perkins Vocational and Technical Education*  
10 *Act, the Adult Education and Family Literacy Act, and*  
11 *title VIII–D of the Higher Education Act of 1965, as*  
12 *amended, and Public Law 102–73, \$1,726,600,000, of which*  
13 *\$1,000,000 shall remain available until expended, and of*  
14 *which \$929,000,000 shall become available on July 1, 2001*  
15 *and shall remain available through September 30, 2002 and*  
16 *of which \$791,000,000 shall become available on October 1,*  
17 *2001 and shall remain available through September 30,*  
18 *2002: Provided, That of the amounts made available for the*  
19 *Carl D. Perkins Vocational and Technical Education Act,*  
20 *\$5,600,000 shall be for tribally controlled postsecondary vo-*  
21 *catinal and technical institutions under section 117: Pro-*  
22 *vided further, That \$9,000,000 shall be for carrying out sec-*  
23 *tion 118 of such Act: Provided further, That up to 15 per-*  
24 *cent of the funds provided may be used by the national enti-*  
25 *ty designated under section 118(a) to cover the cost of au-*

1 *thorized activities and operations, including Federal sala-*  
2 *ries and expenses: Provided further, That the national enti-*  
3 *ty is authorized, effective upon enactment, to charge fees*  
4 *for publications, training, and technical assistance devel-*  
5 *oped by that national entity: Provided further, That reve-*  
6 *nues received from publications and delivery of technical*  
7 *assistance and training, notwithstanding 31 U.S.C. 3302,*  
8 *may be credited to the national entity's account and shall*  
9 *be available to the national entity, without fiscal year limi-*  
10 *tation, so long as such revenues are used for authorized ac-*  
11 *tivities and operations of the national entity: Provided fur-*  
12 *ther, That of the funds made available to carry out section*  
13 *204 of the Perkins Act, all funds that a State receives in*  
14 *excess of its prior-year allocation shall be competitively*  
15 *awarded: Provided further, That in making these awards,*  
16 *each State shall give priority to consortia whose applica-*  
17 *tions most effectively integrate all components under section*  
18 *204(c): Provided further, That of the amounts made avail-*  
19 *able for the Carl D. Perkins Vocational and Technical Edu-*  
20 *cation Act, \$5,000,000 shall be for demonstration activities*  
21 *authorized by section 207: Provided further, That of the*  
22 *amounts made available for the Adult Education and Fam-*  
23 *ily Literacy Act, \$14,000,000 shall be for national leader-*  
24 *ship activities under section 243 and \$6,500,000 shall be*  
25 *for the National Institute for Literacy under section 242:*

1 *Provided further, That \$22,000,000 shall be for Youth Of-*  
2 *fender Grants, of which \$5,000,000 shall be used in accord-*  
3 *ance with section 601 of Public Law 102–73 as that section*  
4 *was in effect prior to the enactment of Public Law 105–*  
5 *220: Provided further, That of the amounts made available*  
6 *for title I of the Perkins Act, the Secretary may reserve up*  
7 *to 0.54 percent for incentive grants under section 503 of*  
8 *the Workforce Investment Act, without regard to section*  
9 *111(a)(1)(C) of the Perkins Act: Provided further, That of*  
10 *the amounts made available for the Adult Education and*  
11 *Family Literacy Act, the Secretary may reserve up to 0.54*  
12 *percent for incentive grants under section 503 of the Work-*  
13 *force Investment Act, without regard to section 211(a)(3)*  
14 *of the Adult Education and Family Literacy Act.*

15 *OFFICE OF STUDENT FINANCIAL ASSISTANCE*

16 *STUDENT FINANCIAL ASSISTANCE*

17 *For carrying out subparts 1, 3 and 4 of part A, part*  
18 *C and part E of title IV of the Higher Education Act of*  
19 *1965, as amended, \$10,624,000,000, which shall remain*  
20 *available through September 30, 2002.*

21 *The maximum Pell Grant for which a student shall*  
22 *be eligible during award year 2001–2002 shall be \$3,650:*  
23 *Provided, That notwithstanding section 401(g) of the Act,*  
24 *if the Secretary determines, prior to publication of the pay-*  
25 *ment schedule for such award year, that the amount in-*

1 *cluded within this appropriation for Pell Grant awards in*  
2 *such award year, and any funds available from the fiscal*  
3 *year 2000 appropriation for Pell Grant awards, are insuffi-*  
4 *cient to satisfy fully all such awards for which students are*  
5 *eligible, as calculated under section 401(b) of the Act, the*  
6 *amount paid for each such award shall be reduced by either*  
7 *a fixed or variable percentage, or by a fixed dollar amount,*  
8 *as determined in accordance with a schedule of reductions*  
9 *established by the Secretary for this purpose.*

10 *FEDERAL FAMILY EDUCATION LOAN PROGRAM ACCOUNT*

11 *For Federal administrative expenses to carry out*  
12 *guaranteed student loans authorized by title IV, part B, of*  
13 *the Higher Education Act of 1965, as amended,*  
14 *\$48,000,000.*

15 *OFFICE OF POSTSECONDARY EDUCATION*

16 *HIGHER EDUCATION*

17 *For carrying out, to the extent not otherwise provided,*  
18 *section 121 and titles II, III, IV, V, VI, VII, and VIII of*  
19 *the Higher Education Act of 1965, as amended, and the*  
20 *Mutual Educational and Cultural Exchange Act of 1961;*  
21 *\$1,694,520,000, of which \$10,000,000 for interest subsidies*  
22 *authorized by section 121 of the Higher Education Act of*  
23 *1965, shall remain available until expended: Provided, That*  
24 *\$11,000,000, to remain available through September 30,*  
25 *2002, shall be available to fund fellowships under part A,*  
26 *subpart 1 of title VII of said Act, of which up to \$1,000,000*

1 *shall be available to fund fellowships for academic year*  
2 *2001–2002, and the remainder shall be available to fund*  
3 *fellowships for academic year 2002–2003: Provided further,*  
4 *That \$3,000,000 is for data collection and evaluation ac-*  
5 *tivities for programs under the Higher Education Act of*  
6 *1965, including such activities needed to comply with the*  
7 *Government Performance and Results Act of 1993: Provided*  
8 *further, That section 404F(a) of the Higher Education*  
9 *Amendments of 1998 is amended by striking out “using*  
10 *funds appropriated under section 404H that do not exceed*  
11 *\$200,000” and inserting in lieu thereof “using not more*  
12 *than 0.2 percent of the funds appropriated under section*  
13 *404H”.*

14 *HOWARD UNIVERSITY*

15 *For partial support of Howard University (20 U.S.C.*  
16 *121 et seq.), \$224,000,000, of which not less than \$3,530,000*  
17 *shall be for a matching endowment grant pursuant to the*  
18 *Howard University Endowment Act (Public Law 98–480)*  
19 *and shall remain available until expended.*

20 *COLLEGE HOUSING AND ACADEMIC FACILITIES LOANS*

21 *PROGRAM*

22 *For Federal administrative expenses authorized under*  
23 *section 121 of the Higher Education Act of 1965, \$737,000*  
24 *to carry out activities related to existing facility loans en-*  
25 *tered into under the Higher Education Act of 1965.*

1 *HISTORICALLY BLACK COLLEGE AND UNIVERSITY CAPITAL*  
2 *FINANCING PROGRAM ACCOUNT*

3 *The total amount of bonds insured pursuant to section*  
4 *344 of title III, part D of the Higher Education Act of 1965*  
5 *shall not exceed \$357,000,000, and the cost, as defined in*  
6 *section 502 of the Congressional Budget Act of 1974, of such*  
7 *bonds shall not exceed zero.*

8 *For administrative expenses to carry out the Histori-*  
9 *cally Black College and University Capital Financing Pro-*  
10 *gram entered into pursuant to title III, part D of the High-*  
11 *er Education Act of 1965, as amended, \$208,000.*

12 *OFFICE OF EDUCATIONAL RESEARCH AND IMPROVEMENT*  
13 *EDUCATION RESEARCH, STATISTICS, AND IMPROVEMENT*

14 *For carrying out activities authorized by the Edu-*  
15 *cational Research, Development, Dissemination, and Im-*  
16 *provement Act of 1994, including part E; the National*  
17 *Education Statistics Act of 1994, including sections 411*  
18 *and 412; section 2102 of title II, and parts A, B, and K*  
19 *and section 10102, section 10105, and 10601 of title X, and*  
20 *part C of title XIII of the Elementary and Secondary Edu-*  
21 *cation Act of 1965, as amended, and title VI of Public Law*  
22 *103–227, \$506,519,000, of which \$250,000 shall be for the*  
23 *Web-Based Education Commission: Provided, That of the*  
24 *funds appropriated under section 10601 of title X of the*  
25 *Elementary and Secondary Education Act of 1965, as*

1 amended, \$1,500,000 shall be used to conduct a violence pre-  
2 vention demonstration program: Provided further, That of  
3 the funds appropriated \$5,000,000 shall be made available  
4 for a high school State grant program to improve academic  
5 performance and provide technical skills training,  
6 \$5,000,000 shall be made available to provide grants to en-  
7 able elementary and secondary schools to provide physical  
8 education and improve physical fitness: Provided further,  
9 That \$50,000,000 of the funds provided for the national  
10 education research institutes shall be allocated notwith-  
11 standing section 912(m)(1)(B–F) and subparagraphs (B)  
12 and (C) of section 931(c)(2) of Public Law 103–227 and  
13 \$20,000,000 of that \$50,000,000 shall be made available for  
14 the Interagency Education Research Initiative: Provided  
15 further, That the amounts made available under this Act  
16 for the administrative and related expenses of the Depart-  
17 ment of Health and Human Services, the Department of  
18 Labor, and the Department of Education shall be further  
19 reduced on a pro rata basis by \$10,000,000: Provided fur-  
20 ther, That of the funds available for section 10601 of title  
21 X of the Elementary and Secondary Education Act of 1965,  
22 as amended, \$150,000 shall be awarded to the Center for  
23 Educational Technologies to complete production and dis-  
24 tribution of an effective CD–ROM product that would com-  
25 plement the “We the People: The Citizen and the Constitu-

1 *tion” curriculum: Provided further, That, in addition to*  
2 *the funds for title VI of Public Law 103–227 and notwith-*  
3 *standing the provisions of section 601(c)(1)(C) of that Act,*  
4 *\$1,000,000 shall be available to the Center for Civic Edu-*  
5 *cation to conduct a civic education program with Northern*  
6 *Ireland and the Republic of Ireland and, consistent with*  
7 *the civics and Government activities authorized in section*  
8 *601(c)(3) of Public Law 103–227, to provide civic education*  
9 *assistance to democracies in developing countries. The term*  
10 *“developing countries” shall have the same meaning as the*  
11 *term “developing country” in the Education for the Deaf*  
12 *Act: Provided further, That of the amount made available*  
13 *under this heading for activities carried out through the*  
14 *Fund for the Improvement of Education under part A of*  
15 *title X, \$50,000,000 shall be made available to enable the*  
16 *Secretary of Education to award grants to develop, imple-*  
17 *ment, and strengthen programs to teach American history*  
18 *(not social studies) as a separate subject within school cur-*  
19 *ricula.*

20 *DEPARTMENTAL MANAGEMENT*

21 *PROGRAM ADMINISTRATION*

22 *For carrying out, to the extent not otherwise provided,*  
23 *the Department of Education Organization Act, including*  
24 *rental of conference rooms in the District of Columbia and*  
25 *hire of two passenger motor vehicles, \$396,671,000.*



1 *ganization of the grade structure of schools, the pairing of*  
2 *schools, or the clustering of schools, or any combination of*  
3 *grade restructuring, pairing or clustering. The prohibition*  
4 *described in this section does not include the establishment*  
5 *of magnet schools.*

6 *SEC. 303. No funds appropriated under this Act may*  
7 *be used to prevent the implementation of programs of vol-*  
8 *untary prayer and meditation in the public schools.*

9 *(TRANSFER OF FUNDS)*

10 *SEC. 304. Not to exceed 1 percent of any discretionary*  
11 *funds (pursuant to the Balanced Budget and Emergency*  
12 *Deficit Control Act of 1985, as amended) which are appro-*  
13 *riated for the Department of Education in this Act may*  
14 *be transferred between appropriations, but no such appro-*  
15 *priation shall be increased by more than 3 percent by any*  
16 *such transfer: Provided, That the Appropriations Commit-*  
17 *tees of both Houses of Congress are notified at least 15 days*  
18 *in advance of any transfer.*

19 *SEC. 305. IMPACT AID. Notwithstanding any other*  
20 *provision of this Act—*

21 *(1) the total amount appropriated under this*  
22 *title to carry out title VIII of the Elementary and*  
23 *Secondary Education Act of 1965 shall be*  
24 *\$1,075,000,000;*

25 *(2) the total amount appropriated under this*  
26 *title for basic support payments under section*

1       8003(b) of the *Elementary and Secondary Education*  
2       *Act of 1965 shall be \$853,000,000; and*

3               (3) *amounts made available for the administra-*  
4       *tive and related expenses of the Department of Labor,*  
5       *Health and Human Services, and Education, shall be*  
6       *further reduced on a pro rata basis by \$35,000,000.*

7       *SEC. 306. (a) In addition to any amounts appro-*  
8       *priated under this title for the loan forgiveness for child*  
9       *care providers program under section 428K of the Higher*  
10       *Education Act of 1965 (20 U.S.C. 1078–11), an additional*  
11       *\$10,000,000 is appropriated to carry out such program.*

12               (b) *Notwithstanding any other provision of this Act,*  
13       *amounts made available under titles I and II, and this title,*  
14       *for salaries and expenses at the Departments of Labor,*  
15       *Health and Human Services, and Education, respectively,*  
16       *shall be reduced on a pro rata basis by \$10,000,000.*

17       *SEC. 307. TECHNOLOGY AND MEDIA SERVICES. Not-*  
18       *withstanding any other provision of this Act—*

19               (1) *the total amount appropriated under this*  
20       *title under the heading “OFFICE OF SPECIAL EDU-*  
21       *CATION AND REHABILITATIVE SERVICES” under the*  
22       *heading “SPECIAL EDUCATION” to carry out the Indi-*  
23       *viduals with Disabilities Education Act shall be*  
24       *\$7,353,141,000, of which \$35,323,000 shall be avail-*  
25       *able for technology and media services; and*

1           (2) *the total amount appropriated under this*  
2 *title under the heading “DEPARTMENTAL MANAGE-*  
3 *MENT” under the heading “PROGRAM ADMINISTRA-*  
4 *TION” shall be further reduced by \$800,000.*

5       *SEC. 308. (a) In addition to any amounts appro-*  
6 *priated under this title for the Perkin’s loan cancellation*  
7 *program under section 465 of the Higher Education Act*  
8 *of 1965 (20 U.S.C. 1087ee), an additional \$15,000,000 is*  
9 *appropriated to carry out such program.*

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

15       *SEC. 309. The Comptroller General of the United*  
16 *States shall evaluate the extent to which funds made avail-*  
17 *able under part A of title I of the Elementary and Sec-*  
18 *ondary Education Act of 1965 are allocated to schools and*  
19 *local educational agencies with the greatest concentrations*  
20 *of school-age children from low-income families, the extent*  
21 *to which allocations of such funds adjust to shifts in con-*  
22 *centrations of pupils from low-income families in different*  
23 *regions, States, and substate areas, the extent to which the*  
24 *allocation of such funds encourages the targeting of State*  
25 *funds to areas with higher concentrations of children from*

1 *low-income families, the implications of current distribu-*  
2 *tion methods for such funds, and formula and other policy*  
3 *recommendations to improve the targeting of such funds to*  
4 *more effectively serve low-income children in both rural and*  
5 *urban areas, and for preparing interim and final reports*  
6 *based on the results of the study, to be submitted to Congress*  
7 *not later than February 1, 2001, and April 1, 2001.*

8       *SEC. 310. The amount made available under this title*  
9 *under the heading “OFFICE OF POSTSECONDARY EDU-*  
10 *CATION” under the heading “HIGHER EDUCATION” to carry*  
11 *out section 316 of the Higher Education Act of 1965 is in-*  
12 *creased by \$5,000,000, which increase shall be used for con-*  
13 *struction and renovation projects under such section; and*  
14 *the amount made available under this title under the head-*  
15 *ing “OFFICE OF POSTSECONDARY EDUCATION” under the*  
16 *heading “HIGHER EDUCATION” to carry out part B of title*  
17 *VII of the Higher Education Act of 1965 is decreased by*  
18 *\$5,000,000.*

19                   *TITLE IV—RELATED AGENCIES*

20                   *ARMED FORCES RETIREMENT HOME*

21                   *ARMED FORCES RETIREMENT HOME*

22       *For expenses necessary for the Armed Forces Retire-*  
23 *ment Home to operate and maintain the United States Sol-*  
24 *diers’ and Airmen’s Home and the United States Naval*  
25 *Home, to be paid from funds available in the Armed Forces*

1 *Retirement Home Trust Fund, \$69,832,000, of which*  
2 *\$9,832,000 shall remain available until expended for con-*  
3 *struction and renovation of the physical plants at the*  
4 *United States Soldiers' and Airmen's Home and the United*  
5 *States Naval Home: Provided, That, notwithstanding any*  
6 *other provision of law, a single contract or related contracts*  
7 *for development and construction, to include construction*  
8 *of a long-term care facility at the United States Naval*  
9 *Home, may be employed which collectively include the full*  
10 *scope of the project: Provided further, That the solicitation*  
11 *and contract shall contain the clause "availability of funds"*  
12 *found at 48 CFR 52.232-18 and 252.232-7007, Limitation*  
13 *of Government Obligations. In addition, for completion of*  
14 *the long-term care facility at the United States Naval*  
15 *Home, \$6,228,000 to become available on October 1, 2001,*  
16 *and remain available until expended.*

17 *CORPORATION FOR NATIONAL AND COMMUNITY SERVICE*  
18 *DOMESTIC VOLUNTEER SERVICE PROGRAMS, OPERATING*  
19 *EXPENSES*

20 *For expenses necessary for the Corporation for Na-*  
21 *tional and Community Service to carry out the provisions*  
22 *of the Domestic Volunteer Service Act of 1973, as amended,*  
23 *\$302,504,000: Provided, That none of the funds made avail-*  
24 *able to the Corporation for National and Community Serv-*  
25 *ice in this Act for activities authorized by part E of title*

1 *II of the Domestic Volunteer Service Act of 1973 shall be*  
2 *used to provide stipends or other monetary incentives to vol-*  
3 *unteers or volunteer leaders whose incomes exceed 125 per-*  
4 *cent of the national poverty level.*

5 *CORPORATION FOR PUBLIC BROADCASTING*

6 *For payment to the Corporation for Public Broad-*  
7 *casting, as authorized by the Communications Act of 1934,*  
8 *an amount which shall be available within limitations spec-*  
9 *ified by that Act, for the fiscal year 2003, \$365,000,000:*  
10 *Provided, That no funds made available to the Corporation*  
11 *for Public Broadcasting by this Act shall be used to pay*  
12 *for receptions, parties, or similar forms of entertainment*  
13 *for Government officials or employees: Provided further,*  
14 *That none of the funds contained in this paragraph shall*  
15 *be available or used to aid or support any program or activ-*  
16 *ity from which any person is excluded, or is denied benefits,*  
17 *or is discriminated against, on the basis of race, color, na-*  
18 *tional origin, religion, or sex: Provided further, That in ad-*  
19 *dition to the amounts provided above, \$20,000,000, to re-*  
20 *main available until expended, shall be for digitalization,*  
21 *pending enactment of authorizing legislation.*

22 *FEDERAL MEDIATION AND CONCILIATION SERVICE*

23 *SALARIES AND EXPENSES*

24 *For expenses necessary for the Federal Mediation and*  
25 *Conciliation Service to carry out the functions vested in*

1 *it by the Labor Management Relations Act, 1947 (29 U.S.C.*  
2 *171–180, 182–183), including hire of passenger motor vehi-*  
3 *cles; for expenses necessary for the Labor-Management Co-*  
4 *operation Act of 1978 (29 U.S.C. 175a); and for expenses*  
5 *necessary for the Service to carry out the functions vested*  
6 *in it by the Civil Service Reform Act, Public Law 95–454*  
7 *(5 U.S.C. ch. 71), \$38,200,000, including \$1,500,000, to re-*  
8 *main available through September 30, 2002, for activities*  
9 *authorized by the Labor-Management Cooperation Act of*  
10 *1978 (29 U.S.C. 175a): Provided, That notwithstanding 31*  
11 *U.S.C. 3302, fees charged, up to full-cost recovery, for spe-*  
12 *cial training activities and other conflict resolution services*  
13 *and technical assistance, including those provided to foreign*  
14 *governments and international organizations, and for arbi-*  
15 *tration services shall be credited to and merged with this*  
16 *account, and shall remain available until expended: Pro-*  
17 *vided further, That fees for arbitration services shall be*  
18 *available only for education, training, and professional de-*  
19 *velopment of the agency workforce: Provided further, That*  
20 *the Director of the Service is authorized to accept and use*  
21 *on behalf of the United States gifts of services and real, per-*  
22 *sonal, or other property in the aid of any projects or func-*  
23 *tions within the Director’s jurisdiction.*



1                    *NATIONAL COUNCIL ON DISABILITY*2                    *SALARIES AND EXPENSES*

3            *For expenses necessary for the National Council on*  
4 *Disability as authorized by title IV of the Rehabilitation*  
5 *Act of 1973, as amended, \$2,615,000.*

6                    *NATIONAL EDUCATION GOALS PANEL*

7            *For expenses necessary for the National Education*  
8 *Goals Panel, as authorized by title II, part A of the Goals*  
9 *2000: Educate America Act, \$2,350,000.*

10                   *NATIONAL LABOR RELATIONS BOARD*11                   *SALARIES AND EXPENSES*

12            *For expenses necessary for the National Labor Rela-*  
13 *tions Board to carry out the functions vested in it by the*  
14 *Labor-Management Relations Act, 1947, as amended (29*  
15 *U.S.C. 141–167), and other laws, \$216,438,000: Provided,*  
16 *That no part of this appropriation shall be available to or-*  
17 *ganize or assist in organizing agricultural laborers or used*  
18 *in connection with investigations, hearings, directives, or*  
19 *orders concerning bargaining units composed of agricul-*  
20 *tural laborers as referred to in section 2(3) of the Act of*  
21 *July 5, 1935 (29 U.S.C. 152), and as amended by the*  
22 *Labor-Management Relations Act, 1947, as amended, and*  
23 *as defined in section 3(f) of the Act of June 25, 1938 (29*  
24 *U.S.C. 203), and including in said definition employees en-*  
25 *gaged in the maintenance and operation of ditches, canals,*

1 *reservoirs, and waterways when maintained or operated on*  
2 *a mutual, nonprofit basis and at least 95 percent of the*  
3 *water stored or supplied thereby is used for farming pur-*  
4 *poses.*

5 *NATIONAL MEDIATION BOARD*

6 *SALARIES AND EXPENSES*

7 *For expenses necessary to carry out the provisions of*  
8 *the Railway Labor Act, as amended (45 U.S.C. 151–188),*  
9 *including emergency boards appointed by the President,*  
10 *\$10,400,000.*

11 *OCCUPATIONAL SAFETY AND HEALTH REVIEW*

12 *COMMISSION*

13 *SALARIES AND EXPENSES*

14 *For expenses necessary for the Occupational Safety*  
15 *and Health Review Commission (29 U.S.C. 661),*  
16 *\$8,720,000.*

17 *RAILROAD RETIREMENT BOARD*

18 *DUAL BENEFITS PAYMENTS ACCOUNT*

19 *For payment to the Dual Benefits Payments Account,*  
20 *authorized under section 15(d) of the Railroad Retirement*  
21 *Act of 1974, \$160,000,000, which shall include amounts be-*  
22 *coming available in fiscal year 2001 pursuant to section*  
23 *224(c)(1)(B) of Public Law 98–76; and in addition, an*  
24 *amount, not to exceed 2 percent of the amount provided*  
25 *herein, shall be available proportional to the amount by*

1 *which the product of recipients and the average benefit re-*  
2 *ceived exceeds \$160,000,000: Provided, That the total*  
3 *amount provided herein shall be credited in 12 approxi-*  
4 *mately equal amounts on the first day of each month in*  
5 *the fiscal year.*

6 *FEDERAL PAYMENTS TO THE RAILROAD RETIREMENT*

7 *ACCOUNTS*

8 *For payment to the accounts established in the Treas-*  
9 *ury for the payment of benefits under the Railroad Retire-*  
10 *ment Act for interest earned on unnegotiated checks,*  
11 *\$150,000, to remain available through September 30, 2002,*  
12 *which shall be the maximum amount available for payment*  
13 *pursuant to section 417 of Public Law 98-76.*

14 *LIMITATION ON ADMINISTRATION*

15 *For necessary expenses for the Railroad Retirement*  
16 *Board for administration of the Railroad Retirement Act*  
17 *and the Railroad Unemployment Insurance Act,*  
18 *\$92,500,000, to be derived in such amounts as determined*  
19 *by the Board from the railroad retirement accounts and*  
20 *from moneys credited to the railroad unemployment insur-*  
21 *ance administration fund.*

22 *LIMITATION ON THE OFFICE OF INSPECTOR GENERAL*

23 *For expenses necessary for the Office of Inspector Gen-*  
24 *eral for audit, investigatory and review activities, as au-*  
25 *thorized by the Inspector General Act of 1978, as amended,*  
26 *not more than \$5,700,000, to be derived from the railroad*

1 *retirement accounts and railroad unemployment insurance*  
2 *account: Provided, That none of the funds made available*  
3 *in any other paragraph of this Act may be transferred to*  
4 *the Office; used to carry out any such transfer; used to pro-*  
5 *vide any office space, equipment, office supplies, commu-*  
6 *nications facilities or services, maintenance services, or ad-*  
7 *ministrative services for the Office; used to pay any salary,*  
8 *benefit, or award for any personnel of the Office; used to*  
9 *pay any other operating expense of the Office; or used to*  
10 *reimburse the Office for any service provided, or expense*  
11 *incurred, by the Office.*

12 *SOCIAL SECURITY ADMINISTRATION*

13 *PAYMENTS TO SOCIAL SECURITY TRUST FUNDS*

14 *For payment to the Federal Old-Age and Survivors In-*  
15 *surance and the Federal Disability Insurance trust funds,*  
16 *as provided under sections 201(m), 228(g), and 1131(b)(2)*  
17 *of the Social Security Act, \$20,400,000.*

18 *SPECIAL BENEFITS FOR DISABLED COAL MINERS*

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

22 *For making, after July 31 of the current fiscal year,*  
23 *benefit payments to individuals under title IV of the Fed-*  
24 *eral Mine Safety and Health Act of 1977, for costs incurred*  
25 *in the current fiscal year, such amounts as may be nec-*  
26 *essary.*

1        *For making benefit payments under title IV of the Fed-*  
2 *eral Mine Safety and Health Act of 1977 for the first quar-*  
3 *ter of fiscal year 2002, \$114,000,000, to remain available*  
4 *until expended.*

5                    *SUPPLEMENTAL SECURITY INCOME PROGRAM*

6        *For carrying out titles XI and XVI of the Social Secu-*  
7 *rity Act, section 401 of Public Law 92–603, section 212*  
8 *of Public Law 93–66, as amended, and section 405 of Public*  
9 *Law 95–216, including payment to the Social Security*  
10 *trust funds for administrative expenses incurred pursuant*  
11 *to section 201(g)(1) of the Social Security Act,*  
12 *\$23,053,000,000, to remain available until expended: Pro-*  
13 *vided, That any portion of the funds provided to a State*  
14 *in the current fiscal year and not obligated by the State*  
15 *during that year shall be returned to the Treasury.*

16        *From funds provided under the previous paragraph,*  
17 *not less than \$100,000,000 shall be available for payment*  
18 *to the Social Security trust funds for administrative ex-*  
19 *penses for conducting continuing disability reviews.*

20        *In addition, \$210,000,000, to remain available until*  
21 *September 30, 2002, for payment to the Social Security*  
22 *trust funds for administrative expenses for continuing dis-*  
23 *ability reviews as authorized by section 103 of Public Law*  
24 *104–121 and section 10203 of Public Law 105–33. The term*  
25 *“continuing disability reviews” means reviews and redeter-*

1 *minations as defined under section 201(g)(1)(A) of the So-*  
2 *cial Security Act, as amended.*

3 *For making, after June 15 of the current fiscal year,*  
4 *benefit payments to individuals under title XVI of the So-*  
5 *cial Security Act, for unanticipated costs incurred for the*  
6 *current fiscal year, such sums as may be necessary.*

7 *For making benefit payments under title XVI of the*  
8 *Social Security Act for the first quarter of fiscal year 2002,*  
9 *\$10,470,000,000, to remain available until expended.*

10 *LIMITATION ON ADMINISTRATIVE EXPENSES*

11 *For necessary expenses, including the hire of two pas-*  
12 *senger motor vehicles, and not to exceed \$10,000 for official*  
13 *reception and representation expenses, not more than*  
14 *\$6,469,800,000 may be expended, as authorized by section*  
15 *201(g)(1) of the Social Security Act, from any one or all*  
16 *of the trust funds referred to therein: Provided, That not*  
17 *less than \$1,800,000 shall be for the Social Security Advi-*  
18 *sory Board: Provided further, That unobligated balances at*  
19 *the end of fiscal year 2001 not needed for fiscal year 2001*  
20 *shall remain available until expended to invest in the So-*  
21 *cial Security Administration information technology and*  
22 *telecommunications hardware and software infrastructure,*  
23 *including related equipment and non-payroll administra-*  
24 *tive expenses*

1        *From funds provided under the first paragraph, not*  
2 *less than \$200,000,000 shall be available for conducting*  
3 *continuing disability reviews.*

4        *In addition to funding already available under this*  
5 *heading, and subject to the same terms and conditions,*  
6 *\$450,000,000, to remain available until September 30,*  
7 *2002, for continuing disability reviews as authorized by sec-*  
8 *tion 103 of Public Law 104–121 and section 10203 of Pub-*  
9 *lic Law 105–33. The term “continuing disability reviews”*  
10 *means reviews and redeterminations as defined under sec-*  
11 *tion 201(g)(1)(A) of the Social Security Act, as amended.*

12        *In addition, \$91,000,000 to be derived from adminis-*  
13 *tration fees in excess of \$5.00 per supplementary payment*  
14 *collected pursuant to section 1616(d) of the Social Security*  
15 *Act or section 212(b)(3) of Public Law 93–66, which shall*  
16 *remain available until expended. To the extent that the*  
17 *amounts collected pursuant to such section 1616(d) or*  
18 *212(b)(3) in fiscal year 2001 exceed \$91,000,000, the*  
19 *amounts shall be available in fiscal year 2002 only to the*  
20 *extent provided in advance in appropriations Acts.*

21        *From funds previously appropriated for this purpose,*  
22 *any unobligated balances at the end of fiscal year 2000 shall*  
23 *be available to continue Federal-State partnerships which*  
24 *will evaluate means to promote Medicare buy-in programs*

1 *targeted to elderly and disabled individuals under titles*  
2 *XVIII and XIX of the Social Security Act.*

3 *OFFICE OF INSPECTOR GENERAL*  
4 *(INCLUDING TRANSFER OF FUNDS)*

5 *For expenses necessary for the Office of Inspector Gen-*  
6 *eral in carrying out the provisions of the Inspector General*  
7 *Act of 1978, as amended, \$16,944,000, together with not to*  
8 *exceed \$52,500,000, to be transferred and expended as au-*  
9 *thorized by section 201(g)(1) of the Social Security Act from*  
10 *the Federal Old-Age and Survivors Insurance Trust Fund*  
11 *and the Federal Disability Insurance Trust Fund.*

12 *In addition, an amount not to exceed 3 percent of the*  
13 *total provided in this appropriation may be transferred*  
14 *from the “Limitation on Administrative Expenses”, Social*  
15 *Security Administration, to be merged with this account,*  
16 *to be available for the time and purposes for which this*  
17 *account is available: Provided, That notice of such transfers*  
18 *shall be transmitted promptly to the Committees on Appro-*  
19 *priations of the House and Senate.*

20 *UNITED STATES INSTITUTE OF PEACE*  
21 *OPERATING EXPENSES*

22 *For necessary expenses of the United States Institute*  
23 *of Peace as authorized in the United States Institute of*  
24 *Peace Act, \$12,951,000.*

1                    *TITLE V—GENERAL PROVISIONS*

2            *SEC. 501. The Secretaries of Labor, Health and*  
3 *Human Services, and Education are authorized to transfer*  
4 *unexpended balances of prior appropriations to accounts*  
5 *corresponding to current appropriations provided in this*  
6 *Act: Provided, That such transferred balances are used for*  
7 *the same purpose, and for the same periods of time, for*  
8 *which they were originally appropriated.*

9            *SEC. 502. No part of any appropriation contained in*  
10 *this Act shall remain available for obligation beyond the*  
11 *current fiscal year unless expressly so provided herein.*

12           *SEC. 503. (a) No part of any appropriation contained*  
13 *in this Act shall be used, other than for normal and recog-*  
14 *nized executive-legislative relationships, for publicity or*  
15 *propaganda purposes, for the preparation, distribution, or*  
16 *use of any kit, pamphlet, booklet, publication, radio, tele-*  
17 *vision, or video presentation designed to support or defeat*  
18 *legislation pending before the Congress or any State legisla-*  
19 *ture, except in presentation to the Congress or any State*  
20 *legislature itself.*

21           *(b) No part of any appropriation contained in this*  
22 *Act shall be used to pay the salary or expenses of any grant*  
23 *or contract recipient, or agent acting for such recipient, re-*  
24 *lated to any activity designed to influence legislation or ap-*

1 *propriations pending before the Congress or any State legis-*  
2 *lature.*

3       *SEC. 504. The Secretaries of Labor and Education are*  
4 *authorized to make available not to exceed \$20,000 and*  
5 *\$15,000, respectively, from funds available for salaries and*  
6 *expenses under titles I and III, respectively, for official re-*  
7 *ception and representation expenses; the Director of the*  
8 *Federal Mediation and Conciliation Service is authorized*  
9 *to make available for official reception and representation*  
10 *expenses not to exceed \$2,500 from the funds available for*  
11 *“Salaries and expenses, Federal Mediation and Concilia-*  
12 *tion Service”; and the Chairman of the National Mediation*  
13 *Board is authorized to make available for official reception*  
14 *and representation expenses not to exceed \$2,500 from funds*  
15 *available for “Salaries and expenses, National Mediation*  
16 *Board”.*

17       *SEC. 505. Notwithstanding any other provision of this*  
18 *Act, no funds appropriated under this Act shall be used to*  
19 *carry out any program of distributing sterile needles or sy-*  
20 *ringes for the hypodermic injection of any illegal drug un-*  
21 *less the Secretary of Health and Human Services deter-*  
22 *mines that such programs are effective in preventing the*  
23 *spread of HIV and do not encourage the use of illegal drugs.*

24       *SEC. 506. (a) PURCHASE OF AMERICAN-MADE EQUIP-*  
25 *MENT AND PRODUCTS.—It is the sense of the Congress that,*

1 *to the greatest extent practicable, all equipment and prod-*  
2 *ucts purchased with funds made available in this Act should*  
3 *be American-made.*

4 (b) *NOTICE REQUIREMENT.—In providing financial*  
5 *assistance to, or entering into any contract with, any entity*  
6 *using funds made available in this Act, the head of each*  
7 *Federal agency, to the greatest extent practicable, shall pro-*  
8 *vide to such entity a notice describing the statement made*  
9 *in subsection (a) by the Congress.*

10 (c) *PROHIBITION OF CONTRACTS WITH PERSONS*  
11 *FALSELY LABELING PRODUCTS AS MADE IN AMERICA.—*  
12 *If it has been finally determined by a court or Federal agen-*  
13 *cy that any person intentionally affixed a label bearing a*  
14 *“Made in America” inscription, or any inscription with*  
15 *the same meaning, to any product sold in or shipped to*  
16 *the United States that is not made in the United States,*  
17 *the person shall be ineligible to receive any contract or sub-*  
18 *contract made with funds made available in this Act, pur-*  
19 *suant to the debarment, suspension, and ineligibility proce-*  
20 *dures described in sections 9.400 through 9.409 of title 48,*  
21 *Code of Federal Regulations.*

22 *SEC. 507. When issuing statements, press releases, re-*  
23 *quests for proposals, bid solicitations and other documents*  
24 *describing projects or programs funded in whole or in part*  
25 *with Federal money, all grantees receiving Federal funds*

1 *included in this Act, including but not limited to State and*  
2 *local governments and recipients of Federal research grants,*  
3 *shall clearly state: (1) the percentage of the total costs of*  
4 *the program or project which will be financed with Federal*  
5 *money; (2) the dollar amount of Federal funds for the*  
6 *project or program; and (3) percentage and dollar amount*  
7 *of the total costs of the project or program that will be fi-*  
8 *nanced by non-governmental sources.*

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

13       *(b) None of the funds appropriated under this Act, and*  
14 *none of the funds in any trust fund to which funds are*  
15 *appropriated under this Act, shall be expended for health*  
16 *benefits coverage that includes coverage of abortion.*

17       *(c) The term “health benefits coverage” means the*  
18 *package of services covered by a managed care provider or*  
19 *organization pursuant to a contract or other arrangement.*

20       *SEC. 509. (a) The limitations established in the pre-*  
21 *ceding section shall not apply to an abortion—*

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

24               *(2) in the case where a woman suffers from a*  
25               *physical disorder, physical injury, or physical illness,*

1        *including a life-endangering physical condition*  
2        *caused by or arising from the pregnancy itself, that*  
3        *would, as certified by a physician, place the woman*  
4        *in danger of death unless an abortion is performed.*

5        *(b) Nothing in the preceding section shall be construed*  
6        *as prohibiting the expenditure by a State, locality, entity,*  
7        *or private person of State, local, or private funds (other*  
8        *than a State's or locality's contribution of Medicaid match-*  
9        *ing funds).*

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

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

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

20                *(2) research in which a human embryo or em-*  
21                *bryos are destroyed, discarded, or knowingly subjected*  
22                *to risk of injury or death greater than that allowed*  
23                *for research on fetuses in utero under 45 CFR*  
24                *46.208(a)(2) and section 498(b) of the Public Health*  
25                *Service Act (42 U.S.C. 289g(b)).*

1           (b) *For purposes of this section, the term “human em-*  
2 *bryo or embryos” includes any organism, not protected as*  
3 *a human subject under 45 CFR 46 as of the date of the*  
4 *enactment of this Act, that is derived by fertilization, par-*  
5 *thenogenesis, cloning, or any other means from one or more*  
6 *human gametes or human diploid cells.*

7           *SEC. 511. (a) LIMITATION ON USE OF FUNDS FOR*  
8 *PROMOTION OF LEGALIZATION OF CONTROLLED SUB-*  
9 *STANCES.—None of the funds made available in this Act*  
10 *may be used for any activity that promotes the legalization*  
11 *of any drug or other substance included in schedule I of*  
12 *the schedules of controlled substances established by section*  
13 *202 of the Controlled Substances Act (21 U.S.C. 812).*

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

19           *SEC. 512. None of the funds made available in this*  
20 *Act may be obligated or expended to enter into or renew*  
21 *a contract with an entity if—*

22                   (1) *such entity is otherwise a contractor with the*  
23 *United States and is subject to the requirement in*  
24 *section 4212(d) of title 38, United States Code, re-*  
25 *garding submission of an annual report to the Sec-*

1        *retary of Labor concerning employment of certain vet-*  
2        *erans; and*

3                *(2) such entity has not submitted a report as re-*  
4        *quired by that section for the most recent year for*  
5        *which such requirement was applicable to such entity.*

6        *SEC. 513. Except as otherwise specifically provided by*  
7        *law, unobligated balances remaining available at the end*  
8        *of fiscal year 2000 from appropriations made available for*  
9        *salaries and expenses for fiscal year 2000 in this Act, shall*  
10       *remain available through December 31, 2001, for each such*  
11       *account for the purposes authorized: Provided, That the*  
12       *House and Senate Committees on Appropriations shall be*  
13       *notified at least 15 days prior to the obligation of such*  
14       *funds.*

15       *SEC. 514. None of the funds made available in this*  
16       *Act may be used to promulgate or adopt any final standard*  
17       *under section 1173(b) of the Social Security Act (42 U.S.C.*  
18       *1320d-2(b)) providing for, or providing for the assignment*  
19       *of, a unique health identifier for an individual (except in*  
20       *an individual's capacity as an employer or a health care*  
21       *provider), until legislation is enacted specifically approving*  
22       *the standard.*

23       *SEC. 515. Section 410(b) of The Ticket to Work and*  
24       *Work Incentives Improvement Act of 1999 (Public Law*

1 106–170) is amended by striking “2009” both places it ap-  
2 pears and inserting “2001”.

3       *SEC. 516. Amounts made available under this Act for*  
4 *the administrative and related expenses for departmental*  
5 *management for the Department of Labor, the Department*  
6 *of Health and Human Services, and the Department of*  
7 *Education shall be reduced on pro rata basis by*  
8 *\$50,000,000.*

9       *SEC. 517. (a) None of the funds appropriated under*  
10 *this Act to carry out section 330 or title X of the Public*  
11 *Health Service Act (42 U.S.C. 254b, 300 et seq.), title V*  
12 *or XIX of the Social Security Act (42 U.S.C. 701 et seq.,*  
13 *1396 et seq.), or any other provision of law, shall be used*  
14 *for the distribution or provision of postcoital emergency*  
15 *contraception, or the provision of a prescription for*  
16 *postcoital emergency contraception, to an unemancipated*  
17 *minor, on the premises or in the facilities of any elementary*  
18 *school or secondary school.*

19       *(b) This section takes effect 1 day after the date of en-*  
20 *actment of this Act.*

21       *(c) In this section:*

22               *(1) The terms “elementary school” and “sec-*  
23 *ondary school” have the meanings given the terms in*  
24 *section 14101 of the Elementary and Secondary Edu-*  
25 *cation Act of 1965 (20 U.S.C. 8801).*

1           (2) *The term “unemancipated minor” means an*  
2           *unmarried individual who is 17 years of age or*  
3           *younger and is a dependent, as defined in section*  
4           *152(a) of the Internal Revenue Code of 1986.*

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

8           **“PART G—REQUIREMENT RELATING TO THE**  
9           **RIGHTS OF RESIDENTS OF CERTAIN FACILITIES**  
10          **“SEC. 581. REQUIREMENT RELATING TO THE RIGHTS OF**  
11                                   **RESIDENTS OF CERTAIN FACILITIES.**

12          “(a) *IN GENERAL.—A public or private general hos-*  
13          *pital, nursing facility, intermediate care facility, residen-*  
14          *tial treatment center, or other health care facility, that re-*  
15          *ceives support in any form from any program supported*  
16          *in whole or in part with funds appropriated to any Federal*  
17          *department or agency shall protect and promote the rights*  
18          *of each resident of the facility, including the right to be*  
19          *free from physical or mental abuse, corporal punishment,*  
20          *and any restraints or involuntary seclusions imposed for*  
21          *purposes of discipline or convenience.*

22          “(b) *REQUIREMENTS.—Restraints and seclusion may*  
23          *only be imposed on a resident of a facility described in sub-*  
24          *section (a) if—*

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

4           “(2) *the restraints or seclusion are imposed only*  
5 *upon the written order of a physician, or other li-*  
6 *censed independent practitioner permitted by the*  
7 *State and the facility to order such restraint or seclu-*  
8 *sion, that specifies the duration and circumstances*  
9 *under which the restraints are to be used (except in*  
10 *emergency circumstances specified by the Secretary*  
11 *until such an order could reasonably be obtained).*

12       “(c) *DEFINITIONS.—In this section:*

13           “(1) *RESTRAINTS.—The term ‘restraints’*  
14 *means—*

15           “(A) *any physical restraint that is a me-*  
16 *chanical or personal restriction that immobilizes*  
17 *or reduces the ability of an individual to move*  
18 *his or her arms, legs, or head freely, not includ-*  
19 *ing devices, such as orthopedically prescribed de-*  
20 *vices, surgical dressings or bandages, protective*  
21 *helmets, or any other methods that involves the*  
22 *physical holding of a resident for the purpose of*  
23 *conducting routine physical examinations or*  
24 *tests or to protect the resident from falling out*  
25 *of bed or to permit the resident to participate in*

1           *activities without the risk of physical harm to*  
2           *the resident; and*

3           “(B) *a drug or medication that is used as*  
4           *a restraint to control behavior or restrict the*  
5           *resident’s freedom of movement that is not a*  
6           *standard treatment for the resident’s medical or*  
7           *psychiatric condition.*

8           “(2) *SECLUSION.—The term ‘seclusion’ means*  
9           *any separation of the resident from the general popu-*  
10          *lation of the facility that prevents the resident from*  
11          *returning to such population if he or she desires.*

12          **“SEC. 582. REPORTING REQUIREMENT.**

13          “(a) *IN GENERAL.— Each facility to which the Protec-*  
14          *tion and Advocacy for Mentally Ill Individuals Act of 1986*  
15          *applies shall notify the appropriate agency, as determined*  
16          *by the Secretary, of each death that occurs at each such*  
17          *facility while a patient is restrained or in seclusion, of each*  
18          *death occurring within 24 hours after the patient has been*  
19          *removed from restraints and seclusion, or where it is rea-*  
20          *sonable to assume that a patient’s death is a result of such*  
21          *seclusion or restraint. A notification under this section shall*  
22          *include the name of the resident and shall be provided not*  
23          *later than 7 days after the date of the death of the indi-*  
24          *vidual involved.*

1       “(b) *FACILITY*.—In this section, the term ‘facility’ has  
2 the meaning given the term ‘facilities’ in section 102(3) of  
3 the *Protection and Advocacy for Mentally Ill Individuals*  
4 *Act of 1986 (42 U.S.C. 10802(3))*.”

5       **“SEC. 583. REGULATIONS AND ENFORCEMENT.**

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

14       “(b) *REQUIREMENTS*.—The regulations promulgated  
15 under subsection (a) shall require that—

16               “(1) facilities described in subsection (a) ensure  
17 that there is an adequate number of qualified profes-  
18 sional and supportive staff to evaluate patients, for-  
19 mulate written individualized, comprehensive treat-  
20 ment plans, and to provide active treatment meas-  
21 ures;

22               “(2) appropriate training be provided for the  
23 staff of such facilities in the use of restraints and any  
24 alternatives to the use of restraints; and

1           “(3) such facilities provide complete and accu-  
2           rate notification of deaths, as required under section  
3           582(a).

4           “(c) *ENFORCEMENT.*—A facility to which this part ap-  
5           plies that fails to comply with any requirement of this part,  
6           including a failure to provide appropriate training, shall  
7           not be eligible for participation in any program supported  
8           in whole or in part by funds appropriated to any Federal  
9           department or agency.”.

10          *SEC. 519.* It is the sense of the Senate that each entity  
11          carrying out an Early Head Start program under the Head  
12          Start Act should—

13                 (1) determine whether a child eligible to partici-  
14                 pate in the Early Head Start program has received  
15                 a blood lead screening test, using a test that is appro-  
16                 priate for age and risk factors, upon the enrollment  
17                 of the child in the program; and

18                 (2) in the case of an child who has not received  
19                 such a blood lead screening test, ensure that each en-  
20                 rolled child receives such a test either by referral or  
21                 by performing the test (under contract or otherwise).

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

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

4       (c) *Whereas according to the Child Abuse and Neglect*  
5 *Reporting Act, a school administrator is required to report*  
6 *any allegation of sexual abuse to the appropriate authori-*  
7 *ties;*

8       (d) *Whereas an individual who is falsely accused of*  
9 *sexual misconduct with a student deserves appropriate legal*  
10 *and professional protections;*

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

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

16       (g) *Therefore, it is the Sense of the Senate that the*  
17 *Secretary of Education should initiate a study and make*  
18 *recommendations to Congress and State and local govern-*  
19 *ments on the issue of sexual abuse in schools.*

20       *TITLE VI—CHILDREN’S INTERNET PROTECTION*

21       *SEC. 601. SHORT TITLE. This title may be cited as*  
22 *the “Childrens’ Internet Protection Act”.*

23       *SEC. 602. REQUIREMENT FOR SCHOOLS AND LIBRAR-*  
24 *IES TO IMPLEMENT FILTERING OR BLOCKING TECHNOLOGY*  
25 *FOR COMPUTERS WITH INTERNET ACCESS AS CONDITION*

1 *OF UNIVERSAL SERVICE DISCOUNTS. (a) SCHOOLS.—Sec-*  
2 *tion 254(h) of the Communications Act of 1934 (47 U.S.C.*  
3 *254(h)) is amended—*

4           *(1) by redesignating paragraph (5) as para-*  
5 *graph (7); and*

6           *(2) by inserting after paragraph (4) the fol-*  
7 *lowing new paragraph (5):*

8           “*(5) REQUIREMENTS FOR CERTAIN SCHOOLS*  
9 *WITH COMPUTERS HAVING INTERNET ACCESS.—*

10           “*(A) INTERNET FILTERING.—*

11           “*(i) IN GENERAL.—Except as provided*  
12 *in clause (ii), an elementary or secondary*  
13 *school having computers with Internet ac-*  
14 *cess may not receive services at discount*  
15 *rates under paragraph (1)(B) unless the*  
16 *school, school board, or other authority with*  
17 *responsibility for administration of the*  
18 *school—*

19           “*(I) submits to the Commission a*  
20 *certification described in subparagraph*  
21 *(B); and*

22           “*(II) ensures the use of such com-*  
23 *puters in accordance with the certifi-*  
24 *cation.*

1                   “(i) *APPLICABILITY.*—*The prohibition*  
2                   *in paragraph (1) shall not apply with re-*  
3                   *spect to a school that receives services at*  
4                   *discount rates under paragraph (1)(B) only*  
5                   *for purposes other than the provision of*  
6                   *Internet access, Internet service, or internal*  
7                   *connections.*

8                   “(B) *CERTIFICATION.*—*A certification*  
9                   *under this subparagraph is a certification that*  
10                  *the school, school board, or other authority with*  
11                  *responsibility for administration of the school—*

12                  “(i) *has selected a technology for its*  
13                  *computers with Internet access in order to*  
14                  *filter or block Internet access through such*  
15                  *computers to—*

16                  “(I) *material that is obscene; and*

17                  “(II) *child pornography; and*

18                  “(ii) *is enforcing a policy to ensure the*  
19                  *operation of the technology during any use*  
20                  *of such computers by minors.*

21                  “(C) *ADDITIONAL USE OF TECHNOLOGY.*—*A*  
22                  *school, school board, or other authority may also*  
23                  *use a technology covered by a certification under*  
24                  *subparagraph (B) to filter or block Internet ac-*  
25                  *cess through the computers concerned to any ma-*

1            *terial in addition to the material specified in*  
2            *that subparagraph that the school, school board,*  
3            *or other authority determines to be inappro-*  
4            *priate for minors.*

5            *“(D) TIMING OF CERTIFICATIONS.—*

6                    *“(i) SCHOOLS WITH COMPUTERS ON*  
7                    *EFFECTIVE DATE.—*

8                            *“(I) IN GENERAL.—Subject to*  
9                            *subclause (II), in the case of any school*  
10                           *covered by this paragraph as of the ef-*  
11                           *fective date of this paragraph under*  
12                           *section 602(h) of the Childrens’ Inter-*  
13                           *net Protection Act, the certification*  
14                           *under subparagraph (B) shall be made*  
15                           *not later than 30 days after such effec-*  
16                           *tive date.*

17                           *“(II) DELAY.—A certification for*  
18                           *a school covered by subclause (I) may*  
19                           *be made at a date that is later than is*  
20                           *otherwise required by that subclause if*  
21                           *State or local procurement rules or reg-*  
22                           *ulations or competitive bidding re-*  
23                           *quirements prevent the making of the*  
24                           *certification on the date otherwise re-*  
25                           *quired by that subclause. A school,*

1           *school board, or other authority with*  
2           *responsibility for administration of the*  
3           *school shall notify the Commission of*  
4           *the applicability of this subclause to*  
5           *the school. Such notice shall specify the*  
6           *date on which the certification with re-*  
7           *spect to the school shall be effective for*  
8           *purposes of this clause.*

9           “(ii) *SCHOOLS ACQUIRING COMPUTERS*  
10          *AFTER EFFECTIVE DATE.—In the case of*  
11          *any school that first becomes covered by this*  
12          *paragraph after such effective date, the cer-*  
13          *tification under subparagraph (B) shall be*  
14          *made not later than 10 days after the date*  
15          *on which the school first becomes so covered.*

16          “(iii) *NO REQUIREMENT FOR ADDI-*  
17          *TIONAL CERTIFICATIONS.—A school that has*  
18          *submitted a certification under subpara-*  
19          *graph (B) shall not be required for purposes*  
20          *of this paragraph to submit an additional*  
21          *certification under that subparagraph with*  
22          *respect to any computers having Internet*  
23          *access that are acquired by the school after*  
24          *the submittal of the certification.*

25          “(E) *NONCOMPLIANCE.—*

1           “(i) *FAILURE TO SUBMIT CERTIFI-*  
2           *CATION.—Any school that knowingly fails to*  
3           *submit a certification required by this*  
4           *paragraph shall reimburse each tele-*  
5           *communications carrier that provided such*  
6           *school services at discount rates under para-*  
7           *graph (1)(B) after the effective date of this*  
8           *paragraph under section 602(h) of the Chil-*  
9           *drens’ Internet Protection Act in an*  
10          *amount equal to the amount of the discount*  
11          *provided such school by such carrier for*  
12          *such services during the period beginning*  
13          *on such effective date and ending on the*  
14          *date on which the provision of such services*  
15          *at discount rates under paragraph (1)(B) is*  
16          *determined to cease under subparagraph*  
17          *(F).*

18          “(ii) *FAILURE TO COMPLY WITH CER-*  
19          *TIFICATION.—Any school that knowingly*  
20          *fails to ensure the use of its computers in*  
21          *accordance with a certification under sub-*  
22          *paragraph (B) shall reimburse each tele-*  
23          *communications carrier that provided such*  
24          *school services at discount rates under para-*  
25          *graph (1)(B) after the date of such certifi-*

1            *cation in an amount equal to the amount of*  
2            *the discount provided such school by such*  
3            *carrier for such services during the period*  
4            *beginning on the date of such certification*  
5            *and ending on the date on which the provi-*  
6            *sion of such services at discount rates under*  
7            *paragraph (1)(B) is determined to cease*  
8            *under subparagraph (F).*

9            *“(iii) TREATMENT OF REIMBURSE-*  
10           *MENT.—The receipt by a telecommuni-*  
11           *cations carrier of any reimbursement under*  
12           *this subparagraph shall not affect the car-*  
13           *rier’s treatment of the discount on which*  
14           *such reimbursement was based in accord-*  
15           *ance with the third sentence of paragraph*  
16           *(1)(B).*

17           *“(F) CESSATION DATE.—*

18           *“(i) DETERMINATION.—The Commis-*  
19           *sion shall determine the date on which the*  
20           *provision of services at discount rates under*  
21           *paragraph (1)(B) shall cease under this*  
22           *paragraph by reason of the failure of a*  
23           *school to comply with the requirements of*  
24           *this paragraph.*

1           “(ii) *NOTIFICATION.*—*The Commission*  
2           *shall notify telecommunications carriers of*  
3           *each school determined to have failed to*  
4           *comply with the requirements of this para-*  
5           *graph and of the period for which such*  
6           *school shall be liable to make reimbursement*  
7           *under subparagraph (E).*

8           “(G) *RECOMMENCEMENT OF DISCOUNTS.*—

9           “(i) *RECOMMENCEMENT.*—*Upon sub-*  
10           *mittal to the Commission of a certification*  
11           *under subparagraph (B) with respect to a*  
12           *school to which clause (i) or (ii) of subpara-*  
13           *graph (E) applies, the school shall be enti-*  
14           *tled to services at discount rates under*  
15           *paragraph (1)(B).*

16           “(ii) *NOTIFICATION.*—*The Commission*  
17           *shall notify the school and telecommuni-*  
18           *cations carriers of the recommencement of*  
19           *the school’s entitlement to services at dis-*  
20           *count rates under this subparagraph and of*  
21           *the date on which such recommencement be-*  
22           *gins.*

23           “(iii) *ADDITIONAL NONCOMPLIANCE.*—  
24           *The provisions of subparagraphs (E) and*

1           (F) shall apply to any certification sub-  
2           mitted under clause (i).

3           “(H) PUBLIC AVAILABILITY OF POLICY.—A  
4           school, school board, or other authority that en-  
5           forces a policy under subparagraph (B)(ii) shall  
6           take appropriate actions to ensure the ready  
7           availability to the public of information on such  
8           policy and on its policy, if any, relating to the  
9           use of technology under subparagraph (C).

10          “(I) LIMITATION ON FEDERAL ACTION.—

11           “(i) IN GENERAL.—No agency or in-  
12          strumentality of the United States Govern-  
13          ment may—

14           “(I) establish any criteria for  
15          making a determination under sub-  
16          paragraph (C);

17           “(II) review a determination  
18          made by a school, school board, or  
19          other authority for purposes of a cer-  
20          tification under subparagraph (B); or

21           “(III) consider the criteria em-  
22          ployed by a school, school board, or  
23          other authority for purposes of deter-  
24          mining the eligibility of a school for

1                    *services at discount rates under para-*  
2                    *graph (1)(B).*

3                    “(ii) *ACTION BY COMMISSION.—The*  
4                    *Commission may not take any action*  
5                    *against a school, school board, or other au-*  
6                    *thority for a violation of a provision of this*  
7                    *paragraph if the school, school board, or*  
8                    *other authority, as the case may be, has*  
9                    *made a good faith effort to comply with*  
10                   *such provision.”.*

11                (b) *LIBRARIES.—Such section 254(h) is further*  
12                *amended by inserting after paragraph (5), as amended by*  
13                *subsection (a) of this section, the following new paragraph:*

14                    “(6) *REQUIREMENTS FOR CERTAIN LIBRARIES*  
15                    *WITH COMPUTERS HAVING INTERNET ACCESS.—*

16                    “(A) *INTERNET FILTERING.—*

17                    “(i) *IN GENERAL.—A library having*  
18                    *one or more computers with Internet access*  
19                    *may not receive services at discount rates*  
20                    *under paragraph (1)(B) unless the*  
21                    *library—*

22                    “(I) *submits to the Commission a*  
23                    *certification described in subparagraph*  
24                    *(B); and*

1                   “(II) ensures the use of such com-  
2                   puters in accordance with the certifi-  
3                   cation.

4                   “(ii) *APPLICABILITY.*—The prohibition  
5                   in paragraph (1) shall not apply with re-  
6                   spect to a library that receives services at  
7                   discount rates under paragraph (1)(B) only  
8                   for purposes other than the provision of  
9                   Internet access, Internet service, or internal  
10                  connections.

11                  “(B) *CERTIFICATION.*—

12                  “(i) *ACCESS OF MINORS TO CERTAIN*  
13                  *MATERIAL.*—A certification under this sub-  
14                  paragraph is a certification that the  
15                  library—

16                  “(I) has selected a technology for  
17                  its computer or computers with Inter-  
18                  net access in order to filter or block  
19                  Internet access through such computer  
20                  or computers to—

21                  “(aa) material that is ob-  
22                  scene;

23                  “(bb) child pornography; and

1                   “(cc) any other material that  
2                   the library determines to be inap-  
3                   propriate for minors; and

4                   “(II) is enforcing a policy to en-  
5                   sure the operation of the technology  
6                   during any use of such computer or  
7                   computers by minors.

8                   “(ii) ACCESS TO CHILD PORNOGRAPHY  
9                   GENERALLY.—

10                   “(I) IN GENERAL.—A certification  
11                   under this subparagraph with respect  
12                   to a library is also a certification that  
13                   the library—

14                   “(aa) has selected a tech-  
15                   nology for its computer or com-  
16                   puters with Internet access in  
17                   order to filter or block Internet ac-  
18                   cess through such computer or  
19                   computers to child pornography;  
20                   and

21                   “(bb) is enforcing a policy to  
22                   ensure the operation of the tech-  
23                   nology during any use of such  
24                   computer or computers.

1           “(II) *SCOPE.*—For purposes of  
2           *identifying child pornography under*  
3           *subclause (I), a library may utilize the*  
4           *definition of that term in section*  
5           *2256(8) of title 18, United States Code.*

6           “(III) *RELATIONSHIP TO OTHER*  
7           *CERTIFICATIONS.*—The certification  
8           *under this clause is in addition to any*  
9           *other certification applicable with re-*  
10           *spect to a library under this subpara-*  
11           *graph.*

12           “(C) *ADDITIONAL USE OF TECHNOLOGY.*—A  
13           *library may also use a technology covered by a*  
14           *certification under subparagraph (B) to filter or*  
15           *block Internet access through the computers con-*  
16           *cerned to any material in addition to the mate-*  
17           *rial specified in that subparagraph that the li-*  
18           *brary determines to be inappropriate for minors.*

19           “(D) *TIMING OF CERTIFICATIONS.*—

20           “(i) *LIBRARIES WITH COMPUTERS ON*  
21           *EFFECTIVE DATE.*—

22           “(I) *IN GENERAL.*—In the case of  
23           *any library covered by this paragraph*  
24           *as of the effective date of this para-*  
25           *graph under section 602(h) of the Chil-*

1            *drens' Internet Protection Act, the cer-*  
2            *tifications under subparagraph (B)*  
3            *shall be made not later than 30 days*  
4            *after such effective date.*

5            “(II) *DELAY.—The certifications*  
6            *for a library covered by subclause (I)*  
7            *may be made at a date than is later*  
8            *than is otherwise required by that sub-*  
9            *clause if State or local procurement*  
10           *rules or regulations or competitive bid-*  
11           *ding requirements prevent the making*  
12           *of the certifications on the date other-*  
13           *wise required by that subclause. A li-*  
14           *brary shall notify the Commission of*  
15           *the applicability of this subclause to*  
16           *the library. Such notice shall specify*  
17           *the date on which the certifications*  
18           *with respect to the library shall be ef-*  
19           *fective for purposes of this clause.*

20           “(ii) *LIBRARIES ACQUIRING COM-*  
21           *PUTERS AFTER EFFECTIVE DATE.—In the*  
22           *case of any library that first becomes subject*  
23           *to the certifications under subparagraph*  
24           *(B) after such effective date, the certifi-*  
25           *cations under that subparagraph shall be*

1           *made not later than 10 days after the date*  
2           *on which the library first becomes so sub-*  
3           *ject.*

4           “(iii) *NO REQUIREMENT FOR ADDI-*  
5           *TIONAL CERTIFICATIONS.—A library that*  
6           *has submitted the certifications under sub-*  
7           *paragraph (B) shall not be required for*  
8           *purposes of this paragraph to submit an ad-*  
9           *ditional certifications under that subpara-*  
10          *graph with respect to any computers having*  
11          *Internet access that are acquired by the li-*  
12          *brary after the submittal of such certifi-*  
13          *cations.*

14          “(E) *NONCOMPLIANCE.—*

15          “(i) *FAILURE TO SUBMIT CERTIFI-*  
16          *CATION.—Any library that knowingly fails*  
17          *to submit the certifications required by this*  
18          *paragraph shall reimburse each tele-*  
19          *communications carrier that provided such*  
20          *library services at discount rates under*  
21          *paragraph (1)(B) after the effective date of*  
22          *this paragraph under section 602(h) of the*  
23          *Childrens’ Internet Protection Act in an*  
24          *amount equal to the amount of the discount*  
25          *provided such library by such carrier for*

1           *such services during the period beginning*  
2           *on such effective date and ending on the*  
3           *date on which the provision of such services*  
4           *at discount rates under paragraph (1)(B) is*  
5           *determined to cease under subparagraph*  
6           *(F).*

7           “(ii) *FAILURE TO COMPLY WITH CER-*  
8           *TIFICATION.—Any library that knowingly*  
9           *fails to ensure the use of its computers in*  
10           *accordance with a certification under sub-*  
11           *paragraph (B) shall reimburse each tele-*  
12           *communications carrier that provided such*  
13           *library services at discount rates under*  
14           *paragraph (1)(B) after the date of such cer-*  
15           *tification in an amount equal to the*  
16           *amount of the discount provided such li-*  
17           *brary by such carrier for such services dur-*  
18           *ing the period beginning on the date of such*  
19           *certification and ending on the date on*  
20           *which the provision of such services at dis-*  
21           *count rates under paragraph (1)(B) is de-*  
22           *termined to cease under subparagraph (F).*

23           “(iii) *TREATMENT OF REIMBURSE-*  
24           *MENT.—The receipt by a telecommuni-*  
25           *cations carrier of any reimbursement under*

1            *this subparagraph shall not affect the car-*  
2            *rier's treatment of the discount on which*  
3            *such reimbursement was based in accord-*  
4            *ance with the third sentence of paragraph*  
5            *(1)(B).*

6            *“(F) CESSATION DATE.—*

7                    *“(i) DETERMINATION.—The Commis-*  
8                    *sion shall determine the date on which the*  
9                    *provision of services at discount rates under*  
10                   *paragraph (1)(B) shall cease under this*  
11                   *paragraph by reason of the failure of a li-*  
12                   *brary to comply with the requirements of*  
13                   *this paragraph.*

14                   *“(ii) NOTIFICATION.—The Commission*  
15                   *shall notify telecommunications carriers of*  
16                   *each library determined to have failed to*  
17                   *comply with the requirements of this para-*  
18                   *graph and of the period for which such li-*  
19                   *brary shall be liable to make reimbursement*  
20                   *under subparagraph (E).*

21            *“(G) RECOMMENCEMENT OF DISCOUNTS.—*

22                   *“(i) RECOMMENCEMENT.—Upon sub-*  
23                   *mittal to the Commission of a certification*  
24                   *under subparagraph (B) with respect to a*  
25                   *library to which clause (i) or (ii) of sub-*

1 paragraph (E) applies, the library shall be  
2 entitled to services at discount rates under  
3 paragraph (1)(B).

4 “(ii) NOTIFICATION.—The Commission  
5 shall notify the library and telecommuni-  
6 cations carriers of the recommencement of  
7 the library’s entitlement to services at dis-  
8 count rates under this paragraph and of the  
9 date on which such recommencement begins.

10 “(iii) ADDITIONAL NONCOMPLIANCE.—  
11 The provisions of subparagraphs (E) and  
12 (F) shall apply to any certification sub-  
13 mitted under clause (i).

14 “(H) PUBLIC AVAILABILITY OF POLICY.—A  
15 library that enforces a policy under clause (i)(II)  
16 or (ii)(I)(bb) of subparagraph (B) shall take ap-  
17 propriate actions to ensure the ready availability  
18 to the public of information on such policy and  
19 on its policy, if any, relating to the use of tech-  
20 nology under subparagraph (C).

21 “(I) LIMITATION ON FEDERAL ACTION.—

22 “(i) IN GENERAL.—No agency or in-  
23 strumentality of the United States Govern-  
24 ment may—

1                   “(I) establish any criteria for  
2                   making a determination under sub-  
3                   paragraph (C);

4                   “(II) review a determination  
5                   made by a library for purposes of a  
6                   certification under subparagraph (B);  
7                   or

8                   “(III) consider the criteria em-  
9                   ployed by a library purposes of deter-  
10                  mining the eligibility of the library for  
11                  services at discount rates under para-  
12                  graph (1)(B).

13                  “(ii) ACTION BY COMMISSION.—The  
14                  Commission may not take any action  
15                  against a library for a violation of a provi-  
16                  sion of this paragraph if the library has  
17                  made a good faith effort to comply with  
18                  such provision.”.

19                  (c) MINOR DEFINED.—Paragraph (7) of such section,  
20 as redesignated by subsection (a)(1) of this section, is  
21 amended by adding at the end the following:

22                  “(D) MINOR.—The term ‘minor’ means any  
23                  individual who has not attained the age of 17  
24                  years.”.

1       (d) *CONFORMING AMENDMENT.*—Paragraph (4) of  
2 such section is amended by striking “paragraph (5)(A)”  
3 and inserting “paragraph (7)(A)”.

4       (e) *SEPARABILITY.*—If any provision of paragraph (5)  
5 or (6) of section 254(h) of the Communications Act of 1934,  
6 as amended by this section, or the application thereof to  
7 any person or circumstance is held invalid, the remainder  
8 of such paragraph and the application of such paragraph  
9 to other persons or circumstances shall not be affected there-  
10 by.

11       (f) *REGULATIONS.*—

12           (1) *REQUIREMENT.*—The Federal Communica-  
13 tions Commission shall prescribe regulations for pur-  
14 poses of administering the provisions of paragraphs  
15 (5) and (6) of section 254(h) of the Communications  
16 Act of 1934, as amended by this section.

17           (2) *DEADLINE.*—Notwithstanding any other pro-  
18 vision of law, the requirements prescribed under  
19 paragraph (1) shall take effect 120 days after the date  
20 of the enactment of this Act.

21       (g) *AVAILABILITY OF RATES.*—Discounted rates under  
22 section 254(h)(1)(B) of the Communications Act of 1934 (47  
23 U.S.C. 254(h)(1)(B))—

24           (1) shall be available in amounts up to the an-  
25 nual cap on Federal universal service support for

1        *schools and libraries only for services covered by Fed-*  
2        *eral Communications Commission regulations on pri-*  
3        *orities for funding telecommunications services, Inter-*  
4        *net access, Internet services, and Internet connections*  
5        *that assign priority for available funds for the poorest*  
6        *schools; and*

7                (2) *to the extent made available under para-*  
8        *graph (1), may be used for the purchase or acquisi-*  
9        *tion of filtering or blocking products necessary to*  
10       *meet the requirements of section 254(h)(5) and (6) of*  
11       *that Act, but not for the purchase of software or other*  
12       *technology other than what is required to meet those*  
13       *requirements.*

14        (h) *EFFECTIVE DATE.*—*The amendments made by this*  
15       *section shall take effect 120 days after the date of the enact-*  
16       *ment of this Act.*

17        *SEC. 603. FETAL TISSUE.* *The General Accounting Of-*  
18       *fice shall conduct a comprehensive study into Federal in-*  
19       *volvement in the use of fetal tissue for research purposes*  
20       *within the scope of this Act to be completed by September*  
21       *1, 2000. The study shall include but not be limited to—*

22                (1) *the annual number of orders for fetal tissue*  
23        *filled in conjunction with federally funded fetal tissue*  
24        *research or programs over the last 3 years;*

1           (2) *the costs associated with the procurement,*  
2 *dissemination, and other use of fetal tissue, including*  
3 *but not limited to the costs associated with the proc-*  
4 *essing, transportation, preservation, quality control,*  
5 *and storage of such tissue;*

6           (3) *the manner in which Federal agencies ensure*  
7 *that intramural and extramural research facilities*  
8 *and their employees comply with Federal fetal tissue*  
9 *law;*

10          (4) *the number of fetal tissue procurement con-*  
11 *tractors and tissue resource sources, or other entities*  
12 *or individuals that are used to obtain, transport,*  
13 *process, preserve, or store fetal tissue, which receive*  
14 *Federal funds and the quantity, form, and nature of*  
15 *the services provided and the amount of Federal funds*  
16 *received by such entities;*

17          (5) *the number and identity of all Federal agen-*  
18 *cies within the scope of this Act expending or ex-*  
19 *changing Federal funds in connection with obtaining*  
20 *or processing fetal tissue or the conduct of research*  
21 *using such tissue;*

22          (6) *the extent to which Federal fetal tissue pro-*  
23 *urement policies and guidelines adhere to Federal*  
24 *law;*

1           (7) *the criteria that Federal fetal tissue research*  
2           *facilities use for selecting their fetal tissue sources,*  
3           *and the manner in which the facilities ensure that*  
4           *such sources comply with Federal law.*

5           *SEC. 604. PROVISION OF INTERNET FILTERING OR*  
6           *SCREENING SOFTWARE BY CERTAIN INTERNET SERVICE*  
7           *PROVIDERS. (a) REQUIREMENT TO PROVIDE.—Each Inter-*  
8           *net service provider shall at the time of entering an agree-*  
9           *ment with a residential customer for the provision of Inter-*  
10          *net access services, provide to such customer, either at no*  
11          *fee or at a fee not in excess of the amount specified in sub-*  
12          *section (c), computer software or other filtering or blocking*  
13          *system that allows the customer to prevent the access of mi-*  
14          *nors to material on the Internet.*

15          *(b) SURVEYS OF PROVISION OF SOFTWARE OR SYS-*  
16          *TEMS.—*

17                 *(1) SURVEYS.—The Office of Juvenile Justice*  
18                 *and Delinquency Prevention of the Department of*  
19                 *Justice and the Federal Trade Commission shall*  
20                 *jointly conduct surveys of the extent to which Internet*  
21                 *service providers are providing computer software or*  
22                 *systems described in subsection (a) to their sub-*  
23                 *scribers. In performing such surveys, neither the De-*  
24                 *partment nor the Commission shall collect personally*

1        *identifiable information of subscribers of the Internet*  
2        *service providers.*

3            (2) *FREQUENCY.*—*The surveys required by para-*  
4        *graph (1) shall be completed as follows:*

5            (A) *One shall be completed not later than*  
6            *one year after the date of the enactment of this*  
7            *Act.*

8            (B) *One shall be completed not later than*  
9            *two years after that date.*

10          (C) *One shall be completed not later than*  
11          *three years after that date.*

12          (c) *FEES.*—*The fee, if any, charged and collected by*  
13        *an Internet service provider for providing computer soft-*  
14        *ware or a system described in subsection (a) to a residential*  
15        *customer shall not exceed the amount equal to the cost of*  
16        *the provider in providing the software or system to the sub-*  
17        *scriber, including the cost of the software or system and of*  
18        *any license required with respect to the software or system.*

19          (d) *APPLICABILITY.*—*The requirement described in*  
20        *subsection (a) shall become effective only if—*

21            (1) *1 year after the date of the enactment of this*  
22        *Act, the Office and the Commission determine as a re-*  
23        *sult of the survey completed by the deadline in sub-*  
24        *section (b)(2)(A) that less than 75 percent of the total*  
25        *number of residential subscribers of Internet service*

1 providers as of such deadline are provided computer  
2 software or systems described in subsection (a) by  
3 such providers;

4 (2) 2 years after the date of enactment of this  
5 Act, the Office and the Commission determine as a re-  
6 sult of the survey completed by the deadline in sub-  
7 section (b)(2)(B) that less than 85 percent of the total  
8 number of residential subscribers of Internet service  
9 providers as of such deadline are provided such soft-  
10 ware or systems by such providers; or

11 (3) 3 years after the date of the enactment of this  
12 Act, if the Office and the Commission determine as a  
13 result of the survey completed by the deadline in sub-  
14 section (b)(2)(C) that less than 100 percent of the  
15 total number of residential subscribers of Internet  
16 service providers as of such deadline are provided  
17 such software or systems by such providers.

18 (e) *INTERNET SERVICE PROVIDER DEFINED.*—In this  
19 section, the term “Internet service provider” means a serv-  
20 ice provider as defined in section 512(k)(1)(A) of title 17,  
21 United States Code, which has more than 50,000 sub-  
22 sscribers.

1 *TITLE VII—UNIVERSAL SERVICE FOR SCHOOLS*  
2 *AND LIBRARIES*

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

5 *SEC. 702. NO UNIVERSAL SERVICE FOR SCHOOLS OR*  
6 *LIBRARIES THAT FAIL TO IMPLEMENT A FILTERING OR*  
7 *BLOCKING SYSTEM FOR COMPUTERS WITH INTERNET AC-*  
8 *CESS OR ADOPT INTERNET USE POLICIES. (a) NO UNI-*  
9 *VERSAL SERVICE.—*

10 *(1) IN GENERAL.—Section 254 of the Commu-*  
11 *nications Act of 1934 (47 U.S.C. 254) is amended by*  
12 *adding at the end the following:*

13 *“(l) IMPLEMENTATION OF INTERNET FILTERING OR*  
14 *BLOCKING SYSTEM OR USE POLICIES.—*

15 *“(1) IN GENERAL.—No services may be provided*  
16 *under subsection (h)(1)(B) to any elementary or sec-*  
17 *ondary school, or any library, unless it provides the*  
18 *certification required by paragraph (2) to the Com-*  
19 *mission or its designee.*

20 *“(2) CERTIFICATION.—A certification under this*  
21 *paragraph with respect to a school or library is a cer-*  
22 *tification by the school, school board, or other author-*  
23 *ity with responsibility for administration of the*  
24 *school, or the library, or any other entity representing*

1 *the school or library in applying for universal service*  
2 *assistance, that the school or library—*

3 *“(A) has—*

4 *“(i) selected a system for its computers*  
5 *with Internet access that are dedicated to*  
6 *student use in order to filter or block Inter-*  
7 *net access to matter considered to be inap-*  
8 *propriate for minors; and*

9 *“(ii) installed on such computers, or*  
10 *upon obtaining such computers will install*  
11 *on such computers, a system to filter or*  
12 *block Internet access to such matter; or*

13 *“(B)(i) has adopted and implemented an*  
14 *Internet use policy that addresses—*

15 *“(I) access by minors to inappropriate*  
16 *matter on the Internet and World Wide*  
17 *Web;*

18 *“(II) the safety and security of minors*  
19 *when using electronic mail, chat rooms, and*  
20 *other forms of direct electronic communica-*  
21 *tions;*

22 *“(III) unauthorized access, including*  
23 *so-called ‘hacking’, and other unlawful ac-*  
24 *tivities by minors online;*

1           “(IV) *unauthorized disclosure, use, and*  
2           *dissemination of personal identification in-*  
3           *formation regarding minors; and*

4           “(V) *whether the school or library, as*  
5           *the case may be, is employing hardware,*  
6           *software, or other technological means to*  
7           *limit, monitor, or otherwise control or guide*  
8           *Internet access by minors; and*

9           “(i) *provided reasonable public notice and*  
10          *held at least one public hearing or meeting which*  
11          *addressed the proposed Internet use policy.*

12          “(3) *LOCAL DETERMINATION OF CONTENT.—For*  
13          *purposes of a certification under paragraph (2), the*  
14          *determination regarding what matter is inappro-*  
15          *prate for minors shall be made by the school board,*  
16          *library, or other authority responsible for making the*  
17          *determination. No agency or instrumentality of the*  
18          *United States Government may—*

19                 “(A) *establish criteria for making such de-*  
20                 *termination;*

21                 “(B) *review the determination made by the*  
22                 *certifying school, school board, library, or other*  
23                 *authority; or*

24                 “(C) *consider the criteria employed by the*  
25                 *certifying school, school board, library, or other*

1           *authority in the administration of subsection*  
2           *(h)(1)(B).*

3           “(4) *EFFECTIVE DATE.*—*This subsection shall*  
4           *apply with respect to schools and libraries seeking*  
5           *universal service assistance under subsection*  
6           *(h)(1)(B) on or after July 1, 2001.*”.

7           (2) *CONFORMING AMENDMENT.*—*Subsection*  
8           *(h)(1)(B) of that section is amended by striking “All*  
9           *telecommunications” and inserting “Except as pro-*  
10           *vided by subsection (l), all telecommunications”.*

11          (b) *STUDY.*—*Not later than 150 days after the date*  
12          *of the enactment of this Act, the National Telecommuni-*  
13          *cations and Information Administration shall initiate a*  
14          *notice and comment proceeding for purposes of—*

15                (1) *evaluating whether or not currently available*  
16                *commercial Internet blocking, filtering, and moni-*  
17                *toring software adequately addresses the needs of edu-*  
18                *cational institutions;*

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

22                (3) *evaluating the development and effectiveness*  
23                *of local Internet use policies that are currently in op-*  
24                *eration after community input.*

1        *SEC. 703. IMPLEMENTING REGULATIONS. Not later*  
2 *than 100 days after the date of the enactment of this Act,*  
3 *the Federal Communications Commission shall adopt rules*  
4 *implementing this title and the amendments made by this*  
5 *title.*

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

8        *SEC. 801. SHORT TITLE. This title may be cited as*  
9 *the “Social Security and Medicare Off-Budget Lockbox Act*  
10 *of 2000”.*

11        *SEC. 802. STRENGTHENING SOCIAL SECURITY POINTS*  
12 *OF ORDER. (a) IN GENERAL.—Section 312 of the Congres-*  
13 *sional Budget Act of 1974 (2 U.S.C. 643) is amended by*  
14 *inserting at the end the following:*

15                *“(g) STRENGTHENING SOCIAL SECURITY POINT OF*  
16 *ORDER.—It shall not be in order in the House of Represent-*  
17 *atives or the Senate to consider a concurrent resolution on*  
18 *the budget (or any amendment thereto or conference report*  
19 *thereon) or any bill, joint resolution, amendment, motion,*  
20 *or conference report that would violate or amend section*  
21 *13301 of the Budget Enforcement Act of 1990.”.*

22                *(b) SUPER MAJORITY REQUIREMENT.—*

23                        *(1) POINT OF ORDER.—Section 904(c)(1) of the*  
24 *Congressional Budget Act of 1974 is amended by in-*  
25 *serting “312(g),” after “310(d)(2),”.*



1 *as new budget authority, outlays, receipts, or deficit or sur-*  
2 *plus for purposes of—*

3           “(1) *the budget of the United States Government*  
4           *as submitted by the President;*

5           “(2) *the congressional budget; or*

6           “(3) *the Balanced Budget and Emergency Deficit*  
7           *Control Act of 1985.*

8           “(b) *STRENGTHENING MEDICARE POINT OF ORDER.—*  
9 *It shall not be in order in the House of Representatives or*  
10 *the Senate to consider a concurrent resolution on the budget*  
11 *(or any amendment thereto or conference report thereon)*  
12 *or any bill, joint resolution, amendment, motion, or con-*  
13 *ference report that would violate or amend this section.”.*

14           (2) *SUPER MAJORITY REQUIREMENT.—*

15                   (A) *POINT OF ORDER.—Section 904(c)(1) of*  
16 *the Congressional Budget Act of 1974 is amended*  
17 *by inserting “316,” after “313,”.*

18                   (B) *WAIVER.—Section 904(d)(2) of the Con-*  
19 *gressional Budget Act of 1974 is amended by in-*  
20 *serting “316,” after “313,”.*

21           (b) *EXCLUSION OF MEDICARE TRUST FUND FROM*  
22 *CONGRESSIONAL BUDGET.—Section 301(a) of the Congres-*  
23 *sional Budget Act of 1974 (2 U.S.C. 632(a)) is amended*  
24 *by adding at the end the following: “The concurrent resolu-*  
25 *tion shall not include the outlays and revenue totals of the*

1 *Federal Hospital Insurance Trust Fund in the surplus or*  
2 *deficit totals required by this subsection or in any other*  
3 *surplus or deficit totals required by this title.”*

4 *(c) BUDGET TOTALS.—Section 301(a) of the Congres-*  
5 *sional Budget Act of 1974 (2 U.S.C. 632(a)) is amended*  
6 *by inserting after paragraph (7) the following:*

7 *“(8) For purposes of Senate enforcement under*  
8 *this title, revenues and outlays of the Federal Hos-*  
9 *pital Insurance Trust Fund for each fiscal year cov-*  
10 *ered by the budget resolution.”.*

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

14 *(1) striking “SOCIAL SECURITY POINT OF*  
15 *ORDER.—It shall” and inserting “SOCIAL SECURITY*  
16 *AND MEDICARE POINTS OF ORDER.—*

17 *“(1) SOCIAL SECURITY.—It shall”; and*

18 *(2) inserting at the end the following:*

19 *“(2) MEDICARE.—It shall not be in order in the*  
20 *House of Representatives or the Senate to consider*  
21 *any concurrent resolution on the budget (or amend-*  
22 *ment, motion, or conference report on the resolution)*  
23 *that would decrease the excess of the Federal Hospital*  
24 *Insurance Trust Fund revenues over Federal Hospital*  
25 *Insurance Trust Fund outlays in any of the fiscal*

1        *years covered by the concurrent resolution. This para-*  
2        *graph shall not apply to amounts to be expended from*  
3        *the Hospital Insurance Trust Fund for purposes re-*  
4        *lating to programs within part A of Medicare as pro-*  
5        *vided in law on the date of enactment of this para-*  
6        *graph.”.*

7        *(e) MEDICARE FIREWALL.—Section 311(a) of the Con-*  
8        *gressional Budget Act of 1974 (2 U.S.C. 642(a)) is amended*  
9        *by adding after paragraph (3), the following:*

10            *“(4) ENFORCEMENT OF MEDICARE LEVELS IN*  
11            *THE SENATE.—After a concurrent resolution on the*  
12            *budget is agreed to, it shall not be in order in the*  
13            *Senate to consider any bill, joint resolution, amend-*  
14            *ment, motion, or conference report that would cause*  
15            *a decrease in surpluses or an increase in deficits of*  
16            *the Federal Hospital Insurance Trust Fund in any*  
17            *year relative to the levels set forth in the applicable*  
18            *resolution. This paragraph shall not apply to*  
19            *amounts to be expended from the Hospital Insurance*  
20            *Trust Fund for purposes relating to programs within*  
21            *part A of Medicare as provided in law on the date*  
22            *of enactment of this paragraph.”.*

23        *(f) BASELINE TO EXCLUDE HOSPITAL INSURANCE*  
24        *TRUST FUND.—Section 257(b)(3) of the Balanced Budget*  
25        *and Emergency Deficit Control Act of 1985 is amended by*

1 *striking “shall be included in all” and inserting “shall not*  
 2 *be included in any”.*

3       (g) *MEDICARE TRUST FUND EXEMPT FROM SEQUES-*  
 4 *TERS.—Section 255(g)(1)(B) of the Balanced Budget and*  
 5 *Emergency Deficit Control Act of 1985 is amended by add-*  
 6 *ing at the end the following:*

7               *“Medicare as funded through the Federal Hos-*  
 8 *pital Insurance Trust Fund.”.*

9       (h) *BUDGETARY TREATMENT OF HOSPITAL INSUR-*  
 10 *ANCE TRUST FUND.—Section 710(a) of the Social Security*  
 11 *Act (42 U.S.C. 911(a)) is amended—*

12               (1) *by striking “and” the second place it appears*  
 13 *and inserting a comma; and*

14               (2) *by inserting after “Federal Disability Insur-*  
 15 *ance Trust Fund” the following: “, Federal Hospital*  
 16 *Insurance Trust Fund”.*

17       *SEC. 804. PREVENTING ON-BUDGET DEFICITS. (a)*  
 18 *POINTS OF ORDER TO PREVENT ON-BUDGET DEFICITS.—*  
 19 *Section 312 of the Congressional Budget Act of 1974 (2*  
 20 *U.S.C. 643) is amended by adding at the end the following:*

21       *“(h) POINTS OF ORDER TO PREVENT ON-BUDGET*  
 22 *DEFICITS.—*

23               *“(1) CONCURRENT RESOLUTIONS ON THE BUDG-*  
 24 *ET.—It shall not be in order in the House of Rep-*  
 25 *resentatives or the Senate to consider any concurrent*

1 *resolution on the budget, or conference report thereon*  
2 *or amendment thereto, that would cause or increase*  
3 *an on-budget deficit for any fiscal year.*

4 “(2) *SUBSEQUENT LEGISLATION.—Except as*  
5 *provided by paragraph (3), it shall not be in order*  
6 *in the House of Representatives or the Senate to con-*  
7 *sider any bill, joint resolution, amendment, motion,*  
8 *or conference report if—*

9 “(A) *the enactment of that bill or resolution*  
10 *as reported;*

11 “(B) *the adoption and enactment of that*  
12 *amendment; or*

13 “(C) *the enactment of that bill or resolution*  
14 *in the form recommended in that conference re-*  
15 *port,*

16 *would cause or increase an on-budget deficit for any*  
17 *fiscal year.”.*

18 (b) *SUPER MAJORITY REQUIREMENT.—*

19 (1) *POINT OF ORDER.—Section 904(c)(1) of the*  
20 *Congressional Budget Act of 1974 is amended by in-*  
21 *serting “312(h),” after “312(g),”.*

22 (2) *WAIVER.—Section 904(d)(2) of the Congres-*  
23 *sional Budget Act of 1974 is amended by inserting*  
24 *“312(h),” after “312(g),”.*

1        *SEC. 805. SOCIAL SECURITY AND MEDICARE SAFE*  
2 *DEPOSIT BOX ACT OF 2000. (a) SHORT TITLE.—This sec-*  
3 *tion may be cited as the “Social Security and Medicare*  
4 *Safe Deposit Box Act of 2000”.*

5        *(b) PROTECTION OF SOCIAL SECURITY AND MEDICARE*  
6 *SURPLUSES.—*

7            *(1) MEDICARE SURPLUSES OFF-BUDGET.—Not-*  
8 *withstanding any other provision of law, the net sur-*  
9 *plus of any trust fund for part A of Medicare shall*  
10 *not be counted as a net surplus for purposes of—*

11                    *(A) the budget of the United States Govern-*  
12 *ment as submitted by the President;*

13                    *(B) the congressional budget; or*

14                    *(C) the Balanced Budget and Emergency*  
15 *Deficit Control Act of 1985.*

16            *(2) POINTS OF ORDER TO PROTECT SOCIAL SE-*  
17 *CURITY AND MEDICARE SURPLUSES.—Section 312 of*  
18 *the Congressional Budget Act of 1974 is amended by*  
19 *adding at the end the following new subsection:*

20            *“(g) POINTS OF ORDER TO PROTECT SOCIAL SECU-*  
21 *RITY AND MEDICARE SURPLUSES.—*

22                    *“(1) CONCURRENT RESOLUTIONS ON THE BUDG-*  
23 *ET.—It shall not be in order in the House of Rep-*  
24 *resentatives or the Senate to consider any concurrent*  
25 *resolution on the budget, or conference report thereon*

1       or amendment thereto, that would set forth an on-  
2       budget deficit for any fiscal year.

3               “(2) *SUBSEQUENT LEGISLATION.*—It shall not be  
4       in order in the House of Representatives or the Senate  
5       to consider any bill, joint resolution, amendment, mo-  
6       tion, or conference report if—

7               “(A) the enactment of that bill or resolution  
8       as reported;

9               “(B) the adoption and enactment of that  
10       amendment; or

11              “(C) the enactment of that bill or resolution  
12       in the form recommended in that conference re-  
13       port,

14       would cause or increase an on-budget deficit for any  
15       fiscal year.

16              “(3) *DEFINITION.*—For purposes of this section,  
17       the term ‘on-budget deficit’, when applied to a fiscal  
18       year, means the deficit in the budget as set forth in  
19       the most recently agreed to concurrent resolution on  
20       the budget pursuant to section 301(a)(3) for that fis-  
21       cal year.”.

22              (3) *SUPER MAJORITY REQUIREMENT.*—

23              (A) *POINT OF ORDER.*—Section 904(c)(1) of  
24       the Congressional Budget Act of 1974 is amended  
25       by inserting “312(g),” after “310(d)(2),”.

1                   (B) *WAIVER*.—Section 904(d)(2) of the Con-  
2                   gressional Budget Act of 1974 is amended by in-  
3                   serting “312(g),” after “310(d)(2),”.

4                   (c) *PROTECTION OF SOCIAL SECURITY AND MEDICARE*  
5                   *SURPLUSES*.—

6                   (1) *IN GENERAL*.—Chapter 11 of subtitle II of  
7                   title 31, United States Code, is amended by adding  
8                   before section 1101 the following:

9                   “**§ 1100. Protection of social security and medicare**  
10                   **surpluses**

11                   “The budget of the United States Government sub-  
12                   mitted by the President under this chapter shall not rec-  
13                   ommend an on-budget deficit for any fiscal year covered  
14                   by that budget.”.

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

“1100. Protection of social security and medicare surpluses.”.

19                   (d) *EFFECTIVE DATE*.—This section shall take effect  
20                   upon the date of its enactment and the amendments made  
21                   by this section shall apply to fiscal year 2001 and subse-  
22                   quent fiscal years.



1 a group health plan, shall not adjust premium or contribu-  
2 tion amounts for a group on the basis of predictive genetic  
3 information concerning any individual (including a de-  
4 pendent) or family member of the individual (including in-  
5 formation about a request for or receipt of genetic serv-  
6 ices).”.

7 (3) CONFORMING AMENDMENTS.—

8 (A) IN GENERAL.—Section 702(b) of the  
9 Employee Retirement Income Security Act of  
10 1974 (29 U.S.C. 1182(b)) is amended by adding  
11 at the end the following:

12 “(3) REFERENCE TO RELATED PROVISION.—For  
13 a provision prohibiting the adjustment of premium or  
14 contribution amounts for a group under a group  
15 health plan on the basis of predictive genetic informa-  
16 tion (including information about a request for or re-  
17 ceipt of genetic services), see section 714.”.

18 (B) TABLE OF CONTENTS.—The table of  
19 contents in section 1 of the Employee Retirement  
20 Income Security Act of 1974 is amended by in-  
21 serting after the item relating to section 713 the  
22 following new item:

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

23 (b) LIMITATION ON COLLECTION OF PREDICTIVE GE-  
24 NETIC INFORMATION.—Section 702 of the Employee Retire-

1 *ment Income Security Act of 1974 (29 U.S.C. 1182) is*  
2 *amended by adding at the end the following:*

3       “(c) *COLLECTION OF PREDICTIVE GENETIC INFORMA-*  
4 *TION.—*

5               “(1) *LIMITATION ON REQUESTING OR REQUIRING*  
6 *PREDICTIVE GENETIC INFORMATION.—Except as pro-*  
7 *vided in paragraph (2), a group health plan, or a*  
8 *health insurance issuer offering health insurance cov-*  
9 *erage in connection with a group health plan, shall*  
10 *not request or require predictive genetic information*  
11 *concerning any individual (including a dependent) or*  
12 *family member of the individual (including informa-*  
13 *tion about a request for or receipt of genetic services).*

14               “(2) *INFORMATION NEEDED FOR DIAGNOSIS,*  
15 *TREATMENT, OR PAYMENT.—*

16               “(A) *IN GENERAL.—Notwithstanding para-*  
17 *graph (1), a group health plan, or a health in-*  
18 *surance issuer offering health insurance coverage*  
19 *in connection with a group health plan, that*  
20 *provides health care items and services to an in-*  
21 *dividual or dependent may request (but may not*  
22 *require) that such individual or dependent dis-*  
23 *close, or authorize the collection or disclosure of,*  
24 *predictive genetic information for purposes of di-*  
25 *agnosis, treatment, or payment relating to the*

1           *provision of health care items and services to*  
2           *such individual or dependent.*

3           “(B) *NOTICE OF CONFIDENTIALITY PRACTICES AND DESCRIPTION OF SAFEGUARDS.*—As a  
4           *part of a request under subparagraph (A), the*  
5           *group health plan, or a health insurance issuer*  
6           *offering health insurance coverage in connection*  
7           *with a group health plan, shall provide to the in-*  
8           *dividual or dependent a description of the proce-*  
9           *dures in place to safeguard the confidentiality,*  
10           *as described in subsection (d), of such predictive*  
11           *genetic information.*

12           “(d) *CONFIDENTIALITY WITH RESPECT TO PRE-*  
13           *dictive Genetic Information.*—

14           “(1) *NOTICE OF CONFIDENTIALITY PRACTICES.*—

15           “(A) *PREPARATION OF WRITTEN NOTICE.*—  
16           *A group health plan, or a health insurance*  
17           *issuer offering health insurance coverage in con-*  
18           *nection with a group health plan, shall post or*  
19           *provide, in writing and in a clear and con-*  
20           *spicuous manner, notice of the plan or issuer’s*  
21           *confidentiality practices, that shall include—*

22           “(i) *a description of an individual’s*  
23           *rights with respect to predictive genetic in-*  
24           *formation;*  
25

1           “(ii) the procedures established by the  
2           plan or issuer for the exercise of the individ-  
3           ual’s rights; and

4           “(iii) the right to obtain a copy of the  
5           notice of the confidentiality practices re-  
6           quired under this subsection.

7           “(B) *MODEL NOTICE.*—The Secretary, in  
8           consultation with the National Committee on  
9           Vital and Health Statistics and the National As-  
10          sociation of Insurance Commissioners, and after  
11          notice and opportunity for public comment, shall  
12          develop and disseminate model notices of con-  
13          fidentiality practices. Use of the model notice  
14          shall serve as a defense against claims of receiv-  
15          ing inappropriate notice.

16          “(2) *ESTABLISHMENT OF SAFEGUARDS.*—A  
17          group health plan, or a health insurance issuer offer-  
18          ing health insurance coverage in connection with a  
19          group health plan, shall establish and maintain ap-  
20          propriate administrative, technical, and physical  
21          safeguards to protect the confidentiality, security, ac-  
22          curacy, and integrity of predictive genetic informa-  
23          tion created, received, obtained, maintained, used,  
24          transmitted, or disposed of by such plan or issuer.”.

1           (c) *DEFINITIONS.*—Section 733(d) of the *Employee Re-*  
2 *tirement Income Security Act of 1974 (29 U.S.C. 1191b(d))*  
3 *is amended by adding at the end the following:*

4           “(5) *FAMILY MEMBER.*—The term ‘family mem-  
5 *ber’ means with respect to an individual—*

6           “(A) *the spouse of the individual;*

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

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

13           “(6) *GENETIC INFORMATION.*—The term ‘genetic  
14 *information’ means information about genes, gene*  
15 *products, or inherited characteristics that may derive*  
16 *from an individual or a family member (including*  
17 *information about a request for or receipt of genetic*  
18 *services).*

19           “(7) *GENETIC SERVICES.*—The term ‘genetic  
20 *services’ means health services provided to obtain, as-*  
21 *sess, or interpret genetic information for diagnostic*  
22 *and therapeutic purposes, and for genetic education*  
23 *and counseling.*

24           “(8) *PREDICTIVE GENETIC INFORMATION.*—

1           “(A) *IN GENERAL.*—The term ‘predictive ge-  
2           netic information’ means, in the absence of  
3           symptoms, clinical signs, or a diagnosis of the  
4           condition related to such information—

5                   “(i) information about an individual’s  
6                   genetic tests;

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

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

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

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

15                   “(ii) information derived from phys-  
16                   ical tests, such as the chemical, blood, or  
17                   urine analyses of the individual including  
18                   cholesterol tests; and

19                   “(iii) information about physical  
20                   exams of the individual.

21           “(9) *GENETIC TEST.*—The term ‘genetic test’  
22           means the analysis of human DNA, RNA, chro-  
23           mosomes, proteins, and certain metabolites, including  
24           analysis of genotypes, mutations, phenotypes, or  
25           karyotypes, for the purpose of predicting risk of dis-

1 *ease in asymptomatic or undiagnosed individuals.*  
2 *Such term does not include physical tests, such as the*  
3 *chemical, blood, or urine analyses of the individual*  
4 *including cholesterol tests, and physical exams of the*  
5 *individual, in order to detect symptoms, clinical*  
6 *signs, or a diagnosis of disease.”.*

7 *(d) EFFECTIVE DATE.—Except as provided in this sec-*  
8 *tion, this section and the amendments made by this section*  
9 *shall apply with respect to group health plans for plan*  
10 *years beginning 1 year after the date of the enactment of*  
11 *this Act.*

12 *SEC. 903. AMENDMENTS TO THE PUBLIC HEALTH*  
13 *SERVICE ACT. (a) AMENDMENTS RELATING TO THE GROUP*  
14 *MARKET.—*

15 *(1) PROHIBITION OF HEALTH DISCRIMINATION*  
16 *ON THE BASIS OF GENETIC INFORMATION IN THE*  
17 *GROUP MARKET.—*

18 *(A) NO ENROLLMENT RESTRICTION FOR GE-*  
19 *NETIC SERVICES.—Section 2702(a)(1)(F) of the*  
20 *Public Health Service Act (42 U.S.C. 300gg-*  
21 *1(a)(1)(F)) is amended by inserting before the*  
22 *period the following: “(including information*  
23 *about a request for or receipt of genetic serv-*  
24 *ices)”.*

1                   (B) *NO DISCRIMINATION IN PREMIUMS*  
2                   *BASED ON PREDICTIVE GENETIC INFORMATION.*—  
3                   *Subpart 2 of part A of title XXVII of the Public*  
4                   *Health Service Act (42 U.S.C. 300gg–4 et seq.)*  
5                   *is amended by adding at the end the following*  
6                   *new section:*

7                   **“SEC. 2707. PROHIBITING PREMIUM DISCRIMINATION**  
8                   **AGAINST GROUPS ON THE BASIS OF PRE-**  
9                   **DICTIVE GENETIC INFORMATION IN THE**  
10                   **GROUP MARKET.**

11                   *“A group health plan, or a health insurance issuer of-*  
12                   *fering group health insurance coverage in connection with*  
13                   *a group health plan shall not adjust premium or contribu-*  
14                   *tion amounts for a group on the basis of predictive genetic*  
15                   *information concerning any individual (including a de-*  
16                   *pendent) or family member of the individual (including in-*  
17                   *formation about a request for or receipt of genetic serv-*  
18                   *ices).”.*

19                   (C) *CONFORMING AMENDMENT.*—*Section*  
20                   *2702(b) of the Public Health Service Act (42*  
21                   *U.S.C. 300gg–1(b)) is amended by adding at the*  
22                   *end the following:*

23                   **“(3) REFERENCE TO RELATED PROVISION.**—*For*  
24                   *a provision prohibiting the adjustment of premium or*  
25                   *contribution amounts for a group under a group*

1 *health plan on the basis of predictive genetic informa-*  
2 *tion (including information about a request for or re-*  
3 *ceipt of genetic services), see section 2707.”.*

4 (D) *LIMITATION ON COLLECTION AND DIS-*  
5 *CLOSURE OF PREDICTIVE GENETIC INFORMA-*  
6 *TION.—Section 2702 of the Public Health Service*  
7 *Act (42 U.S.C. 300gg–1) is amended by adding*  
8 *at the end the following:*

9 “(c) *COLLECTION OF PREDICTIVE GENETIC INFORMA-*  
10 *TION.—*

11 “(1) *LIMITATION ON REQUESTING OR REQUIRING*  
12 *PREDICTIVE GENETIC INFORMATION.—Except as pro-*  
13 *vided in paragraph (2), a group health plan, or a*  
14 *health insurance issuer offering health insurance cov-*  
15 *erage in connection with a group health plan, shall*  
16 *not request or require predictive genetic information*  
17 *concerning any individual (including a dependent) or*  
18 *a family member of the individual (including infor-*  
19 *mation about a request for or receipt of genetic serv-*  
20 *ices).*

21 “(2) *INFORMATION NEEDED FOR DIAGNOSIS,*  
22 *TREATMENT, OR PAYMENT.—*

23 “(A) *IN GENERAL.—Notwithstanding para-*  
24 *graph (1), a group health plan, or a health in-*  
25 *surance issuer offering health insurance coverage*

1           *in connection with a group health plan, that*  
2           *provides health care items and services to an in-*  
3           *dividual or dependent may request (but may not*  
4           *require) that such individual or dependent dis-*  
5           *close, or authorize the collection or disclosure of,*  
6           *predictive genetic information for purposes of di-*  
7           *agnosis, treatment, or payment relating to the*  
8           *provision of health care items and services to*  
9           *such individual or dependent.*

10           “(B) NOTICE OF CONFIDENTIALITY PRAC-  
11           TICES AND DESCRIPTION OF SAFEGUARDS.—As a  
12           part of a request under subparagraph (A), the  
13           group health plan, or a health insurance issuer  
14           offering health insurance coverage in connection  
15           with a group health plan, shall provide to the in-  
16           dividual or dependent a description of the proce-  
17           dures in place to safeguard the confidentiality,  
18           as described in subsection (d), of such predictive  
19           genetic information.

20           “(d) CONFIDENTIALITY WITH RESPECT TO PRE-  
21           DICTIVE GENETIC INFORMATION.—

22           “(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

23           “(A) PREPARATION OF WRITTEN NOTICE.—

24           A group health plan, or a health insurance  
25           issuer offering health insurance coverage in con-

1            *nection with a group health plan, shall post or*  
2            *provide, in writing and in a clear and con-*  
3            *spicuous manner, notice of the plan or issuer’s*  
4            *confidentiality practices, that shall include—*

5                    *“(i) a description of an individual’s*  
6                    *rights with respect to predictive genetic in-*  
7                    *formation;*

8                    *“(ii) the procedures established by the*  
9                    *plan or issuer for the exercise of the individ-*  
10                   *ual’s rights; and*

11                   *“(iii) the right to obtain a copy of the*  
12                   *notice of the confidentiality practices re-*  
13                   *quired under this subsection.*

14                   *“(B) MODEL NOTICE.—The Secretary, in*  
15                   *consultation with the National Committee on*  
16                   *Vital and Health Statistics and the National As-*  
17                   *sociation of Insurance Commissioners, and after*  
18                   *notice and opportunity for public comment, shall*  
19                   *develop and disseminate model notices of con-*  
20                   *fidentiality practices. Use of the model notice*  
21                   *shall serve as a defense against claims of receiv-*  
22                   *ing inappropriate notice.*

23                   *“(2) ESTABLISHMENT OF SAFEGUARDS.—A*  
24                   *group health plan, or a health insurance issuer offer-*  
25                   *ing health insurance coverage in connection with a*

1 *group health plan, shall establish and maintain ap-*  
2 *propriate administrative, technical, and physical*  
3 *safeguards to protect the confidentiality, security, ac-*  
4 *curacy, and integrity of predictive genetic informa-*  
5 *tion created, received, obtained, maintained, used,*  
6 *transmitted, or disposed of by such plan or issuer.”.*

7 (2) *DEFINITIONS.—Section 2791(d) of the Public*  
8 *Health Service Act (42 U.S.C. 300gg–91(d)) is*  
9 *amended by adding at the end the following:*

10 “(15) *FAMILY MEMBER.—The term ‘family mem-*  
11 *ber’ means, with respect to an individual—*

12 “(A) *the spouse of the individual;*

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

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

19 “(16) *GENETIC INFORMATION.—The term ‘ge-*  
20 *netic information’ means information about genes,*  
21 *gene products, or inherited characteristics that may*  
22 *derive from an individual or a family member (in-*  
23 *cluding information about a request for or receipt of*  
24 *genetic services).*

1           “(17) *GENETIC SERVICES.*—*The term ‘genetic*  
2           *services’ means health services provided to obtain, as-*  
3           *sess, or interpret genetic information for diagnostic*  
4           *and therapeutic purposes, and for genetic education*  
5           *and counseling.*

6           “(18) *PREDICTIVE GENETIC INFORMATION.*—

7           “(A) *IN GENERAL.*—*The term ‘predictive ge-*  
8           *netic information’ means, in the absence of*  
9           *symptoms, clinical signs, or a diagnosis of the*  
10           *condition related to such information—*

11                   “(i) *information about an individual’s*  
12                   *genetic tests;*

13                   “(ii) *information about genetic tests of*  
14                   *family members of the individual; or*

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

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

19                   “(i) *information about the sex or age of*  
20                   *the individual;*

21                   “(ii) *information derived from phys-*  
22                   *ical tests, such as the chemical, blood, or*  
23                   *urine analyses of the individual including*  
24                   *cholesterol tests; and*



1 *market may not use predictive genetic information as a*  
2 *condition of eligibility of an individual to enroll in indi-*  
3 *vidual health insurance coverage (including information*  
4 *about a request for or receipt of genetic services).*

5       “(b) *PROHIBITION ON PREDICTIVE GENETIC INFORMA-*  
6 *TION IN SETTING PREMIUM RATES.—A health insurance*  
7 *issuer offering health insurance coverage in the individual*  
8 *market shall not adjust premium rates for individuals on*  
9 *the basis of predictive genetic information concerning such*  
10 *an individual (including a dependent) or a family member*  
11 *of the individual (including information about a request*  
12 *for or receipt of genetic services).*

13       “(c) *COLLECTION OF PREDICTIVE GENETIC INFORMA-*  
14 *TION.—*

15               “(1) *LIMITATION ON REQUESTING OR REQUIRING*  
16 *PREDICTIVE GENETIC INFORMATION.—Except as pro-*  
17 *vided in paragraph (2), a health insurance issuer of-*  
18 *fering health insurance coverage in the individual*  
19 *market shall not request or require predictive genetic*  
20 *information concerning any individual (including a*  
21 *dependent) or a family member of the individual (in-*  
22 *cluding information about a request for or receipt of*  
23 *genetic services).*

24               “(2) *INFORMATION NEEDED FOR DIAGNOSIS,*  
25 *TREATMENT, OR PAYMENT.—*

1           “(A) *IN GENERAL.*—Notwithstanding para-  
2           *graph (1), a health insurance issuer offering*  
3           *health insurance coverage in the individual mar-*  
4           *ket that provides health care items and services*  
5           *to an individual or dependent may request (but*  
6           *may not require) that such individual or de-*  
7           *pendent disclose, or authorize the collection or*  
8           *disclosure of, predictive genetic information for*  
9           *purposes of diagnosis, treatment, or payment re-*  
10          *lating to the provision of health care items and*  
11          *services to such individual or dependent.*

12           “(B) *NOTICE OF CONFIDENTIALITY PRAC-*  
13          *TICES AND DESCRIPTION OF SAFEGUARDS.*—As a  
14          *part of a request under subparagraph (A), the*  
15          *health insurance issuer offering health insurance*  
16          *coverage in the individual market shall provide*  
17          *to the individual or dependent a description of*  
18          *the procedures in place to safeguard the con-*  
19          *fidentiality, as described in subsection (d), of*  
20          *such predictive genetic information.*

21           “(d) *CONFIDENTIALITY WITH RESPECT TO PRE-*  
22          *dictive Genetic Information.*—

23           “(1) *NOTICE OF CONFIDENTIALITY PRACTICES.*—

24           “(A) *PREPARATION OF WRITTEN NOTICE.*—

25          *A health insurance issuer offering health insur-*

1            *ance coverage in the individual market shall post*  
2            *or provide, in writing and in a clear and con-*  
3            *spicuous manner, notice of the issuer’s confiden-*  
4            *tiality practices, that shall include—*

5                    *“(i) a description of an individual’s*  
6                    *rights with respect to predictive genetic in-*  
7                    *formation;*

8                    *“(ii) the procedures established by the*  
9                    *issuer for the exercise of the individual’s*  
10                   *rights; and*

11                   *“(iii) the right to obtain a copy of the*  
12                   *notice of the confidentiality practices re-*  
13                   *quired under this subsection.*

14                   *“(B) MODEL NOTICE.—The Secretary, in*  
15                   *consultation with the National Committee on*  
16                   *Vital and Health Statistics and the National As-*  
17                   *sociation of Insurance Commissioners, and after*  
18                   *notice and opportunity for public comment, shall*  
19                   *develop and disseminate model notices of con-*  
20                   *fidentiality practices. Use of the model notice*  
21                   *shall serve as a defense against claims of receiv-*  
22                   *ing inappropriate notice.*

23                   *“(2) ESTABLISHMENT OF SAFEGUARDS.—A*  
24                   *health insurance issuer offering health insurance cov-*  
25                   *erage in the individual market shall establish and*

1       *maintain appropriate administrative, technical, and*  
2       *physical safeguards to protect the confidentiality, se-*  
3       *curity, accuracy, and integrity of predictive genetic*  
4       *information created, received, obtained, maintained,*  
5       *used, transmitted, or disposed of by such issuer.”.*

6       (c) *EFFECTIVE DATE.*—*The amendments made by this*  
7       *section shall apply with respect to—*

8               (1) *group health plans, and health insurance*  
9       *coverage offered in connection with group health*  
10       *plans, for plan years beginning after 1 year after the*  
11       *date of enactment of this Act; and*

12               (2) *health insurance coverage offered, sold,*  
13       *issued, renewed, in effect, or operated in the indi-*  
14       *vidual market after 1 year after the date of enactment*  
15       *of this Act.*

16       *SEC. 904. AMENDMENTS TO THE INTERNAL REVENUE*  
17       *CODE OF 1986. (a) PROHIBITION OF HEALTH DISCRIMINA-*  
18       *TION ON THE BASIS OF GENETIC INFORMATION OR GE-*  
19       *NETIC SERVICES.—*

20               (1) *NO ENROLLMENT RESTRICTION FOR GENETIC*  
21       *SERVICES.*—*Section 9802(a)(1)(F) of the Internal*  
22       *Revenue Code of 1986 is amended by inserting before*  
23       *the period the following: “(including information*  
24       *about a request for or receipt of genetic services)”.*

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

3                   (A) *IN GENERAL.*—*Subchapter B of chapter*  
4                   *100 of the Internal Revenue Code of 1986 is fur-*  
5                   *ther amended by adding at the end the following:*

6           **“SEC. 9813. PROHIBITING PREMIUM DISCRIMINATION**  
7                   **AGAINST GROUPS ON THE BASIS OF PRE-**  
8                   **DICTIVE GENETIC INFORMATION.**

9           *“A group health plan shall not adjust premium or con-*  
10           *tribution amounts for a group on the basis of predictive*  
11           *genetic information concerning any individual (including*  
12           *a dependent) or a family member of the individual (includ-*  
13           *ing information about a request for or receipt of genetic*  
14           *services).”.*

15                   (B) *CONFORMING AMENDMENT.*—*Section*  
16                   *9802(b) of the Internal Revenue Code of 1986 is*  
17                   *amended by adding at the end the following:*

18                   “(3) *REFERENCE TO RELATED PROVISION.*—*For*  
19                   *a provision prohibiting the adjustment of premium or*  
20                   *contribution amounts for a group under a group*  
21                   *health plan on the basis of predictive genetic informa-*  
22                   *tion (including information about a request for or the*  
23                   *receipt of genetic services), see section 9813.”.*

24                   (C) *AMENDMENT TO TABLE OF SECTIONS.*—  
25                   *The table of sections for subchapter B of chapter*

1           100 of the Internal Revenue Code of 1986 is  
2           amended by adding at the end the following:

          “Sec. 9813. Prohibiting premium discrimination against groups on the basis of  
          predictive genetic information.”.

3           (b) *LIMITATION ON COLLECTION OF PREDICTIVE GE-*  
4 *NETIC INFORMATION.*—Section 9802 of the Internal Rev-  
5 *enue Code of 1986 is amended by adding at the end the*  
6 *following:*

7           “(d) *COLLECTION OF PREDICTIVE GENETIC INFORMA-*  
8 *TION.*—

9                   “(1) *LIMITATION ON REQUESTING OR REQUIRING*  
10 *PREDICTIVE GENETIC INFORMATION.*—*Except as pro-*  
11 *vided in paragraph (2), a group health plan shall not*  
12 *request or require predictive genetic information con-*  
13 *cerning any individual (including a dependent) or a*  
14 *family member of the individual (including informa-*  
15 *tion about a request for or receipt of genetic services).*

16                   “(2) *INFORMATION NEEDED FOR DIAGNOSIS,*  
17 *TREATMENT, OR PAYMENT.*—

18                           “(A) *IN GENERAL.*—*Notwithstanding para-*  
19 *graph (1), a group health plan that provides*  
20 *health care items and services to an individual*  
21 *or dependent may request (but may not require)*  
22 *that such individual or dependent disclose, or*  
23 *authorize the collection or disclosure of, pre-*  
24 *dictive genetic information for purposes of diag-*

1            *nosis, treatment, or payment relating to the pro-*  
2            *vision of health care items and services to such*  
3            *individual or dependent.*

4            “(B) NOTICE OF CONFIDENTIALITY PRAC-  
5            TICES; DESCRIPTION OF SAFEGUARDS.—As a  
6            part of a request under subparagraph (A), the  
7            group health plan shall provide to the individual  
8            or dependent a description of the procedures in  
9            place to safeguard the confidentiality, as de-  
10          scribed in subsection (e), of such predictive ge-  
11          netic information.

12          “(e) CONFIDENTIALITY WITH RESPECT TO PREDICTIVE  
13          GENETIC INFORMATION.—

14            “(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

15            “(A) PREPARATION OF WRITTEN NOTICE.—  
16            A group health plan shall post or provide, in  
17            writing and in a clear and conspicuous manner,  
18            notice of the plan’s confidentiality practices, that  
19            shall include—

20            “(i) a description of an individual’s  
21            rights with respect to predictive genetic in-  
22            formation;

23            “(ii) the procedures established by the  
24            plan for the exercise of the individual’s  
25            rights; and

1                   “(iii) the right to obtain a copy of the  
2                   notice of the confidentiality practices re-  
3                   quired under this subsection.

4                   “(B) *MODEL NOTICE.*—The Secretary, in  
5                   consultation with the National Committee on  
6                   Vital and Health Statistics and the National As-  
7                   sociation of Insurance Commissioners, and after  
8                   notice and opportunity for public comment, shall  
9                   develop and disseminate model notices of con-  
10                  fidentiality practices. Use of the model notice  
11                  shall serve as a defense against claims of receiv-  
12                  ing inappropriate notice.

13                  “(2) *ESTABLISHMENT OF SAFEGUARDS.*—A  
14                  group health plan shall establish and maintain ap-  
15                  propriate administrative, technical, and physical  
16                  safeguards to protect the confidentiality, security, ac-  
17                  curacy, and integrity of predictive genetic informa-  
18                  tion created, received, obtained, maintained, used,  
19                  transmitted, or disposed of by such plan.”.

20                  “(c) *DEFINITIONS.*—Section 9832(d) of the Internal  
21                  Revenue Code of 1986 is amended by adding at the end  
22                  the following:

23                         “(6) *FAMILY MEMBER.*—The term ‘family mem-  
24                         ber’ means, with respect to an individual—

25                                 “(A) the spouse of the individual;

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

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

7           “(7) *GENETIC INFORMATION*.—The term ‘genetic  
8 information’ means information about genes, gene  
9 products, or inherited characteristics that may derive  
10 from an individual or a family member (including  
11 information about a request for or receipt of genetic  
12 services).

13           “(8) *GENETIC SERVICES*.—The term ‘genetic  
14 services’ means health services provided to obtain, as-  
15 sess, or interpret genetic information for diagnostic  
16 and therapeutic purposes, and for genetic education  
17 and counseling.

18           “(9) *PREDICTIVE GENETIC INFORMATION*.—

19           “(A) *IN GENERAL*.—The term ‘predictive ge-  
20 netic information’ means, in the absence of  
21 symptoms, clinical signs, or a diagnosis of the  
22 condition related to such information—

23           “(i) information about an individual’s  
24 genetic tests;

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

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

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

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

9                   “(ii) information derived from phys-  
10                  ical tests, such as the chemical, blood, or  
11                  urine analyses of the individual including  
12                  cholesterol tests; and

13                  “(iii) information about physical  
14                  exams of the individual.

15                  “(10) GENETIC TEST.—The term ‘genetic test’  
16                  means the analysis of human DNA, RNA, chro-  
17                  mosomes, proteins, and certain metabolites, including  
18                  analysis of genotypes, mutations, phenotypes, or  
19                  karyotypes, for the purpose of predicting risk of dis-  
20                  ease in asymptomatic or undiagnosed individuals.  
21                  Such term does not include physical tests, such as the  
22                  chemical, blood, or urine analyses of the individual  
23                  including cholesterol tests, and physical exams of the  
24                  individual, in order to detect symptoms, clinical  
25                  signs, or a diagnosis of disease.”.

1       (d) *EFFECTIVE DATE.*—*Except as provided in this sec-*  
 2 *tion, this section and the amendments made by this section*  
 3 *shall apply with respect to group health plans for plan*  
 4 *years beginning after 1 year after the date of the enactment*  
 5 *of this Act.*

6       ***DIVISION B—HEALTH CARE AC-***  
 7       ***CESS AND PROTECTIONS FOR***  
 8       ***CONSUMERS***

9       ***SEC. 2001. SHORT TITLE.***

10       *This division may be cited as the ‘Patients’ Bill of*  
 11 *Rights Plus Act’.*

12       ***TITLE XXI—TAX-RELATED***  
 13       ***HEALTH CARE PROVISIONS***  
 14       ***Subtitle A—Health Care and Long-***  
 15       ***Term Care***

16       ***SEC. 2101. DEDUCTION FOR HEALTH AND LONG-TERM CARE***  
 17                   ***INSURANCE COSTS OF INDIVIDUALS NOT***  
 18                   ***PARTICIPATING IN EMPLOYER-SUBSIDIZED***  
 19                   ***HEALTH PLANS.***

20       (a) *IN GENERAL.*—*Part VII of subchapter B of chapter*  
 21 *1 of the Internal Revenue Code of 1986 is amended by redес-*  
 22 *ignating section 222 as section 223 and by inserting after*  
 23 *section 221 the following new section:*

1 **“SEC. 222. HEALTH AND LONG-TERM CARE INSURANCE**  
 2 **COSTS.**

3 *“(a) IN GENERAL.—In the case of an individual, there*  
 4 *shall be allowed as a deduction an amount equal to the ap-*  
 5 *plicable percentage of the amount paid during the taxable*  
 6 *year for insurance which constitutes medical care for the*  
 7 *taxpayer and the taxpayer’s spouse and dependents.*

8 *“(b) APPLICABLE PERCENTAGE.—*

9 *“(1) IN GENERAL.—For purposes of subsection*  
 10 *(a), the applicable percentage shall be determined in*  
 11 *accordance with the following table:*

<b>“For taxable years beginning in calendar year—</b>	<b>The applicable percentage is—</b>
2002 and 2003 .....	25
2004 .....	35
2005 .....	65
2006 and thereafter .....	100.

12 *“(2) LONG-TERM CARE INSURANCE FOR INDIVID-*  
 13 *UALS 60 YEARS OR OLDER.—In the case of amounts*  
 14 *paid for a qualified long-term care insurance contract*  
 15 *for an individual who has attained age 60 before the*  
 16 *close of the taxable year, the applicable percentage is*  
 17 *100.*

18 *“(c) LIMITATION BASED ON OTHER COVERAGE.—*

19 *“(1) COVERAGE UNDER CERTAIN SUBSIDIZED*  
 20 *EMPLOYER PLANS.—*

21 *“(A) IN GENERAL.—Subsection (a) shall not*  
 22 *apply to any taxpayer for any calendar month*

1       *for which the taxpayer participates in any*  
2       *health plan maintained by any employer of the*  
3       *taxpayer or of the spouse of the taxpayer if 50*  
4       *percent or more of the cost of coverage under*  
5       *such plan (determined under section 4980B and*  
6       *without regard to payments made with respect to*  
7       *any coverage described in subsection (e)) is paid*  
8       *or incurred by the employer.*

9               “(B) *EMPLOYER CONTRIBUTIONS TO CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND MEDICAL SAVINGS ACCOUNTS.—Employer contributions to a cafeteria plan, a flexible spending or similar arrangement, or a medical savings account which are excluded from gross income under section 106 shall be treated for purposes of subparagraph (A) as paid by the employer.*

18               “(C) *AGGREGATION OF PLANS OF EMPLOYER.—A health plan which is not otherwise described in subparagraph (A) shall be treated as described in such subparagraph if such plan would be so described if all health plans of persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 were treated as one health plan.*

1           “(D) *SEPARATE APPLICATION TO HEALTH*  
2           *INSURANCE AND LONG-TERM CARE INSURANCE.—*  
3           *Subparagraphs (A) and (C) shall be applied sep-*  
4           *arately with respect to—*

5                     “(i) *plans which include primarily*  
6                     *coverage for qualified long-term care serv-*  
7                     *ices or are qualified long-term care insur-*  
8                     *ance contracts, and*

9                     “(ii) *plans which do not include such*  
10                    *coverage and are not such contracts.*

11           “(2) *COVERAGE UNDER CERTAIN FEDERAL PRO-*  
12           *GRAMS.—*

13                     “(A) *IN GENERAL.—*Subsection (a) shall not  
14                     *apply to any amount paid for any coverage for*  
15                     *an individual for any calendar month if, as of*  
16                     *the first day of such month, the individual is*  
17                     *covered under any medical care program de-*  
18                     *scribed in—*

19                     “(i) *title XVIII, XIX, or XXI of the So-*  
20                     *cial Security Act,*

21                     “(ii) *chapter 55 of title 10, United*  
22                     *States Code,*

23                     “(iii) *chapter 17 of title 38, United*  
24                     *States Code,*

1                   “(iv) chapter 89 of title 5, United  
2                   States Code, or

3                   “(v) the Indian Health Care Improve-  
4                   ment Act.

5                   “(B) EXCEPTIONS.—

6                   “(i) QUALIFIED LONG-TERM CARE.—  
7                   Subparagraph (A) shall not apply to  
8                   amounts paid for coverage under a qualified  
9                   long-term care insurance contract.

10                  “(ii) CONTINUATION COVERAGE OF  
11                  FEHBP.—Subparagraph (A)(iv) shall not  
12                  apply to coverage which is comparable to  
13                  continuation coverage under section 4980B.

14                  “(d) LONG-TERM CARE DEDUCTION LIMITED TO  
15                  QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.—  
16                  In the case of a qualified long-term care insurance contract,  
17                  only eligible long-term care premiums (as defined in section  
18                  213(d)(10)) may be taken into account under subsection (a).

19                  “(e) DEDUCTION NOT AVAILABLE FOR PAYMENT OF  
20                  ANCILLARY COVERAGE PREMIUMS.—Any amount paid as  
21                  a premium for insurance which provides for—

22                         “(1) coverage for accidents, disability, dental  
23                         care, vision care, or a specified illness, or

24                         “(2) making payments of a fixed amount per  
25                         day (or other period) by reason of being hospitalized,

1 *shall not be taken into account under subsection (a).*

2 “(f) *SPECIAL RULES.—*

3 “(1) *COORDINATION WITH DEDUCTION FOR*  
4 *HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDI-*  
5 *VIDUALS.—The amount taken into account by the tax-*  
6 *payer in computing the deduction under section*  
7 *162(l) shall not be taken into account under this sec-*  
8 *tion.*

9 “(2) *COORDINATION WITH MEDICAL EXPENSE*  
10 *DEDUCTION.—The amount taken into account by the*  
11 *taxpayer in computing the deduction under this sec-*  
12 *tion shall not be taken into account under section*  
13 *213.*

14 “(g) *REGULATIONS.—The Secretary shall prescribe*  
15 *such regulations as may be appropriate to carry out this*  
16 *section, including regulations requiring employers to report*  
17 *to their employees and the Secretary such information as*  
18 *the Secretary determines to be appropriate.”.*

19 (b) *DEDUCTION ALLOWED WHETHER OR NOT TAX-*  
20 *PAYER ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of*  
21 *section 62 of such Code is amended by inserting after para-*  
22 *graph (17) the following new item:*

23 “(18) *HEALTH AND LONG-TERM CARE INSUR-*  
24 *ANCE COSTS.—The deduction allowed by section*  
25 *222.”.*

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

*“Sec. 222. Health and long-term care insurance costs.*  
*“Sec. 223. Cross reference.”.*

5       (d) *EFFECTIVE DATE.*—*The amendments made by this*  
 6 *section shall apply to taxable years beginning after Decem-*  
 7 *ber 31, 2001.*

8       **SEC. 2102. DEDUCTION FOR 100 PERCENT OF HEALTH IN-**  
 9                                   **SURANCE COSTS OF SELF-EMPLOYED INDI-**  
 10                                  **VIDUALS.**

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

14                   “(1) *ALLOWANCE OF DEDUCTION.*—*In the case of*  
 15 *an individual who is an employee within the mean-*  
 16 *ing of section 401(c)(1), there shall be allowed as a*  
 17 *deduction under this section an amount equal to 100*  
 18 *percent of the amount paid during the taxable year*  
 19 *for insurance which constitutes medical care for the*  
 20 *taxpayer and the taxpayer’s spouse and dependents.”.*

21       (b) *CLARIFICATION OF LIMITATIONS ON OTHER COV-*  
 22 *ERAGE.*—*The first sentence of section 162(l)(2)(B) of such*  
 23 *Code is amended to read as follows: “Paragraph (1) shall*  
 24 *not apply to any taxpayer for any calendar month for*

1 *which the taxpayer participates in any subsidized health*  
2 *plan maintained by any employer (other than an employer*  
3 *described in section 401(c)(4)) of the taxpayer or the spouse*  
4 *of the taxpayer.”.*

5 (c) *EFFECTIVE DATE.*—*The amendments made by this*  
6 *section shall apply to taxable years beginning after Decem-*  
7 *ber 31, 2001.*

8 **SEC. 2103. LONG-TERM CARE INSURANCE PERMITTED TO BE**  
9 **OFFERED UNDER CAFETERIA PLANS AND**  
10 **FLEXIBLE SPENDING ARRANGEMENTS.**

11 (a) *CAFETERIA PLANS.*—

12 (1) *IN GENERAL.*—*Subsection (f) of section 125*  
13 *of the Internal Revenue Code of 1986 (defining quali-*  
14 *fied benefits) is amended by inserting before the pe-*  
15 *riod at the end “; except that such term shall include*  
16 *the payment of premiums for any qualified long-term*  
17 *care insurance contract (as defined in section 7702B)*  
18 *to the extent the amount of such payment does not ex-*  
19 *ceed the eligible long-term care premiums (as defined*  
20 *in section 213(d)(10)) for such contract”.*

21 (b) *FLEXIBLE SPENDING ARRANGEMENTS.*—*Section*  
22 *106 of such Code (relating to contributions by employer to*  
23 *accident and health plans) is amended by striking sub-*  
24 *section (c).*

1           (c) *EFFECTIVE DATE.*—*The amendments made by this*  
2 *section shall apply to taxable years beginning after Decem-*  
3 *ber 31, 2001.*

4 **SEC. 2104. ADDITIONAL PERSONAL EXEMPTION FOR TAX-**  
5 **PAYER CARING FOR ELDERLY FAMILY MEM-**  
6 **BER IN TAXPAYER'S HOME.**

7           (a) *IN GENERAL.*—*Section 151 of the Internal Revenue*  
8 *Code of 1986 (relating to allowance of deductions for per-*  
9 *sonal exemptions) is amended by redesignating subsection*  
10 *(e) as subsection (f) and by inserting after subsection (d)*  
11 *the following new subsection:*

12           “(e) *ADDITIONAL EXEMPTION FOR CERTAIN ELDERLY*  
13 *FAMILY MEMBERS RESIDING WITH TAXPAYER.*—

14                   “(1) *IN GENERAL.*—*An exemption of the exemp-*  
15 *tion amount for each qualified family member of the*  
16 *taxpayer.*

17                   “(2) *QUALIFIED FAMILY MEMBER.*—*For purposes*  
18 *of this subsection, the term ‘qualified family member’*  
19 *means, with respect to any taxable year, any*  
20 *individual—*

21                           “(A) *who is an ancestor of the taxpayer or*  
22 *of the taxpayer’s spouse or who is the spouse of*  
23 *any such ancestor,*

1           “(B) who is a member for the entire taxable  
2           year of a household maintained by the taxpayer,  
3           and

4           “(C) who has been certified, before the due  
5           date for filing the return of tax for the taxable  
6           year (without extensions), by a physician (as de-  
7           fined in section 1861(r)(1) of the Social Security  
8           Act) as being an individual with long-term care  
9           needs described in paragraph (3) for a period—

10                   “(i) which is at least 180 consecutive  
11                   days, and

12                   “(ii) a portion of which occurs within  
13                   the taxable year.

14           Such term shall not include any individual otherwise  
15           meeting the requirements of the preceding sentence  
16           unless within the 39½ month period ending on such  
17           due date (or such other period as the Secretary pre-  
18           scribes) a physician (as so defined) has certified that  
19           such individual meets such requirements.

20           “(3) INDIVIDUALS WITH LONG-TERM CARE  
21           NEEDS.—An individual is described in this para-  
22           graph if the individual—

23                   “(A) is unable to perform (without substan-  
24                   tial assistance from another individual) at least  
25                   two activities of daily living (as defined in sec-



1           (1) *future demand for long-term health care serv-*  
2           *ices (including institutional and home and commu-*  
3           *nity-based services) in the United States in order to*  
4           *meet the needs in the 21st century; and*

5           (2) *long-term options to finance the provision of*  
6           *such services.*

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

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

12           (2) *The viability and capacity of community-*  
13           *based and other long-term health care services under*  
14           *different federal programs, including through the*  
15           *medicare and medicaid programs, grants to States,*  
16           *housing services, and changes in tax policy.*

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

19           (4) *The integration of long-term health care serv-*  
20           *ices for individuals between different classes of health*  
21           *care providers (such as hospitals, nursing facilities,*  
22           *and home care agencies) and different Federal pro-*  
23           *grams (such as the medicare and medicaid pro-*  
24           *grams).*

1           (5) *The possibility of expanding private sector*  
2 *initiatives, including long-term care insurance, to*  
3 *meet the need to finance such services.*

4           (6) *An examination of the effect of enactment of*  
5 *the Health Insurance Portability and Accountability*  
6 *Act of 1996 on the provision and financing of long-*  
7 *term health care services, including on portability*  
8 *and affordability of private long-term care insurance,*  
9 *the impact of insurance options on low-income older*  
10 *Americans, and the options for eligibility to improve*  
11 *access to such insurance.*

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

15           (c) *REPORT AND RECOMMENDATIONS.*—

16           (1) *IN GENERAL.*—October 1, 2002, the Secretary  
17 *shall provide for a report on the study under this sec-*  
18 *tion.*

19           (2) *RECOMMENDATIONS.*—The report under  
20 *paragraph (1) shall include findings and rec-*  
21 *ommendations regarding each of the following:*

22                   (A) *The most effective and efficient manner*  
23 *that the Federal Government may use its re-*  
24 *sources to educate the public on planning for*  
25 *needs for long-term health care services.*

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

4           (C) *The role of States and local commu-*  
5           *nities in the financing of long-term health care*  
6           *services.*

7           (3) *INCLUSION OF COST ESTIMATES.—The report*  
8           *under paragraph (1) shall include cost estimates of*  
9           *the various options for which recommendations are*  
10          *made.*

11          (d) *CONDUCT OF STUDY.—*

12           (1) *USE OF INSTITUTE OF MEDICINE.—The Sec-*  
13          *retary of Health and Human Services shall seek to*  
14          *enter into an appropriate arrangement with the In-*  
15          *stitute of Medicine of the National Academy of*  
16          *Sciences to conduct the study under this section. If*  
17          *such an arrangement cannot be made, the Secretary*  
18          *may provide for the conduct of the study by any other*  
19          *qualified non-governmental entity.*

20           (2) *CONSULTATION.—The study should be con-*  
21          *ducted under this section in consultation with experts*  
22          *from a wide-range of groups from the public and pri-*  
23          *vate sectors.*

1           **Subtitle B—Medical Savings**  
2                           **Accounts**

3   **SEC. 2111. EXPANSION OF AVAILABILITY OF MEDICAL SAV-**  
4                           **INGS ACCOUNTS.**

5           (a) *REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL*  
6   *SAVINGS ACCOUNTS.—*

7                   (1) *IN GENERAL.—Subsections (i) and (j) of sec-*  
8                   *tion 220 of the Internal Revenue Code of 1986 are*  
9                   *hereby repealed.*

10                  (2) *CONFORMING AMENDMENTS.—*

11                           (A) *Paragraph (1) of section 220(c) of such*  
12                           *Code is amended by striking subparagraph (D).*

13                           (B) *Section 138 of such Code is amended by*  
14                           *striking subsection (f).*

15           (b) *AVAILABILITY NOT LIMITED TO ACCOUNTS FOR*  
16   *EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED*  
17   *INDIVIDUALS.—*

18                   (1) *IN GENERAL.—Section 220(c)(1)(A) of such*  
19                   *Code (relating to eligible individual) is amended to*  
20                   *read as follows:*

21                           “(A) *IN GENERAL.—The term ‘eligible indi-*  
22                           *vidual’ means, with respect to any month, any*  
23                           *individual if—*

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

4           “(ii) such individual is not, while cov-  
5           ered under a high deductible health plan,  
6           covered under any health plan—

7           “(I) which is not a high deduct-  
8           ible health plan, and

9           “(II) which provides coverage for  
10          any benefit which is covered under the  
11          high deductible health plan.”.

12          (2) *CONFORMING AMENDMENTS.*—

13                (A) Section 220(c)(1) of such Code is  
14                amended by striking subparagraph (C).

15                (B) Section 220(c) of such Code is amended  
16                by striking paragraph (4) (defining small em-  
17                ployer) and by redesignating paragraph (5) as  
18                paragraph (4).

19                (C) Section 220(b) of such Code is amended  
20                by striking paragraph (4) (relating to deduction  
21                limited by compensation) and by redesignating  
22                paragraphs (5), (6), and (7) as paragraphs (4),  
23                (5), and (6), respectively.

24          (c) *INCREASE IN AMOUNT OF DEDUCTION ALLOWED*  
25 *FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.*—

1           (1) *IN GENERAL.*—Paragraph (2) of section  
2   220(b) of such Code is amended to read as follows:

3           “(2) *MONTHLY LIMITATION.*—The monthly limi-  
4   tation for any month is the amount equal to  $\frac{1}{12}$  of  
5   the annual deductible (as of the first day of such  
6   month) of the individual’s coverage under the high de-  
7   ductible health plan.”.

8           (2) *CONFORMING AMENDMENT.*—Clause (ii) of  
9   section 220(d)(1)(A) of such Code is amended by  
10   striking “75 percent of”.

11          (d) *BOTH EMPLOYERS AND EMPLOYEES MAY CON-*  
12   *TRIBUTE TO MEDICAL SAVINGS ACCOUNTS.*—Paragraph  
13   (4) of section 220(b) of such Code (as redesignated by sub-  
14   section (b)(2)(C)) is amended to read as follows:

15          “(4) *COORDINATION WITH EXCLUSION FOR EM-*  
16   *PLOYER CONTRIBUTIONS.*—The limitation which  
17   would (but for this paragraph) apply under this sub-  
18   section to the taxpayer for any taxable year shall be  
19   reduced (but not below zero) by the amount which  
20   would (but for section 106(b)) be includible in the  
21   taxpayer’s gross income for such taxable year.”.

22          (e) *REDUCTION OF PERMITTED DEDUCTIBLES UNDER*  
23   *HIGH DEDUCTIBLE HEALTH PLANS.*—

1           (1) *IN GENERAL.*—Subparagraph (A) of section  
2           220(c)(2) of such Code (defining high deductible  
3           health plan) is amended—

4                   (A) by striking “\$1,500” in clause (i) and  
5                   inserting “\$1,000”;

6                   (B) by striking “\$3,000” in clause (ii) and  
7                   inserting “\$2,000”; and

8                   (C) by striking the matter preceding sub-  
9                   clause (I) in clause (iii) and inserting “pursuant  
10                   to which the annual out-of-pocket expenses (in-  
11                   cluding deductibles and co-payments) are re-  
12                   quired to be paid under the plan (other than for  
13                   premiums) for covered benefits and may not ex-  
14                   ceed—”.

15           (2) *CONFORMING AMENDMENT.*—Subsection (g)  
16           of section 220 of such Code is amended to read as fol-  
17           lows:

18           “(g) *COST-OF-LIVING ADJUSTMENT.*—

19                   “(1) *IN GENERAL.*—In the case of any taxable  
20                   year beginning in a calendar year after 2002, each  
21                   dollar amount in subsection (c)(2) shall be increased  
22                   by an amount equal to—

23                           “(A) such dollar amount, multiplied by

24                           “(B) the cost-of-living adjustment deter-  
25                           mined under section 1(f)(3) for the calendar year

1           *in which such taxable year begins by sub-*  
2           *stituting ‘calendar year 2001’ for ‘calendar year*  
3           *1992’ in subparagraph (B) thereof.*

4           “(2) *SPECIAL RULES.—In the case of the \$1,000*  
5           *amount in subsection (c)(2)(A)(i) and the \$2,000*  
6           *amount in subsection (c)(2)(A)(ii), paragraph (1)(B)*  
7           *shall be applied by substituting ‘calendar year 2002’*  
8           *for ‘calendar year 2001’.*

9           “(3) *ROUNDING.—If any increase under para-*  
10          *graph (1) or (2) is not a multiple of \$50, such in-*  
11          *crease shall be rounded to the nearest multiple of*  
12          *\$50.”.*

13          (f) *LIMITATION ON ADDITIONAL TAX ON DISTRIBUTI-*  
14          *ONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—*  
15          *Section 220(f)(4) of such Code (relating to additional tax*  
16          *on distributions not used for qualified medical expenses) is*  
17          *amended by adding at the end the following:*

18                 “(D) *EXCEPTION IN CASE OF SUFFICIENT*  
19                 *ACCOUNT BALANCE.—Subparagraph (A) shall*  
20                 *not apply to any payment or distribution in*  
21                 *any taxable year, but only to the extent such*  
22                 *payment or distribution does not reduce the fair*  
23                 *market value of the assets of the medical savings*  
24                 *account to an amount less than the annual de-*  
25                 *ductible for the high deductible health plan of the*

1           *account holder (determined as of the earlier of*  
2           *January 1 of the calendar year in which the tax-*  
3           *able year begins or January 1 of the last cal-*  
4           *endar year in which the account holder is cov-*  
5           *ered under a high deductible health plan).”.*

6           *(g) TREATMENT OF NETWORK-BASED MANAGED CARE*  
7           *PLANS.—Section 220(c)(2)(B) of such Code (relating to spe-*  
8           *cial rules for high deductible health plans) is amended by*  
9           *adding at the end the following:*

10                           *“(iii) TREATMENT OF NETWORK-BASED*  
11                           *MANAGED CARE PLANS.—A plan which pro-*  
12                           *vides health care services through a network*  
13                           *of contracted or affiliated health care pro-*  
14                           *viders, if the benefits provided when services*  
15                           *are obtained through network providers*  
16                           *meet the requirements of subparagraph (A),*  
17                           *shall not fail to be treated as a high deduct-*  
18                           *ible health plan by reason of providing ben-*  
19                           *efits for services rendered by providers who*  
20                           *are not members of the network, so long as*  
21                           *the annual deductible and annual limit on*  
22                           *out-of-pocket expenses applicable to services*  
23                           *received from non-network providers are not*  
24                           *lower than those applicable to services re-*  
25                           *ceived from the network providers.”.*

1       (h) *MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED*  
2 *UNDER CAFETERIA PLANS.*—Subsection (f) of section 125  
3 of such Code is amended by striking “106(b),”.

4       (i) *EFFECTIVE DATE.*—

5           (1) *IN GENERAL.*—Except as provided by para-  
6 graph (2), the amendments made by this section shall  
7 apply to taxable years beginning after December 31,  
8 2001.

9           (2) *LIMITATION ON ADDITIONAL TAX ON DIS-*  
10 *TRIBUTIONS NOT USED FOR QUALIFIED MEDICAL*  
11 *EXPENSES.*—The amendment made by subsection (f)  
12 shall apply to taxable years beginning after December  
13 31, 2005.

14 **SEC. 2112. AMENDMENTS TO TITLE 5, UNITED STATES**  
15 **CODE, RELATING TO MEDICAL SAVINGS AC-**  
16 **COUNTS AND HIGH DEDUCTIBLE HEALTH**  
17 **PLANS UNDER FEHBP.**

18       (a) *MEDICAL SAVINGS ACCOUNTS.*—

19           (1) *CONTRIBUTIONS.*—Title 5, United States  
20 Code, is amended by redesignating section 8906a as  
21 section 8906c and by inserting after section 8906 the  
22 following:

1 **“§ 8906a. Government contributions to medical sav-**  
2 **ings accounts**

3 “(a) *An employee or annuitant enrolled in a high de-*  
4 *ductible health plan is entitled, in addition to the Govern-*  
5 *ment contribution under section 8906(b) toward the sub-*  
6 *scription charge for such plan, to have a Government con-*  
7 *tribution made, in accordance with succeeding provisions*  
8 *of this section, to a medical savings account of such em-*  
9 *ployee or annuitant.*

10 “(b)(1) *The biweekly Government contribution under*  
11 *this section shall, in the case of any such employee or annu-*  
12 *itant, be equal to the amount (if any) by which—*

13 “(A) *the biweekly equivalent of the maximum*  
14 *Government contribution for the contract year in-*  
15 *volved (as defined by paragraph (2)), exceeds*

16 “(B) *the amount of the biweekly Government*  
17 *contribution payable on such employee’s or annu-*  
18 *itant’s behalf under section 8906(b) for the period in-*  
19 *volved.*

20 “(2) *For purposes of this section, the term ‘maximum*  
21 *Government contribution’ means, with respect to a contract*  
22 *year, the maximum Government contribution that could be*  
23 *made for health benefits for an employee or annuitant for*  
24 *such contract year, as determined under section 8906(b)*  
25 *(disregarding paragraph (2) thereof).*

1       “(3) Notwithstanding any other provision of this sec-  
2 tion, no contribution under this section shall be payable to  
3 any medical savings account of an employee or annuitant  
4 for any period—

5               “(A) if, as of the first day of the month before  
6 the month in which such period commences, such em-  
7 ployee or annuitant (or the spouse of such employee  
8 or annuitant, if coverage is for self and family) is en-  
9 titled to benefits under part A of title XVIII of the  
10 Social Security Act;

11               “(B) to the extent that such contribution, when  
12 added to previous contributions made under this sec-  
13 tion for that same year with respect to such employee  
14 or annuitant, would cause the total to exceed—

15                       “(i) the limitation under paragraph (1) of  
16 section 220(b) of the Internal Revenue Code of  
17 1986 (determined without regard to paragraph  
18 (3) thereof) which is applicable to such employee  
19 or annuitant for the calendar year in which such  
20 period commences; or

21                       “(ii) such lower amount as the employee or  
22 annuitant may specify in accordance with regu-  
23 lations of the Office, including an election not to  
24 receive contributions under this section for a  
25 year or the remainder of a year; or

1           “(C) for which any information (or documenta-  
2           tion) under subsection (d) that is needed in order to  
3           make such contribution has not been timely sub-  
4           mitted.

5           “(4) Notwithstanding any other provision of this sec-  
6           tion, no contribution under this section shall be payable to  
7           any medical savings account of an employee for any period  
8           in a contract year unless that employee was enrolled in a  
9           health benefits plan under this chapter as an employee for  
10          not less than—

11           “(A) the 1 year of service immediately before the  
12          start of such contract year, or

13           “(B) the full period or periods of service between  
14          the last day of the first period, as prescribed by regu-  
15          lations of the Office of Personnel Management, in  
16          which he is eligible to enroll in the plan and the day  
17          before the start of such contract year,  
18          whichever is shorter.

19           “(5) The Office shall provide for the conversion of bi-  
20          weekly rates of contributions specified by paragraph (1) to  
21          rates for employees and annuitants whose pay or annuity  
22          is provided on other than a biweekly basis, and for this  
23          purpose may provide for the adjustment of the converted  
24          rate to the nearest cent.

25           “(c) A Government contribution under this section—



1 *with applicable regulations under subsection (c) such*  
2 *amount as the employee or annuitant may specify.*

3 “(b) *Notwithstanding subsection (a), no withholding*  
4 *under this section may be made from the pay or annuity*  
5 *of an employee or annuitant for any period—*

6 “(1) *if, or to the extent that, a Government con-*  
7 *tribution for such period under section 8906a would*  
8 *not be allowable by reason of subparagraph (A) or*  
9 *(B)(i) of subsection (b)(3) thereof;*

10 “(2) *for which any information (or documenta-*  
11 *tion) that is needed in order to make such contribu-*  
12 *tion has not been timely submitted; or*

13 “(3) *if the employee or annuitant submits a re-*  
14 *quest for termination of withholdings, beginning on*  
15 *or after the effective date of the request and before the*  
16 *end of the year.*

17 “(c) *The Office of Personnel Management shall pre-*  
18 *scribe any regulations necessary to carry out this section,*  
19 *including provisions relating to the time, form, and manner*  
20 *in which any request for withholdings under this section*  
21 *may be made, changed, or terminated.”.*

22 (2) *RULES OF CONSTRUCTION.—Nothing in this*  
23 *section or in any amendment made by this section*  
24 *shall be considered—*

1           (A) to permit or require that any contribu-  
2           tions to a medical savings account (whether by  
3           the Government or through withholdings from  
4           pay or annuity) be paid into the Employees  
5           Health Benefits Fund; or

6           (B) to affect any authority under section  
7           1005(f) of title 39, United States Code, to vary,  
8           add to, or substitute for any provision of chapter  
9           89 of title 5, United States Code, as amended by  
10          this section.

11          (3) CONFORMING AMENDMENTS.—

12           (A) The table of sections at the beginning of  
13           chapter 89 of title 5, United States Code, is  
14           amended by striking the item relating to section  
15           8906a and inserting the following:

“8906a. Government contributions to medical savings accounts.

“8906b. Individual contributions to medical savings accounts.

“8906c. Temporary employees.”.

16           (B) Section 8913(b)(4) of title 5, United  
17           States Code, is amended by striking “8906a(a)”  
18           and inserting “8906c(a)”.

19          (b) INFORMATIONAL REQUIREMENTS.—Section 8907 of  
20          title 5, United States Code, is amended by adding at the  
21          end the following:

22           “(c) In addition to any information otherwise required  
23          under this section, the Office shall make available to all em-

1 *ployees and annuitants eligible to enroll in a high deduct-*  
2 *ible health plan, information relating to—*

3           “(1) *the conditions under which Government*  
4 *contributions under section 8906a shall be made to a*  
5 *medical savings account;*

6           “(2) *the amount of any Government contribu-*  
7 *tions under section 8906a to which an employee or*  
8 *annuitant may be entitled (or how such amount may*  
9 *be ascertained);*

10           “(3) *the conditions under which contributions to*  
11 *a medical savings account may be made under section*  
12 *8906b through withholdings from pay or annuity;*  
13 *and*

14           “(4) *any other matter the Office considers appro-*  
15 *priate in connection with medical savings accounts.”.*

16       (c) *HIGH DEDUCTIBLE HEALTH PLAN AND MEDICAL*  
17 *SAVINGS ACCOUNT DEFINED.—Section 8901 of title 5,*  
18 *United States Code, is amended—*

19           (1) *in paragraph (10) by striking “and” after*  
20 *the semicolon;*

21           (2) *in paragraph (11) by striking the period and*  
22 *inserting a semicolon; and*

23           (3) *by adding at the end the following:*

1           “(12) the term ‘high deductible health plan’  
2           means a plan described by section 8903(5) or section  
3           8903a(d); and

4           “(13) the term ‘medical savings account’ has the  
5           meaning given such term by section 220(d) of the In-  
6           ternal Revenue Code of 1986.”.

7           (d) *AUTHORITY TO CONTRACT FOR HIGH DEDUCT-*  
8           *IBLE HEALTH PLANS, ETC.—*

9           (1) *CONTRACTS FOR HIGH DEDUCTIBLE HEALTH*  
10          *PLANS.—Section 8902 of title 5, United States Code,*  
11          *is amended by adding at the end the following:*

12          “(p)(1) *The Office shall contract under this chapter for*  
13          *a high deductible health plan with any qualified carrier*  
14          *that offers such a plan and, as of the date of enactment*  
15          *of this subsection, offers a health benefits plan under this*  
16          *chapter.*

17          “(2) *The Office may contract under this chapter for*  
18          *a high deductible health plan with any qualified carrier*  
19          *that offers such a plan, but does not, as of the date of enact-*  
20          *ment of this subsection, offer a health benefits plan under*  
21          *this chapter.”.*

22          (2) *COMPUTATION OF GOVERNMENT CONTRIBU-*  
23          *TIONS TO PLANS UNDER CHAPTER 89 NOT AFFECTED*  
24          *BY HIGH DEDUCTIBLE HEALTH PLANS.—Paragraph*  
25          *(2) of section 8906(a) of title 5, United States Code,*

1        *is amended by striking “(2)” and inserting “(2)(A)”,*  
 2        *and adding at the end the following:*

3        *“(B) Notwithstanding any other provision of this sec-*  
 4        *tion, the subscription charges for, and the number of enroll-*  
 5        *ees enrolled in, high deductible health plans shall be dis-*  
 6        *regarded for purposes of determining any weighted average*  
 7        *under paragraph (1).”.*

8        *(e) DESCRIPTION OF HIGH DEDUCTIBLE HEALTH*  
 9        *PLANS AND BENEFITS TO BE PROVIDED THEREUNDER.—*

10        *(1) IN GENERAL.—Section 8903 of title 5,*  
 11        *United States Code, is amended by adding at the end*  
 12        *the following:*

13        *“(5) HIGH DEDUCTIBLE HEALTH PLANS.—(A)*  
 14        *One or more plans described by paragraph (1), (2),*  
 15        *(3), or (4), which—*

16        *“(i) are high deductible health plans (as de-*  
 17        *finied by section 220(c)(2) of the Internal Rev-*  
 18        *enue Code of 1986); and*

19        *“(ii) provide benefits of the types referred to*  
 20        *by section 8904(a)(5).*

21        *“(B) Nothing in this section shall be*  
 22        *considered—*

23        *“(i) to prevent a carrier from simulta-*  
 24        *neously offering a plan described by subpara-*

1           *graph (A) and a plan described by paragraph*  
2           *(1) or (2); or*

3                   *“(i) to require that a high deductible health*  
4           *plan offer two levels of benefits.”.*

5           (2) *TYPES OF BENEFITS.*—*Section 8904(a) of*  
6           *title 5, United States Code, is amended by inserting*  
7           *after paragraph (4) the following:*

8                   *“(5) HIGH DEDUCTIBLE HEALTH PLANS.—Ben-*  
9           *efits of the types named under paragraph (1) or (2)*  
10           *of this subsection or both.”.*

11           (3) *CONFORMING AMENDMENTS.*—

12                   (A) *Section 8903a of title 5, United States*  
13           *Code, is amended by redesignating subsection (d)*  
14           *as subsection (e) and by inserting after sub-*  
15           *section (c) the following:*

16                   *“(d) The plans under this section may include one or*  
17           *more plans, otherwise allowable under this section, that sat-*  
18           *isfy the requirements of clauses (i) and (ii) of section*  
19           *8903(5)(A).”.*

20                   (B) *Section 8909(d) of title 5, United States*  
21           *Code, is amended by striking “8903a(d)” and in-*  
22           *serting “8903a(e)”.*

23           (4) *REFERENCES.*—*Section 8903 of title 5,*  
24           *United States Code, is amended by adding after para-*

1        *graph (5) (as added by paragraph (1) of this sub-*  
2        *section) as a flush left sentence, the following:*

3        *“The Office shall prescribe regulations in accordance with*  
4        *which the requirements of section 8902(c), 8902(n), 8909(e),*  
5        *and any other provision of this chapter that applies with*  
6        *respect to a plan described by paragraph (1), (2), (3), or*  
7        *(4) of this section shall apply with respect to the cor-*  
8        *responding plan under paragraph (5) of this section. Simi-*  
9        *lar regulations shall be prescribed with respect to any plan*  
10       *under section 8903a(d).”.*

11       *(f) EFFECTIVE DATE.—The amendments made by this*  
12       *section shall apply with respect to contract years beginning*  
13       *on or after October 1, 2001. The Office of Personnel Man-*  
14       *agement shall take appropriate measures to ensure that cov-*  
15       *erage under a high deductible health plan under chapter*  
16       *89 of title 5, United States Code (as amended by this sec-*  
17       *tion) shall be available as of the beginning of the first con-*  
18       *tract year described in the preceding sentence.*

19       **SEC. 2113. RULE WITH RESPECT TO CERTAIN PLANS.**

20       *(a) IN GENERAL.—Notwithstanding any other provi-*  
21       *sion of law, health insurance issuers may offer, and eligible*  
22       *individuals may purchase, high deductible health plans de-*  
23       *scribed in section 220(c)(2)(A) of the Internal Revenue Code*  
24       *of 1986. Effective for the 5-year period beginning on Octo-*  
25       *ber 1, 2001, such health plans shall not be required to pro-*

1 *vide* payment for any health care items or services that are  
 2 exempt from the plan’s deductible.

3 (b) *EXISTING STATE LAWS.*—A State law relating to  
 4 payment for health care items and services in effect on the  
 5 date of enactment of this Act that is preempted under para-  
 6 graph (1), shall not apply to high deductible health plans  
 7 after the expiration of the 5-year period described in such  
 8 paragraph unless the State reenacts such law after such pe-  
 9 riod.

## 10 ***Subtitle C—Other Health-Related*** 11 ***Provisions***

### 12 ***SEC. 2121. EXPANDED HUMAN CLINICAL TRIALS QUALI-*** 13 ***FYING FOR ORPHAN DRUG CREDIT.***

14 (a) *IN GENERAL.*—Subclause (I) of section  
 15 45C(b)(2)(A)(i) of the Internal Revenue Code of 1986 is  
 16 amended to read as follows:

17 “(I) after the date that the appli-  
 18 cation is filed for designation under  
 19 such section 526, and”.

20 (b) *CONFORMING AMENDMENT.*—Clause (i) of section  
 21 45C(b)(2)(A) of such Code is amended by inserting “which  
 22 is” before “being” and by inserting before the comma at  
 23 the end “and which is designated under section 526 of such  
 24 Act”.

1           (c) *EFFECTIVE DATE.*—*The amendments made by this*  
 2 *section shall apply to amounts paid or incurred after De-*  
 3 *cember 31, 2001.*

4 **SEC. 2122. CARRYOVER OF UNUSED BENEFITS FROM CAFETERIA PLANS, FLEXIBLE SPENDING ARRANGEMENTS, AND HEALTH FLEXIBLE SPENDING ACCOUNTS.**

8           (a) *IN GENERAL.*—*Section 125 of the Internal Revenue*  
 9 *Code of 1986 (relating to cafeteria plans) is amended by*  
 10 *redesignating subsections (h) and (i) as subsections (i) and*  
 11 *(j) and by inserting after subsection (g) the following new*  
 12 *subsection:*

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

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

16                   “(A) *notwithstanding subsection (d)(2), a*  
 17 *plan or other arrangement shall not fail to be*  
 18 *treated as a cafeteria plan or flexible spending or*  
 19 *similar arrangement, and*

20                   “(B) *no amount shall be required to be in-*  
 21 *cluded in gross income by reason of this section*  
 22 *or any other provision of this chapter,*

23 *solely because under such plan or other arrangement*  
 24 *any nontaxable benefit which is unused as of the close*

1       of a taxable year may be carried forward to 1 or more  
2       succeeding taxable years.

3           “(2) *LIMITATION.*—Paragraph (1) shall not  
4       apply to amounts carried from a plan to the extent  
5       such amounts exceed \$500 (applied on an annual  
6       basis). For purposes of this paragraph, all plans and  
7       arrangements maintained by an employer or any re-  
8       lated person shall be treated as 1 plan.

9           “(3) *ALLOWANCE OF ROLLOVER.*—

10           “(A) *IN GENERAL.*—In the case of any un-  
11       used benefit described in paragraph (1) which  
12       consists of amounts in a health flexible spending  
13       account or dependent care flexible spending ac-  
14       count, the plan or arrangement shall provide  
15       that a participant may elect, in lieu of such car-  
16       ryover, to have such amounts distributed to the  
17       participant.

18           “(B) *AMOUNTS NOT INCLUDED IN IN-*  
19       *COME.*—Any distribution under subparagraph  
20       (A) shall not be included in gross income to the  
21       extent that such amount is transferred in a  
22       trustee-to-trustee transfer, or is contributed with-  
23       in 60 days of the date of the distribution, to—

24           “(i) a qualified cash or deferred ar-  
25       rangement described in section 401(k),

1           “(ii) a plan under which amounts are  
2           contributed by an individual’s employer for  
3           an annuity contract described in section  
4           403(b),

5           “(iii) an eligible deferred compensation  
6           plan described in section 457, or

7           “(iv) a medical savings account (with-  
8           in the meaning of section 220).

9           Any amount rolled over under this subparagraph  
10          shall be treated as a rollover contribution for the  
11          taxable year from which the unused amount  
12          would otherwise be carried.

13          “(C) *TREATMENT OF ROLLOVER.*—Any  
14          amount rolled over under subparagraph (B)  
15          shall be treated as an eligible rollover under sec-  
16          tion 220, 401(k), 403(b), or 457, whichever is ap-  
17          plicable, and shall be taken into account in ap-  
18          plying any limitation (or participation require-  
19          ment) on employer or employee contributions  
20          under such section or any other provision of this  
21          chapter for the taxable year of the rollover.

22          “(4) *COST-OF-LIVING ADJUSTMENT.*—In the case  
23          of any taxable year beginning in a calendar year  
24          after 2002, the \$500 amount under paragraph (2)  
25          shall be adjusted at the same time and in the same

1 manner as under section 415(d)(2), except that the  
2 base period taken into account shall be the calendar  
3 quarter beginning October 1, 2001, and any increase  
4 which is not a multiple of \$50 shall be rounded to the  
5 next lowest multiple of \$50.

6 “(5) *APPLICABILITY*.—This subsection shall  
7 apply to taxable years beginning after December 31,  
8 2001.”.

9 (b) *EFFECTIVE DATE*.—The amendments made by this  
10 section shall apply to taxable years beginning after Decem-  
11 ber 31, 2001.

12 **SEC. 2123. REDUCTION IN TAX ON VACCINES.**

13 (a) *IN GENERAL*.—Paragraph (1) of section 4131(b)  
14 of the Internal Revenue Code of 1986 (relating to amount  
15 of tax) is amended by striking “75 cents” and inserting  
16 “50 cents”.

17 (b) *EFFECTIVE DATE*.—The amendment made by sub-  
18 section (a) shall take effect on January 1, 2002.

19 ***Subtitle D—Miscellaneous***  
20 ***Provisions***

21 **SEC. 2131. NO IMPACT ON SOCIAL SECURITY TRUST FUND.**

22 (a) *IN GENERAL*.—Nothing in this division (or an  
23 amendment made by this division) shall be construed to  
24 alter or amend the Social Security Act (or any regulation  
25 promulgated under that Act).

1       (b) *TRANSFERS.*—

2           (1) *ESTIMATE OF SECRETARY.*—*The Secretary of*  
3 *the Treasury shall annually estimate the impact that*  
4 *the enactment of this division has on the income and*  
5 *balances of the trust funds established under section*  
6 *201 of the Social Security Act (42 U.S.C. 401).*

7           (2) *TRANSFER OF FUNDS.*—*If, under paragraph*  
8 *(1), the Secretary of the Treasury estimates that the*  
9 *enactment of this division has a negative impact on*  
10 *the income and balances of the trust funds established*  
11 *under section 201 of the Social Security Act (42*  
12 *U.S.C. 401), the Secretary shall transfer, not less fre-*  
13 *quently than quarterly, from the general revenues of*  
14 *the Federal Government an amount sufficient so as to*  
15 *ensure that the income and balances of such trust*  
16 *funds are not reduced as a result of the enactment of*  
17 *such division.*

18 **SEC. 2132. CUSTOMS USER FEES.**

19       *Section 13031(j)(3) of the Consolidated Omnibus*  
20 *Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)) is*  
21 *amended by striking “2003” and inserting “2010”.*

1 **SEC. 2133. ESTABLISHMENT OF MEDICARE ADMINISTRA-**  
2 **TIVE FEE FOR SUBMISSION OF PAPER**  
3 **CLAIMS.**

4 (a) *IMPOSITION OF FEE.*—Notwithstanding any other  
5 provision of law and subject to subsection (b), the Secretary  
6 of Health and Human Services shall establish (in the form  
7 of a separate fee or reduction of payment otherwise made  
8 under the medicare program under title XVIII of the Social  
9 Security Act (42 U.S.C. 1395 et seq.)) an administrative  
10 fee of \$1 for the submission of a claim in a paper or non-  
11 electronic form for items or services for which payment is  
12 sought under such title.

13 (b) *EXCEPTION AUTHORITY.*—The Secretary of Health  
14 and Human Services shall waive the imposition of the fee  
15 under subsection (a)—

16 (1) *in cases in which there is no method avail-*  
17 *able for the submission of claims other than in a*  
18 *paper or non-electronic form; and*

19 (2) *for rural providers and small providers that*  
20 *the Secretary determines, under procedures established*  
21 *by the Secretary, are unable to purchase the necessary*  
22 *hardware in order to submit claims electronically.*

23 (c) *TREATMENT OF FEES FOR PURPOSES OF COST RE-*  
24 *PORTS.*—An entity may not include a fee assessed pursuant  
25 to this section as an allowable item on a cost report under

1 *title XVIII of the Social Security Act (42 U.S.C. 1395 et*  
2 *seq.) or title XIX of such Act (42 U.S.C. 1396 et seq.).*

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

5 **SEC. 2134. ESTABLISHMENT OF MEDICARE ADMINISTRA-**  
6 **TIVE FEE FOR SUBMISSION OF DUPLICATE**  
7 **AND UNPROCESSABLE CLAIMS.**

8 (a) *IMPOSITION OF FEE.*—*Notwithstanding any other*  
9 *provision of law, the Secretary of Health and Human Serv-*  
10 *ices shall establish (in the form of a separate fee or reduc-*  
11 *tion of payment otherwise made under the medicare pro-*  
12 *gram under title XVIII of the Social Security Act (42*  
13 *U.S.C. 1395 et seq.)) an administrative fee of \$2 for the*  
14 *submission of a claim described in subsection (b).*

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

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

20 (2) *either—*

21 (A) *duplicates, in whole or in part, another*  
22 *claim submitted by the same individual or enti-*  
23 *ty; or*

24 (B) *is a claim that cannot be processed and*  
25 *must, in accordance with the Secretary of Health*





1 *participation, provide coverage for emergency ambulance*  
2 *services to the extent that a prudent layperson, who pos-*  
3 *sesses an average knowledge of health and medicine, would*  
4 *determine such emergency ambulance services to be nec-*  
5 *essary.*

6 “(c) *CARE AFTER STABILIZATION.*—

7 “(1) *IN GENERAL.*—*In the case of medically nec-*  
8 *essary and appropriate items or services related to the*  
9 *emergency medical condition that may be provided to*  
10 *a participant or beneficiary by a nonparticipating*  
11 *provider after the participant or beneficiary is sta-*  
12 *bilized, the nonparticipating provider shall contact*  
13 *the plan as soon as practicable, but not later than 2*  
14 *hours after stabilization occurs, with respect to*  
15 *whether—*

16 “(A) *the provision of items or services is ap-*  
17 *proved;*

18 “(B) *the participant or beneficiary will be*  
19 *transferred; or*

20 “(C) *other arrangements will be made con-*  
21 *cerning the care and treatment of the partici-*  
22 *pant or beneficiary.*

23 “(2) *FAILURE TO RESPOND AND MAKE ARRANGE-*  
24 *MENTS.*—*If a group health plan fails to respond and*  
25 *make arrangements within 2 hours of being contacted*

1       *in accordance with paragraph (1), then the plan shall*  
2       *be responsible for the cost of any additional items or*  
3       *services provided by the nonparticipating provider*  
4       *if—*

5               “(A) *coverage for items or services of the*  
6               *type furnished by the nonparticipating provider*  
7               *is available under the plan;*

8               “(B) *the items or services are medically nec-*  
9               *essary and appropriate and related to the emer-*  
10              *gency medical condition involved; and*

11              “(C) *the timely provision of the items or*  
12              *services is medically necessary and appropriate.*

13              “(3) *RULE OF CONSTRUCTION.—Nothing in this*  
14              *subsection shall be construed to apply to a group*  
15              *health plan that does not require prior authorization*  
16              *for items or services provided to a participant or ben-*  
17              *eficiary after the participant or beneficiary is sta-*  
18              *bilized.*

19              “(d) *REIMBURSEMENT TO A NON-PARTICIPATING PRO-*  
20              *VIDER.—The responsibility of a group health plan to pro-*  
21              *vide reimbursement to a nonparticipating provider under*  
22              *this section shall cease accruing upon the earlier of—*

23                      “(1) *the transfer or discharge of the participant*  
24                      *or beneficiary; or*

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

3           “(e) *RESPONSIBILITY OF PARTICIPANT.*—With respect  
4 to items or services provided by a nonparticipating pro-  
5 vider under this section, the participant or beneficiary shall  
6 not be responsible for amounts that exceed the amounts (in-  
7 cluding co-insurance, co-payments, deductibles or any other  
8 form of cost-sharing) that would be incurred if the care was  
9 provided by a participating health care provider with prior  
10 authorization.

11          “(f) *RULE OF CONSTRUCTION.*—Nothing in this sec-  
12 tion shall be construed to prohibit a group health plan from  
13 negotiating reimbursement rates with a nonparticipating  
14 provider for items or services provided under this section.

15          “(g) *DEFINITIONS.*—In this section:

16               “(1) *EMERGENCY AMBULANCE SERVICES.*—The  
17 term ‘emergency ambulance services’ means, with re-  
18 spect to a participant or beneficiary under a group  
19 health plan (other than a fully insured group health  
20 plan), ambulance services furnished to transport an  
21 individual who has an emergency medical condition  
22 to a treating facility for receipt of emergency medical  
23 care if—

1           “(A) the emergency services are covered  
2 under the group health plan (other than a fully  
3 insured group health plan) involved; and

4           “(B) a prudent layperson who possesses an  
5 average knowledge of health and medicine could  
6 reasonably expect the absence of such transport  
7 to result in placing the health of the participant  
8 or beneficiary (or, with respect to a pregnant  
9 woman, the health of the woman or her unborn  
10 child) in serious jeopardy, serious impairment to  
11 bodily functions, or serious dysfunction of any  
12 bodily organ or part.

13           “(2) *EMERGENCY MEDICAL CARE.*—The term  
14 ‘emergency medical care’ means, with respect to a  
15 participant or beneficiary under a group health plan  
16 (other than a fully insured group health plan), cov-  
17 ered inpatient and outpatient items or services that—

18           “(A) are furnished by any provider, includ-  
19 ing a nonparticipating provider, that is quali-  
20 fied to furnish such items or services; and

21           “(B) are needed to evaluate or stabilize (as  
22 such term is defined in section 1867(e)(3) of the  
23 Social Security Act (42 U.S.C. 1395dd(e)(3)) an  
24 emergency medical condition.

1           “(3) *EMERGENCY MEDICAL CONDITION.*—The  
2           term ‘emergency medical condition’ means a medical  
3           condition manifesting itself by acute symptoms of suf-  
4           ficient severity (including severe pain) such that a  
5           prudent layperson, who possesses an average knowl-  
6           edge of health and medicine, could reasonably expect  
7           the absence of immediate medical attention to result  
8           in placing the health of the participant or beneficiary  
9           (or, with respect to a pregnant woman, the health of  
10          the woman or her unborn child) in serious jeopardy,  
11          serious impairment to bodily functions, or serious  
12          dysfunction of any bodily organ or part.

13       **“SEC. 722. OFFERING OF CHOICE OF COVERAGE OPTIONS.**

14           “(a) *REQUIREMENT.*—If a group health plan (other  
15          than a fully insured group health plan) provides coverage  
16          for benefits only through a defined set of participating  
17          health care professionals, the plan shall offer the participant  
18          the option to purchase point-of-service coverage (as defined  
19          in subsection (b)) for all such benefits for which coverage  
20          is otherwise so limited. Such option shall be made available  
21          to the participant at the time of enrollment under the plan  
22          and at such other times as the plan offers the participant  
23          a choice of coverage options.

24           “(b) *POINT-OF-SERVICE COVERAGE DEFINED.*—In  
25          this section, the term ‘point-of-service coverage’ means, with

1 *respect to benefits covered under a group health plan (other*  
2 *than a fully insured group health plan), coverage of such*  
3 *benefits when provided by a nonparticipating health care*  
4 *professional.*

5 “(c) *SMALL EMPLOYER EXEMPTION.*—

6 “(1) *IN GENERAL.*—*This section shall not apply*  
7 *to any group health plan (other than a fully insured*  
8 *group health plan) of a small employer.*

9 “(2) *SMALL EMPLOYER.*—*For purposes of para-*  
10 *graph (1), the term ‘small employer’ means, in con-*  
11 *nection with a group health plan (other than a fully*  
12 *insured group health plan) with respect to a calendar*  
13 *year and a plan year, an employer who employed an*  
14 *average of at least 2 but not more than 50 employees*  
15 *on business days during the preceding calendar year*  
16 *and who employs at least 2 employees on the first day*  
17 *of the plan year. For purposes of this paragraph, the*  
18 *provisions of subparagraph (C) of section 712(c)(1)*  
19 *shall apply in determining employer size.*

20 “(d) *RULE OF CONSTRUCTION.*—*Nothing in this sec-*  
21 *tion shall be construed—*

22 “(1) *as requiring coverage for benefits for a par-*  
23 *ticular type of health care professional;*

1           “(2) as requiring an employer to pay any costs  
2 as a result of this section or to make equal contribu-  
3 tions with respect to different health coverage options;

4           “(3) as preventing a group health plan (other  
5 than a fully insured group health plan) from impos-  
6 ing higher premiums or cost-sharing on a participant  
7 for the exercise of a point-of-service coverage option;  
8 or

9           “(4) to require that a group health plan (other  
10 than a fully insured group health plan) include cov-  
11 erage of health care professionals that the plan ex-  
12 cludes because of fraud, quality of care, or other simi-  
13 lar reasons with respect to such professionals.

14 **“SEC. 723. PATIENT ACCESS TO OBSTETRIC AND GYNECO-**  
15 **LOGICAL CARE.**

16           “(a) *GENERAL RIGHTS.*—

17           “(1) *DIRECT ACCESS.*—A group health plan de-  
18 scribed in subsection (b) may not require authoriza-  
19 tion or referral by the primary care provider de-  
20 scribed in subsection (b)(2) in the case of a female  
21 participant or beneficiary who seeks coverage for ob-  
22 stetrical or gynecological care provided by a partici-  
23 pating physician who specializes in obstetrics or gyn-  
24 ecology.

1           “(2) *OBSTETRICAL AND GYNECOLOGICAL CARE.*—  
2           *A group health plan described in subsection (b) shall*  
3           *treat the provision of obstetrical and gynecological*  
4           *care, and the ordering of related obstetrical and gynecological*  
5           *items and services, pursuant to the direct access*  
6           *described under paragraph (1), by a participating*  
7           *health care professional who specializes in ob-*  
8           *stetrics or gynecology as the authorization of the pri-*  
9           *mary care provider.*

10          “(b) *APPLICATION OF SECTION.*—*A group health plan*  
11          *described in this subsection is a group health plan (other*  
12          *than a fully insured group health plan), that—*

13                 “(1) *provides coverage for obstetric or*  
14                 *gynecologic care; and*

15                 “(2) *requires the designation by a participant or*  
16                 *beneficiary of a participating primary care provider*  
17                 *other than a physician who specializes in obstetrics or*  
18                 *gynecology.*

19          “(c) *RULES OF CONSTRUCTION.*—*Nothing in this sec-*  
20          *tion shall be construed—*

21                 “(1) *to require that a group health plan approve*  
22                 *or provide coverage for—*

23                         “(A) *any items or services that are not cov-*  
24                         *ered under the terms and conditions of the group*  
25                         *health plan;*

1           “(B) any items or services that are not  
2           medically necessary and appropriate; or

3           “(C) any items or services that are pro-  
4           vided, ordered, or otherwise authorized under  
5           subsection (a)(2) by a physician unless such  
6           items or services are related to obstetric or  
7           gynecologic care;

8           “(2) to preclude a group health plan from re-  
9           quiring that the physician described in subsection (a)  
10          notify the designated primary care professional or  
11          case manager of treatment decisions in accordance  
12          with a process implemented by the plan, except that  
13          the group health plan shall not impose such a notifi-  
14          cation requirement on the participant or beneficiary  
15          involved in the treatment decision;

16          “(3) to preclude a group health plan from re-  
17          quiring authorization, including prior authorization,  
18          for certain items and services from the physician de-  
19          scribed in subsection (a) who specializes in obstetrics  
20          and gynecology if the designated primary care pro-  
21          vider of the participant or beneficiary would other-  
22          wise be required to obtain authorization for such  
23          items or services;

24          “(4) to require that the participant or bene-  
25          ficiary described in subsection (a)(1) obtain author-

1        *ization or a referral from a primary care provider in*  
2        *order to obtain obstetrical or gynecological care from*  
3        *a health care professional other than a physician if*  
4        *the provision of obstetrical or gynecological care by*  
5        *such professional is permitted by the group health*  
6        *plan and consistent with State licensure,*  
7        *credentialing, and scope of practice laws and regula-*  
8        *tions; or*

9            *“(5) to preclude the participant or beneficiary*  
10        *described in subsection (a)(1) from designating a*  
11        *health care professional other than a physician as a*  
12        *primary care provider if such designation is per-*  
13        *mitted by the group health plan and the treatment by*  
14        *such professional is consistent with State licensure,*  
15        *credentialing, and scope of practice laws and regula-*  
16        *tions.*

17        **“SEC. 724. ACCESS TO PEDIATRIC CARE.**

18            *“(a) PEDIATRIC CARE.—If a group health plan (other*  
19        *than a fully insured group health plan) requires or provides*  
20        *for a participant or beneficiary to designate a participating*  
21        *primary care provider for a child of such participant or*  
22        *beneficiary, the plan shall permit the participant or bene-*  
23        *ficiary to designate a physician who specializes in pediat-*  
24        *rics as the child’s primary care provider if such provider*  
25        *participates in the network of the plan.*

1       “(b) *RULES OF CONSTRUCTION.*—With respect to the  
2 *child of a participant or beneficiary, nothing in subsection*  
3 *(a) shall be construed to—*

4               “(1) *require that the participant or beneficiary*  
5 *obtain prior authorization or a referral from a pri-*  
6 *mary care provider in order to obtain pediatric care*  
7 *from a health care professional other than a physi-*  
8 *cian if the provision of pediatric care by such profes-*  
9 *sional is permitted by the plan and consistent with*  
10 *State licensure, credentialing, and scope of practice*  
11 *laws and regulations; or*

12               “(2) *preclude the participant or beneficiary from*  
13 *designating a health care professional other than a*  
14 *physician as a primary care provider for the child if*  
15 *such designation is permitted by the plan and the*  
16 *treatment by such professional is consistent with*  
17 *State licensure, credentialing, and scope of practice*  
18 *laws.*

19 **“SEC. 725. TIMELY ACCESS TO SPECIALISTS.**

20       “(a) *TIMELY ACCESS.*—

21               “(1) *IN GENERAL.*—A group health plan (other  
22 *than a fully insured group health plan) shall ensure*  
23 *that participants and beneficiaries receive timely cov-*  
24 *erage for access to specialists who are appropriate to*  
25 *the medical condition of the participant or bene-*

1       *ficiary, when such specialty care is a covered benefit*  
2       *under the plan.*

3               “(2) *RULE OF CONSTRUCTION.—Nothing in*  
4       *paragraph (1) shall be construed—*

5                       “(A) *to require the coverage under a group*  
6       *health plan (other than a fully insured group*  
7       *health plan) of benefits or services;*

8                       “(B) *to prohibit a plan from including pro-*  
9       *viders in the network only to the extent necessary*  
10       *to meet the needs of the plan’s participants and*  
11       *beneficiaries;*

12                      “(C) *to prohibit a plan from establishing*  
13       *measures designed to maintain quality and con-*  
14       *trol costs consistent with the responsibilities of*  
15       *the plan; or*

16                      “(D) *to override any State licensure or*  
17       *scope-of-practice law.*

18               “(3) *ACCESS TO CERTAIN PROVIDERS.—*

19                      “(A) *PARTICIPATING PROVIDERS.—Nothing*  
20       *in this section shall be construed to prohibit a*  
21       *group health plan (other than a fully insured*  
22       *group health plan) from requiring that a partic-*  
23       *ipant or beneficiary obtain specialty care from a*  
24       *participating specialist.*

25                      “(B) *NONPARTICIPATING PROVIDERS.—*

1           “(i) *IN GENERAL.*—*With respect to spe-*  
2           *cialty care under this section, if a group*  
3           *health plan (other than a fully insured*  
4           *group health plan) determines that a par-*  
5           *ticipating specialist is not available to pro-*  
6           *vide such care to the participant or bene-*  
7           *ficiary, the plan shall provide for coverage*  
8           *of such care by a nonparticipating spe-*  
9           *cialist.*

10           “(ii) *TREATMENT OF NONPARTICI-*  
11           *PATING PROVIDERS.*—*If a group health plan*  
12           *(other than a fully insured group health*  
13           *plan) refers a participant or beneficiary to*  
14           *a nonparticipating specialist pursuant to*  
15           *clause (i), such specialty care shall be pro-*  
16           *vided at no additional cost to the partici-*  
17           *part or beneficiary beyond what the partici-*  
18           *part or beneficiary would otherwise pay*  
19           *for such specialty care if provided by a par-*  
20           *ticipating specialist.*

21           “(b) *REFERRALS.*—

22           “(1) *AUTHORIZATION.*—*Nothing in this section*  
23           *shall be construed to prohibit a group health plan*  
24           *(other than a fully insured group health plan) from*  
25           *requiring an authorization in order to obtain cov-*

1 *erage for specialty services so long as such authoriza-*  
2 *tion is for an appropriate duration or number of re-*  
3 *ferrals.*

4 “(2) *REFERRALS FOR ONGOING SPECIAL CONDI-*  
5 *TIONS.—*

6 “(A) *IN GENERAL.—A group health plan*  
7 *(other than a fully insured group health plan)*  
8 *shall permit a participant or beneficiary who*  
9 *has an ongoing special condition (as defined in*  
10 *subparagraph (B)) to receive a referral to a spe-*  
11 *cialist for the treatment of such condition and*  
12 *such specialist may authorize such referrals, pro-*  
13 *cedures, tests, and other medical services with re-*  
14 *spect to such condition, or coordinate the care for*  
15 *such condition, subject to the terms of a treat-*  
16 *ment plan referred to in subsection (c) with re-*  
17 *spect to the condition.*

18 “(B) *ONGOING SPECIAL CONDITION DE-*  
19 *FINED.—In this subsection, the term ‘ongoing*  
20 *special condition’ means a condition or disease*  
21 *that—*

22 “(i) *is life-threatening, degenerative, or*  
23 *disabling; and*

24 “(ii) *requires specialized medical care*  
25 *over a prolonged period of time.*

1       “(c) *TREATMENT PLANS.*—

2               “(1) *IN GENERAL.*—*Nothing in this section shall*  
3 *be construed to prohibit a group health plan (other*  
4 *than a fully insured group health plan) from requir-*  
5 *ing that specialty care be provided pursuant to a*  
6 *treatment plan so long as the treatment plan is—*

7                       “(A) *developed by the specialist, in con-*  
8 *sultation with the case manager or primary care*  
9 *provider, and the participant or beneficiary;*

10                      “(B) *approved by the plan in a timely*  
11 *manner if the plan requires such approval; and*

12                      “(C) *in accordance with the applicable*  
13 *quality assurance and utilization review stand-*  
14 *ards of the plan.*

15               “(2) *NOTIFICATION.*—*Nothing in paragraph (1)*  
16 *shall be construed as prohibiting a plan from requir-*  
17 *ing the specialist to provide the plan with regular up-*  
18 *dates on the specialty care provided, as well as all*  
19 *other necessary medical information.*

20               “(d) *SPECIALIST DEFINED.*—*For purposes of this sec-*  
21 *tion, the term ‘specialist’ means, with respect to the medical*  
22 *condition of the participant or beneficiary, a health care*  
23 *professional, facility, or center (such as a center of excel-*  
24 *lence) that has adequate expertise (including age-appro-*

1 *priate expertise) through appropriate training and experi-*  
2 *ence.*

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

8 **“SEC. 726. CONTINUITY OF CARE.**

9       “(a) *TERMINATION OF PROVIDER.*—If a contract be-  
10 *tween a group health plan (other than a fully insured group*  
11 *health plan) and a treating health care provider is termi-*  
12 *nated (as defined in paragraph (e)(4)), or benefits or cov-*  
13 *erage provided by a health care provider are terminated*  
14 *because of a change in the terms of provider participation*  
15 *in such plan, and an individual who is a participant or*  
16 *beneficiary in the plan is undergoing an active course of*  
17 *treatment for a serious and complex condition, institutional*  
18 *care, pregnancy, or terminal illness from the provider at*  
19 *the time the plan receives or provides notice of such termi-*  
20 *nation, the plan shall—*

21               “(1) *notify the individual, or arrange to have the*  
22               *individual notified pursuant to subsection (d)(2), on*  
23               *a timely basis of such termination;*

1           “(2) provide the individual with an opportunity  
2 to notify the plan of the individual’s need for transi-  
3 tional care; and

4           “(3) subject to subsection (c), permit the indi-  
5 vidual to elect to continue to be covered with respect  
6 to the active course of treatment with the provider’s  
7 consent during a transitional period (as provided for  
8 under subsection (b)).

9           “(b) *TRANSITIONAL PERIOD.*—

10           “(1) *SERIOUS AND COMPLEX CONDITIONS.*—*The*  
11 *transitional period under this section with respect to*  
12 *a serious and complex condition shall extend for up*  
13 *to 90 days from the date of the notice described in*  
14 *subsection (a)(1) of the provider’s termination.*

15           “(2) *INSTITUTIONAL OR INPATIENT CARE.*—

16           “(A) *IN GENERAL.*—*The transitional period*  
17 *under this section for institutional or non-elec-*  
18 *tive inpatient care from a provider shall extend*  
19 *until the earlier of—*

20           “(i) *the expiration of the 90-day period*  
21 *beginning on the date on which the notice*  
22 *described in subsection (a)(1) of the pro-*  
23 *vider’s termination is provided; or*

1           “(ii) the date of discharge of the indi-  
2           vidual from such care or the termination of  
3           the period of institutionalization.

4           “(B) *SCHEDULED CARE*.—The 90 day limi-  
5           tation described in subparagraph (A)(i) shall in-  
6           clude post-surgical follow-up care relating to  
7           non-elective surgery that has been scheduled be-  
8           fore the date of the notice of the termination of  
9           the provider under subsection (a)(1).

10          “(3) *PREGNANCY*.—If—

11           “(A) a participant or beneficiary has en-  
12           tered the second trimester of pregnancy at the  
13           time of a provider’s termination of participa-  
14           tion; and

15           “(B) the provider was treating the preg-  
16           nancy before the date of the termination;  
17           the transitional period under this subsection with re-  
18           spect to provider’s treatment of the pregnancy shall  
19           extend through the provision of post-partum care di-  
20           rectly related to the delivery.

21          “(4) *TERMINAL ILLNESS*.—If—

22           “(A) a participant or beneficiary was deter-  
23           mined to be terminally ill (as determined under  
24           section 1861(dd)(3)(A) of the Social Security

1           *Act) at the time of a provider’s termination of*  
2           *participation; and*

3                   “(B) *the provider was treating the terminal*  
4                   *illness before the date of termination;*

5           *the transitional period under this subsection shall ex-*  
6           *tend for the remainder of the individual’s life for care*  
7           *that is directly related to the treatment of the ter-*  
8           *минаl illness.*

9           “(c) *PERMISSIBLE TERMS AND CONDITIONS.—A group*  
10          *health plan (other than a fully insured group health plan)*  
11          *may condition coverage of continued treatment by a pro-*  
12          *vider under this section upon the provider agreeing to the*  
13          *following terms and conditions:*

14                   “(1) *The treating health care provider agrees to*  
15                   *accept reimbursement from the plan and individual*  
16                   *involved (with respect to cost-sharing) at the rates ap-*  
17                   *plicable prior to the start of the transitional period*  
18                   *as payment in full (or at the rates applicable under*  
19                   *the replacement plan after the date of the termination*  
20                   *of the contract with the group health plan) and not*  
21                   *to impose cost-sharing with respect to the individual*  
22                   *in an amount that would exceed the cost-sharing that*  
23                   *could have been imposed if the contract referred to in*  
24                   *this section had not been terminated.*

1           “(2) *The treating health care provider agrees to*  
2           *adhere to the quality assurance standards of the plan*  
3           *responsible for payment under paragraph (1) and to*  
4           *provide to such plan necessary medical information*  
5           *related to the care provided.*

6           “(3) *The treating health care provider agrees*  
7           *otherwise to adhere to such plan’s policies and proce-*  
8           *dures, including procedures regarding referrals and*  
9           *obtaining prior authorization and providing services*  
10          *pursuant to a treatment plan (if any) approved by*  
11          *the plan.*

12          “(d) *RULES OF CONSTRUCTION.—Nothing in this sec-*  
13          *tion shall be construed—*

14                 “(1) *to require the coverage of benefits which*  
15                 *would not have been covered if the provider involved*  
16                 *remained a participating provider; or*

17                 “(2) *with respect to the termination of a contract*  
18                 *under subsection (a) to prevent a group health plan*  
19                 *from requiring that the health care provider—*

20                         “(A) *notify participants or beneficiaries of*  
21                         *their rights under this section; or*

22                         “(B) *provide the plan with the name of*  
23                         *each participant or beneficiary who the provider*  
24                         *believes is eligible for transitional care under*  
25                         *this section.*

1       “(e) *DEFINITIONS.*—*In this section:*

2               “(1) *CONTRACT.*—*The term ‘contract between a*  
3 *plan and a treating health care provider’ shall in-*  
4 *clude a contract between such a plan and an orga-*  
5 *nized network of providers.*

6               “(2) *HEALTH CARE PROVIDER.*—*The term*  
7 *‘health care provider’ or ‘provider’ means—*

8                       “(A) *any individual who is engaged in the*  
9 *delivery of health care services in a State and*  
10 *who is required by State law or regulation to be*  
11 *licensed or certified by the State to engage in the*  
12 *delivery of such services in the State; and*

13                       “(B) *any entity that is engaged in the de-*  
14 *livery of health care services in a State and that,*  
15 *if it is required by State law or regulation to be*  
16 *licensed or certified by the State to engage in the*  
17 *delivery of such services in the State, is so li-*  
18 *censed.*

19               “(3) *SERIOUS AND COMPLEX CONDITION.*—*The*  
20 *term ‘serious and complex condition’ means, with re-*  
21 *spect to a participant or beneficiary under the plan,*  
22 *a condition that is medically determinable and—*

23                       “(A) *in the case of an acute illness, is a*  
24 *condition serious enough to require specialized*

1           *medical treatment to avoid the reasonable possi-*  
2           *bility of death or permanent harm; or*

3           “(B) *in the case of a chronic illness or con-*  
4           *dition, is an illness or condition that—*

5                   “(i) *is complex and difficult to man-*  
6                   *age;*

7                   “(ii) *is disabling or life-threatening;*  
8                   *and*

9                   “(iii) *requires—*

10                           “(I) *frequent monitoring over a*  
11                           *prolonged period of time and requires*  
12                           *substantial on-going specialized med-*  
13                           *ical care; or*

14                           “(II) *frequent ongoing specialized*  
15                           *medical care across a variety of do-*  
16                           *mains of care.*

17           “(4) *TERMINATED.—The term ‘terminated’ in-*  
18           *cludes, with respect to a contract (as defined in para-*  
19           *graph (1)), the expiration or nonrenewal of the con-*  
20           *tract by the group health plan, but does not include*  
21           *a termination of the contract by the plan for failure*  
22           *to meet applicable quality standards or for fraud.*

23           “(f) *RIGHT TO EXTERNAL REVIEW.—Pursuant to the*  
24           *requirements of section 503B, a participant or beneficiary*  
25           *shall have the right to an independent external review if*

1 *the denial of an item or service or condition that is required*  
2 *to be covered under this section is eligible for such review.*

3 **“SEC. 727. PROTECTION OF PATIENT-PROVIDER COMMU-**  
4 **NICATIONS.**

5 *“(a) IN GENERAL.—Subject to subsection (b), a group*  
6 *health plan (other than a fully insured group health plan*  
7 *and in relation to a participant or beneficiary) shall not*  
8 *prohibit or otherwise restrict a health care professional from*  
9 *advising such a participant or beneficiary who is a patient*  
10 *of the professional about the health status of the participant*  
11 *or beneficiary or medical care or treatment for the condition*  
12 *or disease of the participant or beneficiary, regardless of*  
13 *whether coverage for such care or treatment are provided*  
14 *under the contract, if the professional is acting within the*  
15 *lawful scope of practice.*

16 *“(b) RULE OF CONSTRUCTION.—Nothing in this sec-*  
17 *tion shall be construed as requiring a group health plan*  
18 *(other than a fully insured group health plan) to provide*  
19 *specific benefits under the terms of such plan.*

20 **“SEC. 728. PATIENT’S RIGHT TO PRESCRIPTION DRUGS.**

21 *“(a) IN GENERAL.—To the extent that a group health*  
22 *plan (other than a fully insured group health plan) pro-*  
23 *vides coverage for benefits with respect to prescription*  
24 *drugs, and limits such coverage to drugs included in a for-*  
25 *mulary, the plan shall—*





1           “(C) may not discriminate against the in-  
2           dividual on the basis of the participant’s or  
3           beneficiaries participation in such trial.

4           “(2) *EXCLUSION OF CERTAIN COSTS.*—For pur-  
5           poses of paragraph (1)(B), routine patient costs do  
6           not include the cost of the tests or measurements con-  
7           ducted primarily for the purpose of the clinical trial  
8           involved.

9           “(3) *USE OF IN-NETWORK PROVIDERS.*—If one or  
10          more participating providers is participating in a  
11          clinical trial, nothing in paragraph (1) shall be con-  
12          strued as preventing a plan from requiring that a  
13          qualified individual participate in the trial through  
14          such a participating provider if the provider will ac-  
15          cept the individual as a participant in the trial.

16          “(b) *QUALIFIED INDIVIDUAL DEFINED.*—For purposes  
17          of subsection (a), the term ‘qualified individual’ means an  
18          individual who is a participant or beneficiary in a group  
19          health plan and who meets the following conditions:

20                 “(1)(A) *The individual has been diagnosed with*  
21                 *cancer for which no standard treatment is effective.*

22                 “(B) *The individual is eligible to participate in*  
23                 *an approved clinical trial according to the trial pro-*  
24                 *cedure with respect to treatment of such illness.*

1           “(C) *The individual’s participation in the trial*  
2           *offers meaningful potential for significant clinical*  
3           *benefit for the individual.*

4           “(2) *Either—*

5                 “(A) *the referring physician is a partici-*  
6                 *parting health care professional and has con-*  
7                 *cluded that the individual’s participation in*  
8                 *such trial would be appropriate based upon the*  
9                 *individual meeting the conditions described in*  
10                *paragraph (1); or*

11               “(B) *the participant or beneficiary provides*  
12               *medical and scientific information establishing*  
13               *that the individual’s participation in such trial*  
14               *would be appropriate based upon the individual*  
15               *meeting the conditions described in paragraph*  
16                *(1).*

17           “(c) *PAYMENT.—*

18               “(1) *IN GENERAL.—Under this section a group*  
19               *health plan (other than a fully insured group health*  
20               *plan) shall provide for payment for routine patient*  
21               *costs described in subsection (a)(2) but is not required*  
22               *to pay for costs of items and services that are reason-*  
23               *ably expected to be paid for by the sponsors of an ap-*  
24                *proved clinical trial.*

1           “(2) *STANDARDS FOR DETERMINING ROUTINE*  
2           *PATIENT COSTS ASSOCIATED WITH CLINICAL TRIAL*  
3           *PARTICIPATION.—*

4                   “(A) *IN GENERAL.—The Secretary shall, in*  
5                   *accordance with this paragraph, establish stand-*  
6                   *ards relating to the coverage of routine patient*  
7                   *costs for individuals participating in clinical*  
8                   *trials that group health plans must meet under*  
9                   *this section.*

10                   “(B) *FACTORS.—In establishing routine pa-*  
11                   *tient cost standards under subparagraph (A), the*  
12                   *Secretary shall consult with interested parties*  
13                   *and take into account —*

14                           “(i) *quality of patient care;*

15                           “(ii) *routine patient care costs versus*  
16                           *costs associated with the conduct of clinical*  
17                           *trials, including unanticipated patient care*  
18                           *costs as a result of participation in clinical*  
19                           *trials; and*

20                           “(iii) *previous and on-going studies re-*  
21                           *lating to patient care costs associated with*  
22                           *participation in clinical trials.*

23                   “(C) *APPOINTMENT AND MEETINGS OF NE-*  
24                   *GOTIATED RULEMAKING COMMITTEE.—*

1           “(i) *PUBLICATION OF NOTICE.*—Not  
2           *later than November 15, 2000, the Secretary*  
3           *shall publish notice of the establishment of*  
4           *a negotiated rulemaking committee, as pro-*  
5           *vided for under section 564(a) of title 5,*  
6           *United States Code, to develop the stand-*  
7           *ards described in subparagraph (A), which*  
8           *shall include—*

9                     “(I) *the proposed scope of the*  
10                    *committee;*

11                   “(II) *the interests that may be*  
12                    *impacted by the standards;*

13                   “(iii) *a list of the proposed mem-*  
14                    *bership of the committee;*

15                   “(iv) *the proposed meeting sched-*  
16                    *ule of the committee;*

17                   “(v) *a solicitation for public com-*  
18                    *ment on the committee; and*

19                   “(vi) *the procedures under which*  
20                    *an individual may apply for member-*  
21                    *ship on the committee.*

22           “(ii) *COMMENT PERIOD.*—Notwith-  
23           *standing section 564(e) of title 5, United*  
24           *States Code, the Secretary shall provide for*  
25           *a period, beginning on the date on which*

1           *the notice is published under clause (i) and*  
2           *ending on November 30, 2000, for the sub-*  
3           *mission of public comments on the com-*  
4           *mittee under this subparagraph.*

5           “(iii) *APPOINTMENT OF COMMITTEE.—*  
6           *Not later than December 30, 2000, the Sec-*  
7           *retary shall appoint the members of the ne-*  
8           *gotiated rulemaking committee under this*  
9           *subparagraph.*

10          “(iv) *FACILITATOR.—Not later than*  
11          *January 10, 2001, the negotiated rule-*  
12          *making committee shall nominate a*  
13          *facilitator under section 566(c) of title 5,*  
14          *United States Code, to carry out the activi-*  
15          *ties described in subsection (d) of such sec-*  
16          *tion.*

17          “(v) *MEETINGS.—During the period*  
18          *beginning on the date on which the*  
19          *facilitator is nominated under clause (iv)*  
20          *and ending on March 30, 2001, the nego-*  
21          *tiated rulemaking committee shall meet to*  
22          *develop the standards described in subpara-*  
23          *graph (A).*

24          “(D) *PRELIMINARY COMMITTEE REPORT.—*

1           “(i) *IN GENERAL.*—*The negotiated*  
2           *rulemaking committee appointed under sub-*  
3           *paragraph (C) shall report to the Secretary,*  
4           *by not later than March 30, 2001, regard-*  
5           *ing the committee’s progress on achieving a*  
6           *consensus with regard to the rulemaking*  
7           *proceedings and whether such consensus is*  
8           *likely to occur before the target date de-*  
9           *scribed in subsection (F).*

10           “(ii) *TERMINATION OF PROCESS AND*  
11           *PUBLICATION OF RULE BY SECRETARY.*—*If*  
12           *the committee reports under clause (i) that*  
13           *the committee has failed to make significant*  
14           *progress towards such consensus or is un-*  
15           *likely to reach such consensus by the target*  
16           *date described in subsection (F), the Sec-*  
17           *retary shall terminate such process and pro-*  
18           *vide for the publication in the Federal Reg-*  
19           *ister, by not later than June 30, 2001, of a*  
20           *rule under this paragraph through such*  
21           *other methods as the Secretary may provide.*

22           “(E) *FINAL COMMITTEE REPORT AND PUB-*  
23           *LICATION OR RULE BY SECRETARY.*—

24           “(i) *IN GENERAL.*—*If the rulemaking*  
25           *committee is not terminated under subpara-*

1           *graph (D)(ii), the committee shall submit to*  
2           *the Secretary, by not later than May 30,*  
3           *2001, a report containing a proposed rule.*

4           “(i) *PUBLICATION OF RULE.—If the*  
5           *Secretary receives a report under clause (i),*  
6           *the Secretary shall provide for the publica-*  
7           *tion in the Federal Register, by not later*  
8           *than June 30, 2001, of the proposed rule.*

9           “(F) *TARGET DATE FOR PUBLICATION OF*  
10          *RULE.—As part of the notice under subpara-*  
11          *graph (C)(i), and for purposes of this paragraph,*  
12          *the ‘target date for publication’ (referred to in*  
13          *section 564(a)(5) of title 5, United States Code)*  
14          *shall be June 30, 2001.*

15          “(G) *EFFECTIVE DATE.—The provisions of*  
16          *this paragraph shall apply to group health plans*  
17          *(other than a fully insured group health plan)*  
18          *for plan years beginning on or after January 1,*  
19          *2002.*

20          “(3) *PAYMENT RATE.—In the case of covered*  
21          *items and services provided by—*

22                 “(A) *a participating provider, the payment*  
23                 *rate shall be at the agreed upon rate, or*

24                 “(B) *a nonparticipating provider, the pay-*  
25                 *ment rate shall be at the rate the plan would*

1 normally pay for comparable services under sub-  
2 paragraph (A).

3 “(d) *APPROVED CLINICAL TRIAL DEFINED.*—

4 “(1) *IN GENERAL.*—*In this section, the term ‘ap-*  
5 *proved clinical trial’ means a cancer clinical research*  
6 *study or cancer clinical investigation approved or*  
7 *funded (which may include funding through in-kind*  
8 *contributions) by one or more of the following:*

9 “(A) *The National Institutes of Health.*

10 “(B) *A cooperative group or center of the*  
11 *National Institutes of Health.*

12 “(C) *The Food and Drug Administration.*

13 “(D) *Either of the following if the condi-*  
14 *tions described in paragraph (2) are met:*

15 “(i) *The Department of Veterans Af-*  
16 *airs.*

17 “(ii) *The Department of Defense.*

18 “(2) *CONDITIONS FOR DEPARTMENTS.*—*The con-*  
19 *ditions described in this paragraph, for a study or in-*  
20 *vestigation conducted by a Department, are that the*  
21 *study or investigation has been reviewed and ap-*  
22 *proved through a system of peer review that the Sec-*  
23 *retary determines—*

1           “(A) to be comparable to the system of peer  
2           review of studies and investigations used by the  
3           National Institutes of Health, and

4           “(B) assures unbiased review of the highest  
5           scientific standards by qualified individuals who  
6           have no interest in the outcome of the review.

7           “(e) CONSTRUCTION.—Nothing in this section shall be  
8           construed to limit a plan’s coverage with respect to clinical  
9           trials.

10          “(f) PLAN SATISFACTION OF CERTAIN REQUIREMENTS;  
11         RESPONSIBILITIES OF FIDUCIARIES.—

12           “(1) IN GENERAL.—For purposes of this section,  
13           insofar as a group health plan provides benefits in the  
14           form of health insurance coverage through a health in-  
15           surance issuer, the plan shall be treated as meeting  
16           the requirements of this section with respect to such  
17           benefits and not be considered as failing to meet such  
18           requirements because of a failure of the issuer to meet  
19           such requirements so long as the plan sponsor or its  
20           representatives did not cause such failure by the  
21           issuer.

22           “(2) CONSTRUCTION.—Nothing in this section  
23           shall be construed to affect or modify the responsibil-  
24           ities of the fiduciaries of a group health plan under  
25           part 4 of subtitle B.

1       “(g) *STUDY AND REPORT.*—

2               “(1) *STUDY.*—*The Secretary shall study the im-*  
3       *act on group health plans for covering routine pa-*  
4       *tient care costs for individuals who are entitled to*  
5       *benefits under this section and who are enrolled in an*  
6       *approved cancer clinical trial program.*

7               “(2) *REPORT TO CONGRESS.*—*Not later than*  
8       *January 1, 2005, the Secretary shall submit a report*  
9       *to Congress that contains an assessment of—*

10               “(A) *any incremental cost to group health*  
11       *plans resulting from the provisions of this sec-*  
12       *tion;*

13               “(B) *a projection of expenditures to such*  
14       *plans resulting from this section; and*

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

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

22       **“SEC. 730A. PROHIBITION OF DISCRIMINATION AGAINST**  
23       **PROVIDERS BASED ON LICENSURE.**

24       “(a) *IN GENERAL.*—*A group health plan (other than*  
25       *a fully insured group health plan) shall not discriminate*

1 *with respect to participation or indemnification as to any*  
2 *provider who is acting within the scope of the provider’s*  
3 *license or certification under applicable State law, solely*  
4 *on the basis of such license or certification.*

5 “(b) *CONSTRUCTION.*—*Subsection (a) shall not be*  
6 *construed—*

7 “(1) *as requiring the coverage under a group*  
8 *health plan of a particular benefit or service or to*  
9 *prohibit a plan from including providers only to the*  
10 *extent necessary to meet the needs of the plan’s par-*  
11 *ticipants or beneficiaries or from establishing any*  
12 *measure designed to maintain quality and control*  
13 *costs consistent with the responsibilities of the plan;*

14 “(2) *to override any State licensure or scope-of-*  
15 *practice law; or*

16 “(3) *as requiring a plan that offers network cov-*  
17 *erage to include for participation every willing pro-*  
18 *vider who meets the terms and conditions of the plan.*

19 **“SEC. 730B. GENERALLY APPLICABLE PROVISION.**

20 “*In the case of a group health plan that provides bene-*  
21 *fits under 2 or more coverage options, the requirements of*  
22 *this subpart shall apply separately with respect to each cov-*  
23 *erage option.”.*

24 (b) *RULE WITH RESPECT TO CERTAIN PLANS.*—

1           (1) *IN GENERAL.*—Notwithstanding any other  
2           provision of law, health insurance issuers may offer,  
3           and eligible individuals may purchase, high deduct-  
4           ible health plans described in section 220(c)(2)(A) of  
5           the Internal Revenue Code of 1986. Effective for the  
6           5-year period beginning on the date of the enactment  
7           of this Act, such health plans shall not be required to  
8           provide payment for any health care items or services  
9           that are exempt from the plan’s deductible.

10           (2) *EXISTING STATE LAWS.*—A State law relat-  
11           ing to payment for health care items and services in  
12           effect on the date of enactment of this Act that is pre-  
13           empted under paragraph (1), shall not apply to high  
14           deductible health plans after the expiration of the 5-  
15           year period described in such paragraph unless the  
16           State reenacts such law after such period.

17           (c) *DEFINITION.*—Section 733(a) of the Employee Re-  
18           tirement Income Security Act of 1974 (42 U.S.C. 1191(a))  
19           is amended by adding at the end the following:

20           “(3) *FULLY INSURED GROUP HEALTH PLAN.*—  
21           The term ‘fully insured group health plan’ means a  
22           group health plan where benefits under the plan are  
23           provided pursuant to the terms of an arrangement be-  
24           tween a group health plan and a health insurance

1        *issuer and are guaranteed by the health insurance*  
 2        *issuer under a contract or policy of insurance.”.*

3        *(d) CONFORMING AMENDMENT.—The table of contents*  
 4        *in section 1 of the Employee Retirement Income Security*  
 5        *Act of 1974 is amended—*

6                *(1) in the item relating to subpart C of part 7*  
 7        *of subtitle B of title I, by striking “Subpart C” and*  
 8        *inserting “Subpart D”; and*

9                *(2) by adding at the end of the items relating to*  
 10        *subpart B of part 7 of subtitle B of title I, the fol-*  
 11        *lowing:*

“SUBPART C—PATIENT RIGHT TO MEDICAL ADVICE AND CARE

“Sec. 721. Access to emergency medical care.

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

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

“Sec. 724. Access to pediatric care.

“Sec. 725. Timely access to specialists.

“Sec. 726. Continuity of care.

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

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

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

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

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

“Sec. 730B. Generally applicable provision.”.

12    **SEC. 2202. CONFORMING AMENDMENT TO THE INTERNAL**  
 13        **REVENUE CODE OF 1986.**

14        *Subchapter B of chapter 100 of the Internal Revenue*  
 15        *Code of 1986 is amended—*

16                *(1) in the table of sections, by inserting after the*  
 17        *item relating to section 9812 the following new item:*

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

1           *and*

2                   (2) *by inserting after section 9812 the following:*

3   **“SEC. 9813. STANDARD RELATING TO PATIENTS’ BILL OF**  
4                                   **RIGHTS.**

5           *“A group health plan (other than a fully insured group*  
6 *health plan) shall comply with the requirements of subpart*  
7 *C of part 7 of subtitle B of title I of the Employee Retire-*  
8 *ment Income Security Act of 1974, as added by section 2201*  
9 *of the Patients’ Bill of Rights Plus Act, and such require-*  
10 *ments shall be deemed to be incorporated into this section.”.*

11 **SEC. 2203. EFFECTIVE DATE AND RELATED RULES.**

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

18           (b) *LIMITATION ON ENFORCEMENT ACTIONS.*—*No en-*  
19 *forcement action shall be taken, pursuant to the amend-*  
20 *ments made by this subtitle, against a group health plan*  
21 *with respect to a violation of a requirement imposed by such*  
22 *amendments before the date of issuance of regulations issued*  
23 *in connection with such requirement, if the plan has sought*  
24 *to comply in good faith with such requirement.*

1     ***Subtitle B—Right to Information***  
2             ***About Plans and Providers***

3     **SEC. 2211. INFORMATION ABOUT PLANS.**

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

9     **“SEC. 714. HEALTH PLAN INFORMATION.**

10            “(a) *REQUIREMENT—*

11                    “(1) *DISCLOSURE.—*

12                            “(A) *IN GENERAL.—A group health plan,*  
13 *and a health insurance issuer that provides cov-*  
14 *erage in connection with group health insurance*  
15 *coverage, shall provide for the disclosure of the*  
16 *information described in subsection (b) to par-*  
17 *ticipants and beneficiaries—*

18                                    “(i) *at the time of the initial enroll-*  
19 *ment of the participant or beneficiary*  
20 *under the plan or coverage;*

21    “(ii) *on an annual basis after*  
22 *enrollment—*

23    “(I) *in conjunction with the elec-*  
24 *tion period of the plan or coverage if*

1           *the plan or coverage has such an elec-*  
2           *tion period; or*

3           “(II) *in the case of a plan or cov-*  
4           *erage that does not have an election pe-*  
5           *riod, in conjunction with the beginning*  
6           *of the plan or coverage year; and*

7           “(iii) *in the case of any material re-*  
8           *duction to the benefits or information de-*  
9           *scribed in paragraphs (1), (2) and (3) of*  
10          *subsection (b), in the form of a summary*  
11          *notice provided not later than the date on*  
12          *which the reduction takes effect.*

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

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

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

23          “(2) *RULE OF CONSTRUCTION.—Nothing in this*  
24          *section shall be construed to prevent a group health*  
25          *plan sponsor and health insurance issuer from enter-*

1        *ing into an agreement under which either the plan*  
2        *sponsor or the issuer agrees to assume responsibility*  
3        *for compliance with the requirements of this section,*  
4        *in whole or in part, and the party delegating such re-*  
5        *sponsibility is released from liability for compliance*  
6        *with the requirements that are assumed by the other*  
7        *party, to the extent the party delegating such respon-*  
8        *sibility did not cause such noncompliance.*

9            *“(3) PROVISION OF INFORMATION.—Information*  
10        *shall be provided to participants and beneficiaries*  
11        *under this section at the last known address main-*  
12        *tained by the plan or issuer with respect to such par-*  
13        *ticipants or beneficiaries, to the extent that such in-*  
14        *formation is provided to participants or beneficiaries*  
15        *via the United States Postal Service or other private*  
16        *delivery service.*

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

21            *“(1) BENEFITS.—A description of the covered*  
22        *benefits, including—*

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

1           “(B) *specific preventative services covered*  
2           *under the plan or coverage if such services are*  
3           *covered;*

4           “(C) *any benefit limitations, including any*  
5           *annual or lifetime benefit limits and any mone-*  
6           *tary limits or limits on the number of visits,*  
7           *days, or services, and any specific coverage ex-*  
8           *clusions; and*

9           “(D) *any definition of medical necessity*  
10           *used in making coverage determinations by the*  
11           *plan, issuer, or claims administrator.*

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

14           “(A) *any premiums, deductibles, coinsur-*  
15           *ance, copayment amounts, and liability for bal-*  
16           *ance billing above any reasonable and customary*  
17           *charges, for which the participant or beneficiary*  
18           *will be responsible under each option available*  
19           *under the plan;*

20           “(B) *any maximum out-of-pocket expense*  
21           *for which the participant or beneficiary may be*  
22           *liable;*

23           “(C) *any cost-sharing requirements for out-*  
24           *of-network benefits or services received from non-*  
25           *participating providers; and*

1           “(D) any additional cost-sharing or charges  
2           for benefits and services that are furnished with-  
3           out meeting applicable plan or coverage require-  
4           ments, such as prior authorization or  
5           precertification.

6           “(3) SERVICE AREA.—A description of the plan  
7           or issuer’s service area, including the provision of any  
8           out-of-area coverage.

9           “(4) PARTICIPATING PROVIDERS.—A directory of  
10          participating providers (to the extent a plan or issuer  
11          provides coverage through a network of providers)  
12          that includes, at a minimum, the name, address, and  
13          telephone number of each participating provider, and  
14          information about how to inquire whether a partici-  
15          pating provider is currently accepting new patients.

16          “(5) CHOICE OF PRIMARY CARE PROVIDER.—A  
17          description of any requirements and procedures to be  
18          used by participants and beneficiaries in selecting,  
19          accessing, or changing their primary care provider,  
20          including providers both within and outside of the  
21          network (if the plan or issuer permits out-of-network  
22          services), and the right to select a pediatrician as a  
23          primary care provider under section 724 for a partici-  
24          pant or beneficiary who is a child if such section ap-  
25          plies.

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

5           “(7) *EXPERIMENTAL AND INVESTIGATIONAL*  
6           *TREATMENTS.*—A *description of the process for deter-*  
7           *mining whether a particular item, service, or treat-*  
8           *ment is considered experimental or investigational,*  
9           *and the circumstances under which such treatments*  
10          *are covered by the plan or issuer.*

11          “(8) *SPECIALTY CARE.*—A *description of the re-*  
12          *quirements and procedures to be used by participants*  
13          *and beneficiaries in accessing specialty care and ob-*  
14          *taining referrals to participating and nonpartici-*  
15          *pating specialists, including the right to timely cov-*  
16          *erage for access to specialists care under section 725*  
17          *if such section applies.*

18          “(9) *CLINICAL TRIALS.*—A *description the cir-*  
19          *cumstances and conditions under which participation*  
20          *in clinical trials is covered under the terms and con-*  
21          *ditions of the plan or coverage, and the right to ob-*  
22          *tain coverage for approved cancer clinical trials*  
23          *under section 729 if such section applies.*

24          “(10) *PRESCRIPTION DRUGS.*—*To the extent the*  
25          *plan or issuer provides coverage for prescription*

1        *drugs, a statement of whether such coverage is limited*  
2        *to drugs included in a formulary, a description of*  
3        *any provisions and cost-sharing required for obtain-*  
4        *ing on- and off-formulary medications, and a descrip-*  
5        *tion of the rights of participants and beneficiaries in*  
6        *obtaining access to access to prescription drugs under*  
7        *section 727 if such section applies.*

8                *“(11) EMERGENCY SERVICES.—A summary of*  
9        *the rules and procedures for accessing emergency serv-*  
10        *ices, including the right of a participant or bene-*  
11        *ficiary to obtain emergency services under the pru-*  
12        *dent layperson standard under section 721, if such*  
13        *section applies, and any educational information that*  
14        *the plan or issuer may provide regarding the appro-*  
15        *priate use of emergency services.*

16                *“(12) CLAIMS AND APPEALS.—A description of*  
17        *the plan or issuer’s rules and procedures pertaining*  
18        *to claims and appeals, a description of the rights of*  
19        *participants and beneficiaries under sections 503,*  
20        *503A and 503B in obtaining covered benefits, filing*  
21        *a claim for benefits, and appealing coverage decisions*  
22        *internally and externally (including telephone num-*  
23        *bers and mailing addresses of the appropriate author-*  
24        *ity), and a description of any additional legal rights*  
25        *and remedies available under section 502.*

1           “(13) *ADVANCE DIRECTIVES AND ORGAN DONA-*  
2           *TION.—A description of procedures for advance direc-*  
3           *tives and organ donation decisions if the plan or*  
4           *issuer maintains such procedures.*

5           “(14) *INFORMATION ON PLANS AND ISSUERS.—*  
6           *The name, mailing address, and telephone number or*  
7           *numbers of the plan administrator and the issuer to*  
8           *be used by participants and beneficiaries seeking in-*  
9           *formation about plan or coverage benefits and serv-*  
10          *ices, payment of a claim, or authorization for services*  
11          *and treatment. The name of the designated decision-*  
12          *maker (or decision-makers) appointed under section*  
13          *502(n)(2) for purposes of making final determina-*  
14          *tions under section 503A and approving coverage*  
15          *pursuant to the written determination of an inde-*  
16          *pendent medical reviewer under section 503B. Notice*  
17          *of whether the benefits under the plan are provided*  
18          *under a contract or policy of insurance issued by an*  
19          *issuer, or whether benefits are provided directly by the*  
20          *plan sponsor who bears the insurance risk.*

21          “(15) *TRANSLATION SERVICES.—A summary de-*  
22          *scription of any translation or interpretation services*  
23          *(including the availability of printed information in*  
24          *languages other than English, audio tapes, or infor-*  
25          *mation in Braille) that are available for non-English*

1 *speakers and participants and beneficiaries with com-*  
2 *munication disabilities and a description of how to*  
3 *access these items or services.*

4 “(16) *ACCREDITATION INFORMATION.*—*Any in-*  
5 *formation that is made public by accrediting organi-*  
6 *zations in the process of accreditation if the plan or*  
7 *issuer is accredited, or any additional quality indica-*  
8 *tors (such as the results of enrollee satisfaction sur-*  
9 *veys) that the plan or issuer makes public or makes*  
10 *available to participants and beneficiaries.*

11 “(17) *NOTICE OF REQUIREMENTS.*—*A descrip-*  
12 *tion of any rights of participants and beneficiaries*  
13 *that are established by the Patients’ Bill of Rights*  
14 *Plus Act (excluding those described in paragraphs (1)*  
15 *through (16)) if such sections apply. The description*  
16 *required under this paragraph may be combined with*  
17 *the notices required under sections 711(d), 713(b), or*  
18 *606(a)(1), and with any other notice provision that*  
19 *the Secretary determines may be combined.*

20 “(18) *AVAILABILITY OF ADDITIONAL INFORMA-*  
21 *TION.*—*A statement that the information described in*  
22 *subsection (c), and instructions on obtaining such in-*  
23 *formation (including telephone numbers and, if avail-*  
24 *able, Internet websites), shall be made available upon*  
25 *request.*

1       “(c) *ADDITIONAL INFORMATION.*—*The informational*  
2 *materials to be provided upon the request of a participant*  
3 *or beneficiary shall include for each option available under*  
4 *a group health plan or health insurance coverage the fol-*  
5 *lowing:*

6               “(1) *STATUS OF PROVIDERS.*—*The State licen-*  
7 *sure status of the plan or issuer’s participating health*  
8 *care professionals and participating health care fa-*  
9 *ilities, and, if available, the education, training, spe-*  
10 *cialty qualifications or certifications of such profes-*  
11 *sionals.*

12               “(2) *COMPENSATION METHODS.*—*A summary de-*  
13 *scription of the methods (such as capitation, fee-for-*  
14 *service, salary, bundled payments, per diem, or a*  
15 *combination thereof) used for compensating partici-*  
16 *pating health care professionals (including primary*  
17 *care providers and specialists) and facilities in con-*  
18 *nection with the provision of health care under the*  
19 *plan or coverage. The requirement of this paragraph*  
20 *shall not be construed as requiring plans or issuers to*  
21 *provide information concerning proprietary payment*  
22 *methodology.*

23               “(3) *PRESCRIPTION DRUGS.*—*Information about*  
24 *whether a specific prescription medication is included*

1        *in the formulary of the plan or issuer, if the plan or*  
2        *issuer uses a defined formulary.*

3                “(4) *EXTERNAL APPEALS INFORMATION.*—*Aggre-*  
4        *gate information on the number and outcomes of ex-*  
5        *ternal medical reviews, relative to the sample size*  
6        *(such as the number of covered lives) determined for*  
7        *the plan or issuer’s book of business.*

8                “(d) *MANNER OF DISCLOSURE.*—*The information de-*  
9        *scribed in this section shall be disclosed in an accessible me-*  
10       *dium and format that is calculated to be understood by the*  
11       *average participant.*

12               “(e) *RULES OF CONSTRUCTION.*—*Nothing in this sec-*  
13       *tion shall be construed to prohibit a group health plan, or*  
14       *a health insurance issuer in connection with group health*  
15       *insurance coverage, from—*

16               “(1) *distributing any other additional informa-*  
17       *tion determined by the plan or issuer to be important*  
18       *or necessary in assisting participants and bene-*  
19       *ficiaries in the selection of a health plan; and*

20               “(2) *complying with the provisions of this sec-*  
21       *tion by providing information in brochures, through*  
22       *the Internet or other electronic media, or through*  
23       *other similar means, so long as participants and*  
24       *beneficiaries are provided with an opportunity to re-*

1        *quest that informational materials be provided in*  
2        *printed form.*

3        “(f) *CONFORMING REGULATIONS.*—*The Secretary shall*  
4        *issue regulations to coordinate the requirements on group*  
5        *health plans and health insurance issuers under this section*  
6        *with the requirements imposed under part 1, to reduce du-*  
7        *plication with respect to any information that is required*  
8        *to be provided under any such requirements.*

9        “(g) *SECRETARIAL ENFORCEMENT AUTHORITY.*—

10        “(1) *IN GENERAL.*—*The Secretary may assess a*  
11        *civil monetary penalty against the administrator of*  
12        *a plan or issuer in connection with the failure of the*  
13        *plan or issuer to comply with the requirements of this*  
14        *section.*

15        “(2) *AMOUNT OF PENALTY.*—

16        “(A) *IN GENERAL.*—*The amount of the pen-*  
17        *alty to be imposed under paragraph (1) shall not*  
18        *exceed \$100 for each day for each participant*  
19        *and beneficiary with respect to which the failure*  
20        *to comply with the requirements of this section*  
21        *occurs.*

22        “(B) *INCREASE IN AMOUNT.*—*The amount*  
23        *referred to in subparagraph (A) shall be in-*  
24        *creased or decreased, for each calendar year that*  
25        *ends after December 31, 2000, by the same per-*

1           *centage as the percentage by which the medical*  
2           *care expenditure category of the Consumer Price*  
3           *Index for All Urban Consumers (United States*  
4           *city average), published by the Bureau of Labor*  
5           *Statistics, for September of the preceding cal-*  
6           *endar year has increased or decreased from the*  
7           *such Index for September of 2000.*

8           “(3) *FAILURE DEFINED.*—*For purposes of this*  
9           *subsection, a plan or issuer shall have failed to com-*  
10          *ply with the requirements of this section with respect*  
11          *to a participant or beneficiary if the plan or issuer*  
12          *failed or refused to comply with the requirements of*  
13          *this section within 30 days—*

14                 “(A) *of the date described in subsection*  
15                 *(a)(1)(A)(i);*

16                 “(B) *of the date described in subsection*  
17                 *(a)(1)(A)(ii); or*

18                 “(C) *of the date on which additional infor-*  
19                 *mation was requested under subsection (c).”.*

20          (b) *CONFORMING AMENDMENTS.*—

21                 (1) *Section 732(a) of the Employee Retirement*  
22                 *Income Security Act of 1974 (29 U.S.C. 1191a(a)) is*  
23                 *amended by striking “section 711” and inserting*  
24                 *“sections 711 and 714”.*

1           (2) *The table of contents in section 1 of the Em-*  
2           *ployee Retirement Income Security Act of 1974 (29*  
3           *U.S.C. 1001) is amended by inserting after the item*  
4           *relating to section 713, the following:*

          “Sec 714. *Health plan comparative information.*”.

5           (3) *Section 502(b)(3) of the Employee Retirement*  
6           *Income Security Act of 1974 (29 U.S.C.*  
7           *1132(b)(3)) is amended by striking “733(a)(1))” and*  
8           *inserting “733(a)(1)), except with respect to the re-*  
9           *quirements of section 714”.*

10 **SEC. 2212. INFORMATION ABOUT PROVIDERS.**

11           (a) *STUDY.*—*The Secretary of Health and Human*  
12           *Services shall enter into a contract with the Institute of*  
13           *Medicine for the conduct of a study, and the submission*  
14           *to the Secretary of a report, that includes—*

15                   (1) *an analysis of information concerning health*  
16                   *care professionals that is currently available to pa-*  
17                   *tients, consumers, States, and professional societies,*  
18                   *nationally and on a State-by-State basis, including*  
19                   *patient preferences with respect to information about*  
20                   *such professionals and their competencies;*

21                   (2) *an evaluation of the legal and other barriers*  
22                   *to the sharing of information concerning health care*  
23                   *professionals; and*

24                   (3) *recommendations for the disclosure of infor-*  
25                   *mation on health care professionals, including the*

1        *competencies and professional qualifications of such*  
 2        *practitioners, to better facilitate patient choice, qual-*  
 3        *ity improvement, and market competition.*

4        *(b) REPORT.—Not later than 18 months after the date*  
 5        *of enactment of this Act, the Secretary of Health and*  
 6        *Human Services shall forward to the appropriate commit-*  
 7        *tees of Congress a copy of the report and study conducted*  
 8        *under subsection (a).*

9        ***Subtitle C—Right to Hold Health***  
 10        ***Plans Accountable***

11        ***SEC. 2221. AMENDMENTS TO EMPLOYEE RETIREMENT IN-***  
 12        ***COME SECURITY ACT OF 1974.***

13        *(a) IN GENERAL.—Part 5 of subtitle B of title I of*  
 14        *the Employee Retirement Income Security Act of 1974 is*  
 15        *amended by inserting after section 503 (29 U.S.C. 1133)*  
 16        *the following:*

17        ***“SEC. 503A. CLAIMS AND INTERNAL APPEALS PROCEDURES***  
 18        ***FOR GROUP HEALTH PLANS.***

19        ***“(a) INITIAL CLAIM FOR BENEFITS UNDER GROUP***  
 20        ***HEALTH PLANS.—***

21                ***“(1) PROCEDURES.—***

22                        ***“(A) IN GENERAL.—A group health plan, or***  
 23                        ***health insurance issuer offering health insurance***  
 24                        ***coverage in connection with a group health plan,***  
 25                        ***shall ensure that procedures are in place for—***

1           “(i) making a determination on an  
2           initial claim for benefits by a participant  
3           or beneficiary (or authorized representative)  
4           regarding payment or coverage for items or  
5           services under the terms and conditions of  
6           the plan or coverage involved, including  
7           any cost-sharing amount that the partici-  
8           pant or beneficiary is required to pay with  
9           respect to such claim for benefits; and

10           “(ii) notifying a participant or bene-  
11           ficiary (or authorized representative) and  
12           the treating health care professional in-  
13           volved regarding a determination on an ini-  
14           tial claim for benefits made under the terms  
15           and conditions of the plan or coverage, in-  
16           cluding any cost-sharing amounts that the  
17           participant or beneficiary may be required  
18           to make with respect to such claim for bene-  
19           fits, and of the right of the participant or  
20           beneficiary to an internal appeal under  
21           subsection (b).

22           “(B) ACCESS TO INFORMATION.—With re-  
23           spect to an initial claim for benefits, the partici-  
24           pant or beneficiary (or authorized representa-  
25           tive) and the treating health care professional (if

1           any) shall provide the plan or issuer with access  
2           to information necessary to make a determina-  
3           tion relating to the claim, not later than 5 busi-  
4           ness days after the date on which the claim is  
5           filed or to meet the applicable timelines under  
6           clauses (ii) and (iii) of paragraph (2)(A).

7           “(C) *ORAL REQUESTS.*—In the case of a  
8           claim for benefits involving an expedited or con-  
9           current determination, a participant or bene-  
10          ficiary (or authorized representative) may make  
11          an initial claim for benefits orally, but a group  
12          health plan, or health insurance issuer offering  
13          health insurance coverage in connection with a  
14          group health plan, may require that the partici-  
15          pant or beneficiary (or authorized representa-  
16          tive) provide written confirmation of such re-  
17          quest in a timely manner.

18          “(2) *TIMELINE FOR MAKING DETERMINATIONS.*—

19                 “(A) *PRIOR AUTHORIZATION DETERMINA-*  
20                 *TION.*—

21                         “(i) *IN GENERAL.*—A group health  
22                         plan, or health insurance issuer offering  
23                         health insurance coverage in connection  
24                         with a group health plan, shall maintain  
25                         procedures to ensure that a prior authoriza-

1            *tion determination on a claim for benefits*  
2            *is made within 14 business days from the*  
3            *date on which the plan or issuer receives in-*  
4            *formation that is reasonably necessary to*  
5            *enable the plan or issuer to make a deter-*  
6            *mination on the request for prior authoriza-*  
7            *tion, but in no case shall such determina-*  
8            *tion be made later than 28 business days*  
9            *after the receipt of the claim for benefits.*

10            “(i) *EXPEDITED DETERMINATION.—*  
11            *Notwithstanding clause (i), a group health*  
12            *plan, or health insurance issuer offering*  
13            *health insurance coverage in connection*  
14            *with a group health plan, shall maintain*  
15            *procedures for expediting a prior authoriza-*  
16            *tion determination on a claim for benefits*  
17            *described in such clause when a request for*  
18            *such an expedited determination is made by*  
19            *a participant or beneficiary (or authorized*  
20            *representative) at any time during the proc-*  
21            *ess for making a determination and the*  
22            *treating health care professional substan-*  
23            *tiates, with the request, that a determina-*  
24            *tion under the procedures described in*  
25            *clause (i) would seriously jeopardize the life*

1            *or health of the participant or beneficiary.*  
2            *Such determination shall be made within*  
3            *72 hours after a request is received by the*  
4            *plan or issuer under this clause.*

5            *“(iii) CONCURRENT DETERMINA-*  
6            *TIONS.—A group health plan, or health in-*  
7            *surance issuer offering health insurance cov-*  
8            *erage in connection with a group health*  
9            *plan, shall maintain procedures to ensure*  
10           *that a concurrent determination on a claim*  
11           *for benefits that results in a discontinuation*  
12           *of inpatient care is made within 24 hours*  
13           *after the receipt of the claim for benefits.*

14           *“(B) RETROSPECTIVE DETERMINATION.—A*  
15           *group health plan, or health insurance issuer of-*  
16           *fering health insurance coverage in connection*  
17           *with a group health plan, shall maintain proce-*  
18           *dures to ensure that a retrospective determina-*  
19           *tion on a claim for benefits is made within 30*  
20           *business days of the date on which the plan or*  
21           *issuer receives information that is reasonably*  
22           *necessary to enable the plan or issuer to make a*  
23           *determination on the claim, but in no case shall*  
24           *such determination be made later than 60 busi-*

1           *ness days after the receipt of the claim for bene-*  
2           *fits.*

3           “(3) *NOTICE OF A DENIAL OF A CLAIM FOR BEN-*  
4           *EFITS.*—*Written notice of a denial made under an*  
5           *initial claim for benefits shall be issued to the partici-*  
6           *part or beneficiary (or authorized representative) and*  
7           *the treating health care professional not later than 2*  
8           *business days after the determination (or within the*  
9           *72-hour or 24-hour period referred to in clauses (ii)*  
10           *and (iii) of paragraph (2)(A) if applicable).*

11           “(4) *REQUIREMENTS OF NOTICE OF DETERMINA-*  
12           *TIONS.*—*The written notice of a denial of a claim for*  
13           *benefits determination under paragraph (3) shall*  
14           *include—*

15                   “(A) *the reasons for the determination (in-*  
16                   *cluding a summary of the clinical or scientific-*  
17                   *evidence based rationale used in making the de-*  
18                   *termination and instruction on obtaining a*  
19                   *more complete description written in a manner*  
20                   *calculated to be understood by the average par-*  
21                   *ticipant);*

22                   “(B) *the procedures for obtaining addi-*  
23                   *tional information concerning the determination;*  
24                   *and*

1           “(C) notification of the right to appeal the  
2           determination and instructions on how to ini-  
3           tiate an appeal in accordance with subsection  
4           (b).

5           “(b) *INTERNAL APPEAL OF A DENIAL OF A CLAIM FOR*  
6 *BENEFITS.*—

7           “(1) *RIGHT TO INTERNAL APPEAL.*—

8           “(A) *IN GENERAL.*—A participant or bene-  
9           ficiary (or authorized representative) may ap-  
10          peal any denial of a claim for benefits under  
11          subsection (a) under the procedures described in  
12          this subsection.

13          “(B) *TIME FOR APPEAL.*—A group health  
14          plan, or health insurance issuer offering health  
15          insurance coverage in connection with a group  
16          health plan, shall ensure that a participant or  
17          beneficiary (or authorized representative) has a  
18          period of not less than 60 days beginning on the  
19          date of a denial of a claim for benefits under  
20          subsection (a) in which to appeal such denial  
21          under this subsection.

22          “(C) *FAILURE TO ACT.*—The failure of a  
23          plan or issuer to issue a determination on a  
24          claim for benefits under subsection (a) within the  
25          applicable timeline established for such a deter-

1           *mination under such subsection shall be treated*  
2           *as a denial of a claim for benefits for purposes*  
3           *of proceeding to internal review under this sub-*  
4           *section.*

5           “(D) *PLAN WAIVER OF INTERNAL RE-*  
6           *VIEW.—A group health plan, or health insurance*  
7           *issuer offering health insurance coverage in con-*  
8           *nection with a group health plan, may waive the*  
9           *internal review process under this subsection and*  
10          *permit a participant or beneficiary (or author-*  
11          *ized representative) to proceed directly to exter-*  
12          *nal review under section 503B.*

13          “(2) *TIMELINES FOR MAKING DETERMINA-*  
14          *TIONS.—*

15                 “(A) *ORAL REQUESTS.—In the case of an*  
16                 *appeal of a denial of a claim for benefits under*  
17                 *this subsection that involves an expedited or con-*  
18                 *current determination, a participant or bene-*  
19                 *ficiary (or authorized representative) may re-*  
20                 *quest such appeal orally, but a group health*  
21                 *plan, or health insurance issuer offering health*  
22                 *insurance coverage in connection with a group*  
23                 *health plan, may require that the participant or*  
24                 *beneficiary (or authorized representative) pro-*

1           *vide* written confirmation of such request in a  
2           *timely* manner.

3           “(B) *ACCESS TO INFORMATION.*—*With re-*  
4           *spect to an appeal of a denial of a claim for ben-*  
5           *efits, the participant or beneficiary (or author-*  
6           *ized representative) and the treating health care*  
7           *professional (if any) shall provide the plan or*  
8           *issuer with access to information necessary to*  
9           *make a determination relating to the appeal, not*  
10          *later than 5 business days after the date on*  
11          *which the request for the appeal is filed or to*  
12          *meet the applicable timelines under clauses (ii)*  
13          *and (iii) of subparagraph (C).*

14          “(C) *PRIOR AUTHORIZATION DETERMINA-*  
15          *TIONS.*—

16                 “(i) *IN GENERAL.*—*A group health*  
17                 *plan, or health insurance issuer offering*  
18                 *health insurance coverage in connection*  
19                 *with a group health plan, shall maintain*  
20                 *procedures to ensure that a determination*  
21                 *on an appeal of a denial of a claim for ben-*  
22                 *efits under this subsection is made within*  
23                 *14 business days after the date on which the*  
24                 *plan or issuer receives information that is*  
25                 *reasonably necessary to enable the plan or*

1 issuer to make a determination on the ap-  
2 peal, but in no case shall such determina-  
3 tion be made later than 28 business days  
4 after the receipt of the request for the ap-  
5 peal.

6 “(ii) *EXPEDITED DETERMINATION.*—  
7 Notwithstanding clause (i), a group health  
8 plan, or health insurance issuer offering  
9 health insurance coverage in connection  
10 with a group health plan, shall maintain  
11 procedures for expediting a prior authoriza-  
12 tion determination on an appeal of a denial  
13 of a claim for benefits described in clause  
14 (i), when a request for such an expedited de-  
15 termination is made by a participant or  
16 beneficiary (or authorized representative) at  
17 any time during the process for making a  
18 determination and the treating health care  
19 professional substantiates, with the request,  
20 that a determination under the procedures  
21 described in clause (i) would seriously jeop-  
22 ardize the life or health of the participant  
23 or beneficiary. Such determination shall be  
24 made not later than 72 hours after the re-

1            *quest for such appeal is received by the plan*  
2            *or issuer under this clause.*

3            “(iii)    *CONCURRENT    DETERMINA-*  
4            *TIONS.—A group health plan, or health in-*  
5            *surance issuer offering health insurance cov-*  
6            *erage in connection with a group health*  
7            *plan, shall maintain procedures to ensure*  
8            *that a concurrent determination on an ap-*  
9            *peal of a denial of a claim for benefits that*  
10           *results in a discontinuation of inpatient*  
11           *care is made within 24 hours after the re-*  
12           *ceipt of the request for appeal.*

13           “(B) *RETROSPECTIVE DETERMINATION.—A*  
14           *group health plan, or health insurance issuer of-*  
15           *fering health insurance coverage in connection*  
16           *with a group health plan, shall maintain proce-*  
17           *dures to ensure that a retrospective determina-*  
18           *tion on an appeal of a claim for benefits is made*  
19           *within 30 business days of the date on which the*  
20           *plan or issuer receives necessary information*  
21           *that is reasonably required by the plan or issuer*  
22           *to make a determination on the appeal, but in*  
23           *no case shall such determination be made later*  
24           *than 60 business days after the receipt of the re-*  
25           *quest for the appeal.*

1           “(3) *CONDUCT OF REVIEW.*—

2                   “(A) *IN GENERAL.*—*A review of a denial of*  
3 *a claim for benefits under this subsection shall be*  
4 *conducted by an individual with appropriate ex-*  
5 *pertise who was not directly involved in the ini-*  
6 *tial determination.*

7                   “(B) *REVIEW OF MEDICAL DECISIONS BY*  
8 *PHYSICIANS.*—*A review of an appeal of a denial*  
9 *of a claim for benefits that is based on a lack of*  
10 *medical necessity and appropriateness, or based*  
11 *on an experimental or investigational treatment,*  
12 *or requires an evaluation of medical facts, shall*  
13 *be made by a physician with appropriate exper-*  
14 *tise, including age-appropriate expertise, who*  
15 *was not involved in the initial determination.*

16           “(4) *NOTICE OF DETERMINATION.*—

17                   “(A) *IN GENERAL.*—*Written notice of a de-*  
18 *termination made under an internal appeal of a*  
19 *denial of a claim for benefits shall be issued to*  
20 *the participant or beneficiary (or authorized rep-*  
21 *resentative) and the treating health care profes-*  
22 *sional not later than 2 business days after the*  
23 *completion of the review (or within the 72-hour*  
24 *or 24-hour period referred to in paragraph (2)*  
25 *if applicable).*

1           “(B) *FINAL DETERMINATION.*—*The decision*  
2           *by a plan or issuer under this subsection shall*  
3           *be treated as the final determination of the plan*  
4           *or issuer on a denial of a claim for benefits. The*  
5           *failure of a plan or issuer to issue a determina-*  
6           *tion on an appeal of a denial of a claim for ben-*  
7           *efits under this subsection within the applicable*  
8           *timeline established for such a determination*  
9           *shall be treated as a final determination on an*  
10          *appeal of a denial of a claim for benefits for*  
11          *purposes of proceeding to external review under*  
12          *section 503B.*

13           “(C) *REQUIREMENTS OF NOTICE.*—*With re-*  
14          *spect to a determination made under this sub-*  
15          *section, the notice described in subparagraph (A)*  
16          *shall include—*

17                   “(i) *the reasons for the determination*  
18                   *(including a summary of the clinical or sci-*  
19                   *entific-evidence based rationale used in*  
20                   *making the determination and instruction*  
21                   *on obtaining a more complete description*  
22                   *written in a manner calculated to be under-*  
23                   *stood by the average participant);*

1                   “(ii) the procedures for obtaining addi-  
2                   tional information concerning the deter-  
3                   mination; and

4                   “(iii) notification of the right to an  
5                   independent external review under section  
6                   503B and instructions on how to initiate  
7                   such a review.

8                   “(c) *DEFINITIONS.*—The definitions contained in sec-  
9                   tion 503B(i) shall apply for purposes of this section.

10                   “**SEC. 503B. INDEPENDENT EXTERNAL APPEALS PROCE-**  
11                   **DURES FOR GROUP HEALTH PLANS.**

12                   “(a) *RIGHT TO EXTERNAL APPEAL.*—A group health  
13                   plan, and a health insurance issuer offering health insur-  
14                   ance coverage in connection with a group health plan, shall  
15                   provide in accordance with this section participants and  
16                   beneficiaries (or authorized representatives) with access to  
17                   an independent external review for any denial of a claim  
18                   for benefits.

19                   “(b) *INITIATION OF THE INDEPENDENT EXTERNAL*  
20                   *REVIEW PROCESS.*—

21                   “(1) *TIME TO FILE.*—A request for an inde-  
22                   pendent external review under this section shall be  
23                   filed with the plan or issuer not later than 60 busi-  
24                   ness days after the date on which the participant or  
25                   beneficiary receives notice of the denial under section

1       503A(b)(4) or the date on which the internal review  
2       is waived by the plan or issuer under section  
3       503A(b)(1)(D).

4               “(2) *FILING OF REQUEST.*—

5               “(A) *IN GENERAL.*—Subject to the suc-  
6       ceeding provisions of this subsection, a group  
7       health plan, and a health insurance issuer offer-  
8       ing health insurance coverage in connection with  
9       a group health plan, may—

10              “(i) except as provided in subpara-  
11       graph (B)(i), require that a request for re-  
12       view be in writing;

13              “(ii) limit the filing of such a request  
14       to the participant or beneficiary involved  
15       (or an authorized representative);

16              “(iii) except if waived by the plan or  
17       issuer under section 503A(b)(1)(D), condi-  
18       tion access to an independent external re-  
19       view under this section upon a final deter-  
20       mination of a denial of a claim for benefits  
21       under the internal review procedure under  
22       section 503A;

23              “(iv) except as provided in subpara-  
24       graph (B)(ii), require payment of a filing

1           *fee to the plan or issuer of a sum that does*  
2           *not exceed \$50; and*

3           “(v) *require that a request for review*  
4           *include the consent of the participant or*  
5           *beneficiary (or authorized representative)*  
6           *for the release of medical information or*  
7           *records of the participant or beneficiary to*  
8           *the qualified external review entity for pur-*  
9           *poses of conducting external review activi-*  
10          *ties.*

11          “(B) *REQUIREMENTS AND EXCEPTION RE-*  
12          *LATING TO GENERAL RULE.—*

13               “(i) *ORAL REQUESTS PERMITTED IN*  
14               *EXPEDITED OR CONCURRENT CASES.—In*  
15               *the case of an expedited or concurrent exter-*  
16               *nal review as provided for under subsection*  
17               *(e), the request may be made orally. In such*  
18               *case a written confirmation of such request*  
19               *shall be made in a timely manner. Such*  
20               *written confirmation shall be treated as a*  
21               *consent for purposes of subparagraph*  
22               *(A)(v).*

23               “(ii) *EXCEPTION TO FILING FEE RE-*  
24               *QUIREMENT.—*

1           “(I) *INDIGENCY.*—*Payment of a*  
2 *filing fee shall not be required under*  
3 *subparagraph (A)(iv) where there is a*  
4 *certification (in a form and manner*  
5 *specified in guidelines established by*  
6 *the Secretary) that the participant or*  
7 *beneficiary is indigent (as defined in*  
8 *such guidelines). In establishing guide-*  
9 *lines under this subclause, the Sec-*  
10 *retary shall ensure that the guidelines*  
11 *relating to indigency are consistent*  
12 *with the poverty guidelines used by the*  
13 *Secretary of Health and Human Serv-*  
14 *ices under title XIX of the Social Secu-*  
15 *rity Act.*

16           “(II) *FEE NOT REQUIRED.*—*Pay-*  
17 *ment of a filing fee shall not be re-*  
18 *quired under subparagraph (A)(iv) if*  
19 *the plan or issuer waives the internal*  
20 *appeals process under section*  
21 *503A(b)(1)(D).*

22           “(III) *REFUNDING OF FEE.*—*The*  
23 *filing fee paid under subparagraph*  
24 *(A)(iv) shall be refunded if the deter-*  
25 *mination under the independent exter-*

1                    *nal review is to reverse the denial*  
2                    *which is the subject of the review.*

3                    “(IV) *INCREASE IN AMOUNT.—*  
4                    *The amount referred to in subclause (I)*  
5                    *shall be increased or decreased, for each*  
6                    *calendar year that ends after December*  
7                    *31, 2001, by the same percentage as the*  
8                    *percentage by which the Consumer*  
9                    *Price Index for All Urban Consumers*  
10                    *(United States city average), published*  
11                    *by the Bureau of Labor Statistics, for*  
12                    *September of the preceding calendar*  
13                    *year has increased or decreased from*  
14                    *the such Index for September of 2001.*

15                    “(c) *REFERRAL TO QUALIFIED EXTERNAL REVIEW*  
16                    *ENTITY UPON REQUEST.—*

17                    “(1) *IN GENERAL.—Upon the filing of a request*  
18                    *for independent external review with the group health*  
19                    *plan, or health insurance issuer offering coverage in*  
20                    *connection with a group health plan, the plan or*  
21                    *issuer shall refer such request to a qualified external*  
22                    *review entity selected in accordance with this section.*

23                    “(2) *ACCESS TO PLAN OR ISSUER AND HEALTH*  
24                    *PROFESSIONAL INFORMATION.—With respect to an*  
25                    *independent external review conducted under this sec-*

1        *tion, the participant or beneficiary (or authorized*  
2        *representative), the plan or issuer, and the treating*  
3        *health care professional (if any) shall provide the ex-*  
4        *ternal review entity with access to information that*  
5        *is necessary to conduct a review under this section, as*  
6        *determined by the entity, not later than 5 business*  
7        *days after the date on which a request is referred to*  
8        *the qualified external review entity under paragraph*  
9        *(1), or earlier as determined appropriate by the enti-*  
10       *ty to meet the applicable timelines under clauses (ii)*  
11       *and (iii) of subsection (e)(1)(A).*

12                *“(3) SCREENING OF REQUESTS BY QUALIFIED*  
13        *EXTERNAL REVIEW ENTITIES.—*

14                *“(A) IN GENERAL.—With respect to a re-*  
15        *quest referred to a qualified external review enti-*  
16        *ty under paragraph (1) relating to a denial of*  
17        *a claim for benefits, the entity shall refer such*  
18        *request for the conduct of an independent med-*  
19        *ical review unless the entity determines that—*

20                        *“(i) any of the conditions described in*  
21                        *subsection (b)(2)(A) have not been met;*

22                        *“(ii) the thresholds described in sub-*  
23                        *paragraph (B) have not been met;*

1           “(iii) the denial of the claim for bene-  
2           fits does not involve a medically reviewable  
3           decision under subsection (d)(2);

4           “(iv) the denial of the claim for bene-  
5           fits relates to a decision regarding whether  
6           an individual is a participant or bene-  
7           ficiary who is enrolled under the terms of  
8           the plan or coverage (including the applica-  
9           bility of any waiting period under the plan  
10          or coverage); or

11          “(v) the denial of the claim for benefits  
12          is a decision as to the application of cost-  
13          sharing requirements or the application of a  
14          specific exclusion or express limitation on  
15          the amount, duration, or scope of coverage  
16          of items or services under the terms and  
17          conditions of the plan or coverage unless the  
18          decision is a denial described in subsection  
19          (d)(2)(C);

20          Upon making a determination that any of  
21          clauses (i) through (v) applies with respect to the  
22          request, the entity shall determine that the denial  
23          of a claim for benefits involved is not eligible for  
24          independent medical review under subsection (d),

1           *and shall provide notice in accordance with sub-*  
2           *paragraph (D).*

3           “(B) *THRESHOLDS.*—

4                   “(i) *IN GENERAL.*—*The thresholds de-*  
5                   *scribed in this subparagraph are that—*

6                           “(I) *the total amount payable*  
7                           *under the plan or coverage for the item*  
8                           *or service that was the subject of such*  
9                           *denial exceeds a significant financial*  
10                           *threshold (as determined under guide-*  
11                           *lines established by the Secretary); or*

12                           “(II) *a physician has asserted in*  
13                           *writing that there is a significant risk*  
14                           *of placing the life, health, or develop-*  
15                           *ment of the participant or beneficiary*  
16                           *in jeopardy if the denial of the claim*  
17                           *for benefits is sustained.*

18                   “(ii) *THRESHOLDS NOT APPLIED.*—  
19                   *The thresholds described in this subpara-*  
20                   *graph shall not apply if the plan or issuer*  
21                   *involved waives the internal appeals process*  
22                   *with respect to the denial of a claim for*  
23                   *benefits involved under section*  
24                   *503A(b)(1)(D).*

1           “(C) *PROCESS FOR MAKING DETERMINA-*  
2           *TIONS.—*

3                   “(i) *NO DEFERENCE TO PRIOR DETER-*  
4                   *MINATIONS.—In making determinations*  
5                   *under subparagraph (A), there shall be no*  
6                   *deference given to determinations made by*  
7                   *the plan or issuer under section 503A or the*  
8                   *recommendation of a treating health care*  
9                   *professional (if any).*

10                   “(ii) *USE OF APPROPRIATE PER-*  
11                   *SONNEL.—A qualified external review entity*  
12                   *shall use appropriately qualified personnel*  
13                   *to make determinations under this section.*

14           “(D) *NOTICES AND GENERAL TIMELINES*  
15           *FOR DETERMINATION.—*

16                   “(i) *NOTICE IN CASE OF DENIAL OF*  
17                   *REFERRAL.—If the entity under this para-*  
18                   *graph does not make a referral to an inde-*  
19                   *pendent medical reviewer, the entity shall*  
20                   *provide notice to the plan or issuer, the par-*  
21                   *ticipant or beneficiary (or authorized rep-*  
22                   *resentative) filing the request, and the treat-*  
23                   *ing health care professional (if any) that*  
24                   *the denial is not subject to independent*  
25                   *medical review. Such notice—*

1           “(I) shall be written (and, in ad-  
2           dition, may be provided orally) in a  
3           manner calculated to be understood by  
4           an average participant;

5           “(II) shall include the reasons for  
6           the determination; and

7           “(III) include any relevant terms  
8           and conditions of the plan or coverage.

9           “(ii) *GENERAL TIMELINE FOR DETER-*  
10          *MINATIONS.—Upon receipt of information*  
11          *under paragraph (2), the qualified external*  
12          *review entity, and if required the inde-*  
13          *pendent medical reviewer, shall make a de-*  
14          *termination within the overall timeline that*  
15          *is applicable to the case under review as de-*  
16          *scribed in subsection (e), except that if the*  
17          *entity determines that a referral to an inde-*  
18          *pendent medical reviewer is not required,*  
19          *the entity shall provide notice of such deter-*  
20          *mination to the participant or beneficiary*  
21          *(or authorized representative) within 2*  
22          *business days of such determination.*

23          “(d) *INDEPENDENT MEDICAL REVIEW.—*

24                 “(1) *IN GENERAL.—If a qualified external review*  
25          *entity determines under subsection (c) that a denial*

1       of a claim for benefits is eligible for independent med-  
2       ical review, the entity shall refer the denial involved  
3       to an independent medical reviewer for the conduct of  
4       an independent medical review under this subsection.

5           “(2) *MEDICALLY REVIEWABLE DECISIONS.*—A  
6       denial described in this paragraph is one for which  
7       the item or service that is the subject of the denial  
8       would be a covered benefit under the terms and condi-  
9       tions of the plan or coverage but for one (or more) of  
10      the following determinations:

11           “(A) *DENIALS BASED ON MEDICAL NECES-*  
12      *SITY AND APPROPRIATENESS.*—The basis of the  
13      determination is that the item or service is not  
14      medically necessary and appropriate.

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

19           “(C) *DENIALS OTHERWISE BASED ON AN*  
20      *EVALUATION OF MEDICAL FACTS.*—A determina-  
21      tion that the item or service or condition is not  
22      covered but an evaluation of the medical facts by  
23      a health care professional in the specific case in-  
24      volved is necessary to determine whether the item  
25      or service or condition is required to be provided

1           *under the terms and conditions of the plan or*  
2           *coverage.*

3           “(3) *INDEPENDENT MEDICAL REVIEW DETER-*  
4           *MINATION.—*

5                   “(A) *IN GENERAL.—An independent med-*  
6           *ical reviewer under this section shall make a new*  
7           *independent determination with respect to—*

8                           “(i) *whether the item or service or con-*  
9                           *dition that is the subject of the denial is*  
10                           *covered under the terms and conditions of*  
11                           *the plan or coverage; and*

12                           “(ii) *based upon an affirmative deter-*  
13                           *mination under clause (i), whether or not*  
14                           *the denial of a claim for a benefit that is*  
15                           *the subject of the review should be upheld or*  
16                           *reversed.*

17                           “(B) *STANDARD FOR DETERMINATION.—The*  
18           *independent medical reviewer’s determination re-*  
19           *lating to the medical necessity and appropriate-*  
20           *ness, or the experimental or investigation nature,*  
21           *or the evaluation of the medical facts of the item,*  
22           *service, or condition shall be based on the med-*  
23           *ical condition of the participant or beneficiary*  
24           *(including the medical records of the participant*  
25           *or beneficiary) and the valid, relevant scientific*

1 *evidence and clinical evidence, including peer-re-*  
2 *viewed medical literature or findings and in-*  
3 *cluding expert consensus.*

4 “(C) *NO COVERAGE FOR EXCLUDED BENE-*  
5 *FITS.—Nothing in this subsection shall be con-*  
6 *strued to permit an independent medical re-*  
7 *viewer to require that a group health plan, or*  
8 *health insurance issuer offering health insurance*  
9 *coverage in connection with a group health plan,*  
10 *provide coverage for items or services that are*  
11 *specifically excluded or expressly limited under*  
12 *the plan or coverage and that are not covered re-*  
13 *gardless of any determination relating to med-*  
14 *ical necessity and appropriateness, experimental*  
15 *or investigational nature of the treatment, or an*  
16 *evaluation of the medical facts in the case in-*  
17 *volved.*

18 “(D) *EVIDENCE AND INFORMATION TO BE*  
19 *USED IN MEDICAL REVIEWS.—In making a de-*  
20 *termination under this subsection, the inde-*  
21 *pendent medical reviewer shall also consider ap-*  
22 *propriate and available evidence and informa-*  
23 *tion, including the following:*

24 “(i) *The determination made by the*  
25 *plan or issuer with respect to the claim*

1           upon internal review and the evidence or  
2           guidelines used by the plan or issuer in  
3           reaching such determination.

4           “(ii) The recommendation of the treat-  
5           ing health care professional and the evi-  
6           dence, guidelines, and rationale used by the  
7           treating health care professional in reaching  
8           such recommendation.

9           “(iii) Additional evidence or informa-  
10          tion obtained by the reviewer or submitted  
11          by the plan, issuer, participant or bene-  
12          ficiary (or an authorized representative), or  
13          treating health care professional.

14          “(iv) The plan or coverage document.

15          “(E) *INDEPENDENT DETERMINATION.*—In  
16          making the determination, the independent med-  
17          ical reviewer shall—

18               “(i) consider the claim under review  
19               without deference to the determinations  
20               made by the plan or issuer under section  
21               503A or the recommendation of the treating  
22               health care professional (if any);

23               “(ii) consider, but not be bound by the  
24               definition used by the plan or issuer of  
25               ‘medically necessary and appropriate’, or

1           ‘experimental or investigational’, or other  
2           equivalent terms that are used by the plan  
3           or issuer to describe medical necessity and  
4           appropriateness or experimental or inves-  
5           tigational nature of the treatment; and

6           “(iii) notwithstanding clause (ii), ad-  
7           here to the definition used by the plan or  
8           issuer of ‘medically necessary and appro-  
9           priate’, or ‘experimental or investigational’  
10          if such definition is the same as the defini-  
11          tion of such term—

12                   “(I) that has been adopted pursu-  
13                   ant to a State statute or regulation; or

14                   “(II) that is used for purposes of  
15                   the program established under titles  
16                   XVIII or XIX of the Social Security  
17                   Act or under chapter 89 of title 5,  
18                   United States Code.

19           “(F) DETERMINATION OF INDEPENDENT  
20           MEDICAL REVIEWER.—An independent medical  
21           reviewer shall, in accordance with the deadlines  
22           described in subsection (e), prepare a written de-  
23           termination to uphold or reverse the denial  
24           under review. Such written determination shall  
25           include the specific reasons of the reviewer for

1           *such determination, including a summary of the*  
2           *clinical or scientific-evidence based rationale*  
3           *used in making the determination. The reviewer*  
4           *may provide the plan or issuer and the treating*  
5           *health care professional with additional rec-*  
6           *ommendations in connection with such a deter-*  
7           *mination, but any such recommendations shall*  
8           *not be treated as part of the determination.*

9           “(e) *TIMELINES AND NOTIFICATIONS.*—

10           “(1) *TIMELINES FOR INDEPENDENT MEDICAL RE-*  
11           *VIEW.*—

12           “(A) *PRIOR AUTHORIZATION DETERMINA-*  
13           *TION.*—

14           “(i) *IN GENERAL.*—*The independent*  
15           *medical reviewer (or reviewers) shall make*  
16           *a determination on a denial of a claim for*  
17           *benefits that is referred to the reviewer*  
18           *under subsection (c)(3) not later than 14*  
19           *business days after the receipt of informa-*  
20           *tion under subsection (c)(2) if the review*  
21           *involves a prior authorization of items or*  
22           *services.*

23           “(ii) *EXPEDITED DETERMINATION.*—  
24           *Notwithstanding clause (i), the independent*  
25           *medical reviewer (or reviewers) shall make*

1            *an expedited determination on a denial of*  
2            *a claim for benefits described in clause (i),*  
3            *when a request for such an expedited deter-*  
4            *mination is made by a participant or bene-*  
5            *ficiary (or authorized representative) at any*  
6            *time during the process for making a deter-*  
7            *mination, and the treating health care pro-*  
8            *fessional substantiates, with the request,*  
9            *that a determination under the timeline de-*  
10           *scribed in clause (i) would seriously jeop-*  
11           *ardize the life or health of the participant*  
12           *or beneficiary. Such determination shall be*  
13           *made not later than 72 hours after the re-*  
14           *ceipt of information under subsection (c)(2).*

15           “(iii)    *CONCURRENT DETERMINA-*  
16           *TION.—Notwithstanding clause (i), a review*  
17           *described in such subclause shall be com-*  
18           *pleted not later than 24 hours after the re-*  
19           *ceipt of information under subsection (c)(2)*  
20           *if the review involves a discontinuation of*  
21           *inpatient care.*

22           “(B)    *RETROSPECTIVE DETERMINATION.—*  
23           *The independent medical reviewer (or reviewers)*  
24           *shall complete a review in the case of a retrospec-*  
25           *tive determination on an appeal of a denial of*

1           *a claim for benefits that is referred to the re-*  
2           *viewer under subsection (c)(3) not later than 30*  
3           *business days after the receipt of information*  
4           *under subsection (c)(2).*

5           “(2) *NOTIFICATION OF DETERMINATION.*—*The*  
6           *external review entity shall ensure that the plan or*  
7           *issuer, the participant or beneficiary (or authorized*  
8           *representative) and the treating health care profes-*  
9           *sional (if any) receives a copy of the written deter-*  
10          *mination of the independent medical reviewer pre-*  
11          *pared under subsection (d)(3)(F). Nothing in this*  
12          *paragraph shall be construed as preventing an entity*  
13          *or reviewer from providing an initial oral notice of*  
14          *the reviewer’s determination.*

15          “(3) *FORM OF NOTICES.*—*Determinations and*  
16          *notices under this subsection shall be written in a*  
17          *manner calculated to be understood by an average*  
18          *participant.*

19          “(4) *TERMINATION OF EXTERNAL REVIEW PROC-*  
20          *CESS IF APPROVAL OF A CLAIM FOR BENEFITS DURING*  
21          *PROCESS.*—

22                  “(A) *IN GENERAL.*—*If a plan or issuer—*  
23                          “(i) *reverses a determination on a de-*  
24                           *denial of a claim for benefits that is the sub-*  
25                          *ject of an external review under this section*

1           *and authorizes coverage for the claim or*  
2           *provides payment of the claim; and*

3           “(ii) *provides notice of such reversal to*  
4           *the participant or beneficiary (or author-*  
5           *ized representative) and the treating health*  
6           *care professional (if any), and the external*  
7           *review entity responsible for such review,*  
8           *the external review process shall be terminated*  
9           *with respect to such denial and any filing fee*  
10           *paid under subsection (b)(2)(A)(iv) shall be re-*  
11           *funded.*

12           “(B) *TREATMENT OF TERMINATION.—An*  
13           *authorization of coverage under subparagraph*  
14           *(A) by the plan or issuer shall be treated as a*  
15           *written determination to reverse a denial under*  
16           *section (d)(3)(F) for purposes of liability under*  
17           *section 502(n)(1)(B).*

18           “(f) *COMPLIANCE.—*

19           “(1) *APPLICATION OF DETERMINATIONS.—*

20           “(A) *EXTERNAL REVIEW DETERMINATIONS*  
21           *BINDING ON PLAN.—The determinations of an*  
22           *external review entity and an independent med-*  
23           *ical reviewer under this section shall be binding*  
24           *upon the plan or issuer involved.*

1                   “(B) *COMPLIANCE WITH DETERMINATION.*—  
2                   *If the determination of an independent medical*  
3                   *reviewer is to reverse the denial, the plan or*  
4                   *issuer, upon the receipt of such determination,*  
5                   *shall authorize coverage to comply with the med-*  
6                   *ical reviewer’s determination in accordance with*  
7                   *the timeframe established by the medical re-*  
8                   *viewer.*

9                   “(2) *FAILURE TO COMPLY.*—*If a plan or issuer*  
10                  *fails to comply with the timeframe established under*  
11                  *paragraph (1)(B)(i) with respect to a participant or*  
12                  *beneficiary, where such failure to comply is caused by*  
13                  *the plan or issuer, the participant or beneficiary may*  
14                  *obtain the items or services involved (in a manner*  
15                  *consistent with the determination of the independent*  
16                  *external reviewer) from any provider regardless of*  
17                  *whether such provider is a participating provider*  
18                  *under the plan or coverage.*

19                  “(3) *REIMBURSEMENT.*—

20                  “(A) *IN GENERAL.*—*Where a participant or*  
21                  *beneficiary obtains items or services in accord-*  
22                  *ance with paragraph (2), the plan or issuer in-*  
23                  *volved shall provide for reimbursement of the*  
24                  *costs of such items of services. Such reimburse-*  
25                  *ment shall be made to the treating health care*

1           *professional or to the participant or beneficiary*  
2           *(in the case of a participant or beneficiary who*  
3           *pays for the costs of such items or services).*

4           “(B) *AMOUNT.*—*The plan or issuer shall*  
5           *fully reimburse a professional, participant or*  
6           *beneficiary under subparagraph (A) for the total*  
7           *costs of the items or services provided (regardless*  
8           *of any plan limitations that may apply to the*  
9           *coverage of such items of services) so long as—*

10           “(i) *the items or services would have*  
11           *been covered under the terms of the plan or*  
12           *coverage if provided by the plan or issuer;*  
13           *and*

14           “(ii) *the items or services were pro-*  
15           *vided in a manner consistent with the de-*  
16           *termination of the independent medical re-*  
17           *viewer.*

18           “(4) *FAILURE TO REIMBURSE.*—*Where a plan or*  
19           *issuer fails to provide reimbursement to a profes-*  
20           *sional, participant or beneficiary in accordance with*  
21           *this subsection, the professional, participant or bene-*  
22           *ficiary may commence a civil action (or utilize other*  
23           *remedies available under law) to recover only the*  
24           *amount of any such reimbursement that is unpaid*  
25           *and any necessary legal costs or expenses (including*

1 *attorneys' fees) incurred in recovering such reimburse-*  
2 *ment.*

3 *“(g) QUALIFICATIONS OF INDEPENDENT MEDICAL RE-*  
4 *VIEWERS.—*

5 *“(1) IN GENERAL.—In referring a denial to 1 or*  
6 *more individuals to conduct independent medical re-*  
7 *view under subsection (c), the qualified external re-*  
8 *view entity shall ensure that—*

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

12 *“(B) with respect to each review at least 1*  
13 *such reviewer meets the requirements described*  
14 *in paragraphs (4) and (5); and*

15 *“(C) compensation provided by the entity to*  
16 *the reviewer is consistent with paragraph (6).*

17 *“(2) LICENSURE AND EXPERTISE.—Each inde-*  
18 *pendent medical reviewer shall be a physician or*  
19 *health care professional who—*

20 *“(A) is appropriately credentialed or li-*  
21 *censed in 1 or more States to deliver health care*  
22 *services; and*

23 *“(B) typically treats the diagnosis or condi-*  
24 *tion or provides the type or treatment under re-*  
25 *view.*

1           “(3) *INDEPENDENCE.*—

2                   “(A) *IN GENERAL.*—Subject to subpara-  
3 graph (B), each independent medical reviewer in  
4 a case shall—

5                           “(i) not be a related party (as defined  
6 in paragraph (7));

7                           “(ii) not have a material familial, fi-  
8 nancial, or professional relationship with  
9 such a party; and

10                           “(iii) not otherwise have a conflict of  
11 interest with such a party (as determined  
12 under regulations).

13                   “(B) *EXCEPTION.*—Nothing in this sub-  
14 paragraph (A) shall be construed to—

15                           “(i) prohibit an individual, solely on  
16 the basis of affiliation with the plan or  
17 issuer, from serving as an independent med-  
18 ical reviewer if—

19                                   “(I) a non-affiliated individual is  
20 not reasonably available;

21                                   “(II) the affiliated individual is  
22 not involved in the provision of items  
23 or services in the case under review;  
24 and

1                   “(III) the fact of such an affili-  
2                   ation is disclosed to the plan or issuer  
3                   and the participant or beneficiary (or  
4                   authorized representative) and neither  
5                   party objects;

6                   “(ii) prohibit an individual who has  
7                   staff privileges at the institution where the  
8                   treatment involved takes place from serving  
9                   as an independent medical reviewer if the  
10                  affiliation is disclosed to the plan or issuer  
11                  and the participant or beneficiary (or au-  
12                  thorized representative), and neither party  
13                  objects;

14                  “(iii) permit an employee of a plan or  
15                  issuer, or an individual who provides serv-  
16                  ices exclusively or primarily to or on behalf  
17                  of a plan or issuer, from serving as an inde-  
18                  pendent medical reviewer; or

19                  “(iv) prohibit receipt of compensation  
20                  by an independent medical reviewer from  
21                  an entity if the compensation is provided  
22                  consistent with paragraph (6).

23                  “(4) PRACTICING HEALTH CARE PROFESSIONAL  
24                  IN SAME FIELD.—

1           “(A) *IN GENERAL.*—*The requirement of this*  
2 *paragraph with respect to a reviewer in a case*  
3 *involving treatment, or the provision of items or*  
4 *services, by—*

5           “(i) *a physician, is that the reviewer*  
6 *be a practicing physician of the same or*  
7 *similar specialty, when reasonably avail-*  
8 *able, as a physician who typically treats the*  
9 *diagnosis or condition or provides such*  
10 *treatment in the case under review; or*

11           “(ii) *a health care professional (other*  
12 *than a physician), is that the reviewer be a*  
13 *practicing physician or, if determined ap-*  
14 *propriate by the qualified external review*  
15 *entity, a health care professional (other*  
16 *than a physician), of the same or similar*  
17 *specialty as the health care professional who*  
18 *typically treats the diagnosis or condition*  
19 *or provides the treatment in the case under*  
20 *review.*

21           “(B) *PRACTICING DEFINED.*—*For pur-*  
22 *poses of this paragraph, the term ‘prac-*  
23 *ticing’ means, with respect to an individual*  
24 *who is a physician or other health care pro-*  
25 *fessional that the individual provides health*

1                   *care services to individual patients on aver-*  
2                   *age at least 1 day per week.*

3                   “(5) *AGE-APPROPRIATE EXPERTISE.*—*The inde-*  
4                   *pendent medical reviewer shall have expertise under*  
5                   *paragraph (2) that is age-appropriate to the partici-*  
6                   *pant or beneficiary involved.*

7                   “(6) *LIMITATIONS ON REVIEWER COMPENSA-*  
8                   *TION.*—*Compensation provided by a qualified exter-*  
9                   *nal review entity to an independent medical reviewer*  
10                  *in connection with a review under this section shall—*

11                    “(A) *not exceed a reasonable level; and*

12                    “(B) *not be contingent on the decision ren-*  
13                    *dered by the reviewer.*

14                  “(7) *RELATED PARTY DEFINED.*—*For purposes*  
15                  *of this section, the term ‘related party’ means, with*  
16                  *respect to a denial of a claim under a plan or cov-*  
17                  *erage relating to a participant or beneficiary, any of*  
18                  *the following:*

19                    “(A) *The plan, plan sponsor, or issuer in-*  
20                    *volved, or any fiduciary, officer, director, or em-*  
21                    *ployee of such plan, plan sponsor, or issuer.*

22                    “(B) *The participant or beneficiary (or au-*  
23                    *thorized representative).*

24                    “(C) *The health care professional that pro-*  
25                    *vides the items of services involved in the denial.*

1           “(D) *The institution at which the items or*  
2           *services (or treatment) involved in the denial are*  
3           *provided.*

4           “(E) *The manufacturer of any drug or*  
5           *other item that is included in the items or serv-*  
6           *ices involved in the denial.*

7           “(F) *Any other party determined under any*  
8           *regulations to have a substantial interest in the*  
9           *denial involved.*

10          “(h) *QUALIFIED EXTERNAL REVIEW ENTITIES.—*

11           “(1) *SELECTION OF QUALIFIED EXTERNAL RE-*  
12          *VIEW ENTITIES.—*

13           “(A) *LIMITATION ON PLAN OR ISSUER SE-*  
14          *LECTION.—The Secretary shall implement proce-*  
15          *dures with respect to the selection of qualified ex-*  
16          *ternal review entities by a plan or issuer to as-*  
17          *sure that the selection process among qualified*  
18          *external review entities will not create any in-*  
19          *centives for external review entities to make a de-*  
20          *cision in a biased manner.*

21           “(B) *STATE AUTHORITY WITH RESPECT TO*  
22          *QUALIFIED EXTERNAL REVIEW ENTITIES FOR*  
23          *HEALTH INSURANCE ISSUERS.—With respect to*  
24          *health insurance issuers offering health insur-*  
25          *ance coverage in connection with a group health*

1           *plan in a State, the State may, pursuant to a*  
2           *State law that is enacted after the date of enact-*  
3           *ment of the Patients’ Bill of Rights Plus Act,*  
4           *provide for the designation or selection of quali-*  
5           *fied external review entities in a manner deter-*  
6           *mined by the State to assure an unbiased deter-*  
7           *mination in conducting external review activi-*  
8           *ties. In conducting reviews under this section, an*  
9           *entity designated or selected under this subpara-*  
10          *graph shall comply with the provision of this*  
11          *section.*

12           “(2) *CONTRACT WITH QUALIFIED EXTERNAL RE-*  
13          *VIEW ENTITY.—Except as provided in paragraph*  
14          *(1)(B), the external review process of a plan or issuer*  
15          *under this section shall be conducted under a contract*  
16          *between the plan or issuer and 1 or more qualified ex-*  
17          *ternal review entities (as defined in paragraph*  
18          *(4)(A)).*

19           “(3) *TERMS AND CONDITIONS OF CONTRACT.—*  
20          *The terms and conditions of a contract under para-*  
21          *graph (2) shall—*

22                   “(A) *be consistent with the standards the*  
23                   *Secretary shall establish to assure there is no*  
24                   *real or apparent conflict of interest in the con-*  
25                   *duct of external review activities; and*

1           “(B) provide that the costs of the external  
2           review process shall be borne by the plan or  
3           issuer.

4           Subparagraph (B) shall not be construed as applying  
5           to the imposition of a filing fee under subsection  
6           (b)(2)(A)(iv) or costs incurred by the participant or  
7           beneficiary (or authorized representative) or treating  
8           health care professional (if any) in support of the re-  
9           view, including the provision of additional evidence  
10          or information.

11          “(4) QUALIFICATIONS.—

12           “(A) IN GENERAL.—In this section, the  
13           term ‘qualified external review entity’ means, in  
14           relation to a plan or issuer, an entity that is  
15           initially certified (and periodically recertified)  
16           under subparagraph (C) as meeting the following  
17           requirements:

18           “(i) The entity has (directly or through  
19           contracts or other arrangements) sufficient  
20           medical, legal, and other expertise and suffi-  
21           cient staffing to carry out duties of a quali-  
22           fied external review entity under this sec-  
23           tion on a timely basis, including making  
24           determinations under subsection (b)(2)(A)

1           and providing for independent medical re-  
2           views under subsection (d).

3           “(ii) *The entity is not a plan or issuer*  
4           *or an affiliate or a subsidiary of a plan or*  
5           *issuer, and is not an affiliate or subsidiary*  
6           *of a professional or trade association of*  
7           *plans or issuers or of health care providers.*

8           “(iii) *The entity has provided assur-*  
9           *ances that it will conduct external review*  
10           *activities consistent with the applicable re-*  
11           *quirements of this section and standards*  
12           *specified in subparagraph (C), including*  
13           *that it will not conduct any external review*  
14           *activities in a case unless the independence*  
15           *requirements of subparagraph (B) are met*  
16           *with respect to the case.*

17           “(iv) *The entity has provided assur-*  
18           *ances that it will provide information in a*  
19           *timely manner under subparagraph (D).*

20           “(v) *The entity meets such other re-*  
21           *quirements as the Secretary provides by reg-*  
22           *ulation.*

23           “(B) *INDEPENDENCE REQUIREMENTS.—*

24           “(i) *IN GENERAL.—Subject to clause*  
25           *(ii), an entity meets the independence re-*

1            *quirements of this subparagraph with re-*  
2            *spect to any case if the entity—*

3                    *“(I) is not a related party (as de-*  
4                    *fin ed in subsection (g)(7));*

5                    *“(II) does not have a material fa-*  
6                    *m ilial, financial, or professional rela-*  
7                    *tionship with such a party; and*

8                    *“(III) does not otherwise have a*  
9                    *conflict of interest with such a party*  
10                   *(as determined under regulations).*

11                   *“(ii) EXCEPTION FOR REASONABLE*  
12                   *COMPENSATION.—Nothing in clause (i) shall*  
13                   *be construed to prohibit receipt by a quali-*  
14                   *fied external review entity of compensation*  
15                   *from a plan or issuer for the conduct of ex-*  
16                   *ternal review activities under this section if*  
17                   *the compensation is provided consistent*  
18                   *with clause (iii).*

19                   *“(iii) LIMITATIONS ON ENTITY COM-*  
20                   *PENSATION.—Compensation provided by a*  
21                   *plan or issuer to a qualified external review*  
22                   *entity in connection with reviews under this*  
23                   *section shall—*

24                            *“(I) not exceed a reasonable level;*  
25                            *and*

1                   “(II) not be contingent on the de-  
2                   cision rendered by the entity or by any  
3                   independent medical reviewer.

4                   “(C) CERTIFICATION AND RECERTIFICATION  
5                   PROCESS.—

6                   “(i) IN GENERAL.—The initial certifi-  
7                   cation and recertification of a qualified ex-  
8                   ternal review entity shall be made—

9                   “(I) under a process that is recog-  
10                  nized or approved by the Secretary; or

11                  “(II) by a qualified private stand-  
12                  ard-setting organization that is ap-  
13                  proved by the Secretary under clause  
14                  (iii).

15                  “(ii) PROCESS.—The Secretary shall  
16                  not recognize or approve a process under  
17                  clause (i)(I) unless the process applies  
18                  standards (as promulgated in regulations)  
19                  that ensure that a qualified external review  
20                  entity—

21                  “(I) will carry out (and has car-  
22                  ried out, in the case of recertification)  
23                  the responsibilities of such an entity in  
24                  accordance with this section, including  
25                  meeting applicable deadlines;

1           “(II) will meet (and has met, in  
2           the case of recertification) appropriate  
3           indicators of fiscal integrity;

4           “(III) will maintain (and has  
5           maintained, in the case of recertifi-  
6           cation) appropriate confidentiality  
7           with respect to individually identifi-  
8           able health information obtained in the  
9           course of conducting external review  
10          activities; and

11          “(IV) in the case recertification,  
12          shall review the matters described in  
13          clause (iv).

14          “(iii) APPROVAL OF QUALIFIED PRI-  
15          VATE STANDARD-SETTING ORGANIZA-  
16          TIONS.—For purposes of clause (i)(II), the  
17          Secretary may approve a qualified private  
18          standard-setting organization if the Sec-  
19          retary finds that the organization only cer-  
20          tifies (or recertifies) external review entities  
21          that meet at least the standards required for  
22          the certification (or recertification) of exter-  
23          nal review entities under clause (ii).

24          “(iv) CONSIDERATIONS IN RECERTIFI-  
25          CATIONS.—In conducting recertifications of

1           *a qualified external review entity under this*  
2           *paragraph, the Secretary or organization*  
3           *conducting the recertification shall review*  
4           *compliance of the entity with the require-*  
5           *ments for conducting external review activi-*  
6           *ties under this section, including the fol-*  
7           *lowing:*

8                     *“(I) Provision of information*  
9                     *under subparagraph (D).*

10                    *“(II) Adherence to applicable*  
11                    *deadlines (both by the entity and by*  
12                    *independent medical reviewers it refers*  
13                    *cases to).*

14                    *“(III) Compliance with limita-*  
15                    *tions on compensation (with respect to*  
16                    *both the entity and independent med-*  
17                    *ical reviewers it refers cases to).*

18                    *“(IV) Compliance with applicable*  
19                    *independence requirements.*

20                    *“(v) PERIOD OF CERTIFICATION OR RE-*  
21                    *CERTIFICATION.—A certification or recer-*  
22                    *tification provided under this paragraph*  
23                    *shall extend for a period not to exceed 5*  
24                    *years.*

1           “(vi) *REVOCATION.*—A certification or  
2           *recertification under this paragraph may be*  
3           *revoked by the Secretary or by the organiza-*  
4           *tion providing such certification upon a*  
5           *showing of cause.*

6           “(D) *PROVISION OF INFORMATION.*—

7           “(i) *IN GENERAL.*—A qualified exter-  
8           *nal review entity shall provide to the Sec-*  
9           *retary, in such manner and at such times*  
10           *as the Secretary may require, such informa-*  
11           *tion (relating to the denials which have been*  
12           *referred to the entity for the conduct of ex-*  
13           *ternal review under this section) as the Sec-*  
14           *retary determines appropriate to assure*  
15           *compliance with the independence and other*  
16           *requirements of this section to monitor and*  
17           *assess the quality of its external review ac-*  
18           *tivities and lack of bias in making deter-*  
19           *minations. Such information shall include*  
20           *information described in clause (i) but*  
21           *shall not include individually identifiable*  
22           *medical information.*

23           “(ii) *INFORMATION TO BE IN-*  
24           *CLUDED.*—The information described in

1            *this subclause with respect to an entity is as*  
2            *follows:*

3                    *“(I) The number and types of de-*  
4                    *nials for which a request for review has*  
5                    *been received by the entity.*

6                    *“(II) The disposition by the entity*  
7                    *of such denials, including the number*  
8                    *referred to a independent medical re-*  
9                    *viewer and the reasons for such dis-*  
10                   *positions (including the application of*  
11                   *exclusions), on a plan or issuer-specific*  
12                   *basis and on a health care specialty-*  
13                   *specific basis.*

14                   *“(III) The length of time in mak-*  
15                   *ing determinations with respect to such*  
16                   *denials.*

17                   *“(IV) Updated information on the*  
18                   *information required to be submitted*  
19                   *as a condition of certification with re-*  
20                   *spect to the entity’s performance of ex-*  
21                   *ternal review activities.*

22                   *“(iii) INFORMATION TO BE PROVIDED*  
23                   *TO CERTIFYING ORGANIZATION.—*

24                   *“(I) IN GENERAL.—In the case of*  
25                   *a qualified external review entity*

1           *which is certified (or recertified) under*  
2           *this subsection by a qualified private*  
3           *standard-setting organization, at the*  
4           *request of the organization, the entity*  
5           *shall provide the organization with the*  
6           *information provided to the Secretary*  
7           *under clause (i).*

8                   “(II) *ADDITIONAL INFORMA-*  
9                   *TION.—Nothing in this subparagraph*  
10                  *shall be construed as preventing such*  
11                  *an organization from requiring addi-*  
12                  *tional information as a condition of*  
13                  *certification or recertification of an en-*  
14                  *tity.*

15                   “(iv) *USE OF INFORMATION.—Informa-*  
16                  *tion provided under this subparagraph may*  
17                  *be used by the Secretary and qualified pri-*  
18                  *ivate standard-setting organizations to con-*  
19                  *duct oversight of qualified external review*  
20                  *entities, including recertification of such en-*  
21                  *tities, and shall be made available to the*  
22                  *public in an appropriate manner.*

23                   “(E) *LIMITATION ON LIABILITY.—No quali-*  
24                  *fied external review entity having a contract*  
25                  *with a plan or issuer, and no person who is em-*

1           *employed by any such entity or who furnishes pro-*  
2           *fessional services to such entity (including as an*  
3           *independent medical reviewer), shall be held by*  
4           *reason of the performance of any duty, function,*  
5           *or activity required or authorized pursuant to*  
6           *this section, to be civilly liable under any law of*  
7           *the United States or of any State (or political*  
8           *subdivision thereof) if there was no actual malice*  
9           *or gross misconduct in the performance of such*  
10          *duty, function, or activity.*

11          “(i) *DEFINITIONS.—In this section:*

12                 “(1) *AUTHORIZED REPRESENTATIVE.—The term*  
13                 ‘*authorized representative*’ *means, with respect to a*  
14                 *participant or beneficiary—*

15                         “(A) *a person to whom a participant or*  
16                         *beneficiary has given express written consent to*  
17                         *represent the participant or beneficiary in any*  
18                         *proceeding under this section;*

19                         “(B) *a person authorized by law to provide*  
20                         *substituted consent for the participant or bene-*  
21                         *ficiary; or*

22                         “(C) *a family member of the participant or*  
23                         *beneficiary (or the estate of the participant or*  
24                         *beneficiary) or the participant’s or beneficiary’s*

1           *treating health care professional when the partic-*  
2           *ipant or beneficiary is unable to provide consent.*

3           “(2) *CLAIM FOR BENEFITS.*—*The term ‘claim for*  
4           *benefits’ means any request by a participant or bene-*  
5           *ficiary (or authorized representative) for benefits (in-*  
6           *cluding requests that are subject to authorization of*  
7           *coverage or utilization review), for eligibility, or for*  
8           *payment in whole or in part, for an item or service*  
9           *under a group health plan or health insurance cov-*  
10           *erage offered by a health insurance issuer in connec-*  
11           *tion with a group health plan.*

12           “(3) *GROUP HEALTH PLAN.*—*The term ‘group*  
13           *health plan’ shall have the meaning given such term*  
14           *in section 733(a). In applying this paragraph, ex-*  
15           *cepted benefits described in section 733(c) shall not be*  
16           *treated as benefits consisting of medical care.*

17           “(4) *HEALTH INSURANCE COVERAGE.*—*The term*  
18           *‘health insurance coverage’ has the meaning given*  
19           *such term in section 733(b)(1). In applying this*  
20           *paragraph, excepted benefits described in section*  
21           *733(c) shall not be treated as benefits consisting of*  
22           *medical care.*

23           “(5) *HEALTH INSURANCE ISSUER.*—*The term*  
24           *‘health insurance issuer’ has the meaning given such*  
25           *term in section 733(b)(2).*

1           “(6) *PRIOR AUTHORIZATION DETERMINATION.*—

2           *The term ‘prior authorization determination’ means a*  
3           *determination by the group health plan or health in-*  
4           *surance issuer offering health insurance coverage in*  
5           *connection with a group health plan prior to the pro-*  
6           *vision of the items and services as a condition of cov-*  
7           *erage of the items and services under the terms and*  
8           *conditions of the plan or coverage.*

9           “(7) *TREATING HEALTH CARE PROFESSIONAL.*—

10          *The term ‘treating health care professional’ with re-*  
11          *spect to a group health plan, health insurance issuer*  
12          *or provider sponsored organization means a physi-*  
13          *cian (medical doctor or doctor of osteopathy) or other*  
14          *health care practitioner who is acting within the*  
15          *scope of his or her State licensure or certification for*  
16          *the delivery of health care services and who is pri-*  
17          *marily responsible for delivering those services to the*  
18          *participant or beneficiary.*

19          “(8) *UTILIZATION REVIEW.*—*The term ‘utiliza-*  
20          *tion review’ with respect to a group health plan or*  
21          *health insurance coverage means procedures used in*  
22          *the determination of coverage for a participant or*  
23          *beneficiary, such as procedures to evaluate the med-*  
24          *ical necessity, appropriateness, efficacy, quality, or ef-*  
25          *ficacy of health care services, procedures or settings,*

1       and includes prospective review, concurrent review,  
2       second opinions, case management, discharge plan-  
3       ning, or retrospective review.”.

4       **(b) CONFORMING AMENDMENT.**—*The table of contents*  
5 *in section 1 of the Employee Retirement Income Security*  
6 *Act of 1974 is amended by inserting after the item relating*  
7 *to section 503 the following:*

      “Sec. 503A. Claims and internal appeals procedures for group health plans.

      “Sec. 503B. Independent external appeals procedures for group health plans.”.

8       **(c) EFFECTIVE DATE.**—*The amendments made by this*  
9 *section shall apply with respect to plan years beginning on*  
10 *or after 2 years after the date of enactment of this Act. The*  
11 *Secretary shall issue all regulations necessary to carry out*  
12 *the amendments made by this section before the effective*  
13 *date thereof.*

14 **SEC. 2222. ENFORCEMENT.**

15       *Section 502(c) of the Employee Retirement Income Se-*  
16 *curity Act of 1974 (29 U.S.C. 1132(c)) is amended by add-*  
17 *ing at the end the following:*

18       “(8) *The Secretary may assess a civil penalty against*  
19 *any plan of up to \$10,000 for the plan’s failure or refusal*  
20 *to comply with any deadline applicable under section 503B*  
21 *or any determination under such section, except that in any*  
22 *case in which treatment was not commenced by the plan*  
23 *in accordance with the determination of an independent ex-*  
24 *ternal reviewer, the Secretary shall assess a civil penalty*

1 of \$10,000 against the plan and the plan shall pay such  
2 penalty to the participant or beneficiary involved.”.

### 3 **Subtitle D—Remedies**

#### 4 **SEC. 2231. AVAILABILITY OF COURT REMEDIES.**

5 (a) *IN GENERAL.*—Section 502 of the Employee Re-  
6 tirement Income Security Act of 1974 (29 U.S.C. 1132) is  
7 amended by adding at the end the following:

8 “(n) *CAUSE OF ACTION RELATING TO DENIAL OF A*  
9 *CLAIM FOR HEALTH BENEFITS.*—

10 “(1) *IN GENERAL.*—

11 “(A) *FAILURE TO COMPLY WITH EXTERNAL*  
12 *MEDICAL REVIEW.*—*In any case in which—*

13 “(i) *a designated decision-maker de-*  
14 *scribed in paragraph (2) fails to exercise or-*  
15 *inary care in approving coverage pursuant*  
16 *to the written determination of an inde-*  
17 *pendent medical reviewer under section*  
18 *503B(d)(3)(F) that reverses a denial of a*  
19 *claim for benefits; and*

20 “(ii) *the failure described in clause (i)*  
21 *is the proximate cause of substantial harm*  
22 *to, or the wrongful death of, the participant*  
23 *or beneficiary;*

24 *such designated decision-maker shall be liable to*  
25 *the participant or beneficiary (or the estate of*

1           *such participant or beneficiary) for economic*  
2           *and noneconomic damages in connection with*  
3           *such failure and such injury or death (subject to*  
4           *paragraph (4)).*

5           “(B) *WRONGFUL DETERMINATION RESULT-*  
6           *ING IN DELAY IN PROVIDING BENEFITS.—In any*  
7           *case in which—*

8                   “(i) *a designated decision-maker de-*  
9                   *scribed in paragraph (2) acts in bad faith*  
10                   *in making a final determination denying a*  
11                   *claim for benefits under section 503A(b);*

12                   “(ii) *the denial described in clause (i)*  
13                   *is reversed by an independent medical re-*  
14                   *viewer under section 503B(d); and*

15                   “(iii) *the delay attributable to the fail-*  
16                   *ure described in clause (i) is the proximate*  
17                   *cause of substantial harm to, or the wrong-*  
18                   *ful death of, the participant or beneficiary;*  
19           *such designated decision-maker shall be liable to*  
20           *the participant or beneficiary (or the estate of*  
21           *such participant or beneficiary) for economic*  
22           *and noneconomic damages in connection with*  
23           *such failure and such injury or death (subject to*  
24           *paragraph (4)).*

1           “(2) *DESIGNATED DECISION-MAKERS FOR PUR-*  
2           *POSES OF LIABILITY.*—An employer or plan sponsor  
3           shall not be liable under any cause of action described  
4           in paragraph (1) if the employer or plan sponsor  
5           complies with the following provisions:

6                   “(A) *APPOINTMENT.*—A group health plan  
7                   may designate one or more persons to serve as  
8                   the designated decision-maker for purposes of  
9                   paragraph (1). Such designated decision-makers  
10                  shall have the exclusive authority under the  
11                  group health plan (or under the health insurance  
12                  coverage in the case of a health insurance issuer  
13                  offering coverage in connection with a group  
14                  health plan) to make determinations described in  
15                  section 503A with respect to claims for benefits  
16                  and determination to approve coverage pursuant  
17                  to written determination of independent medical  
18                  reviewers under section 503B, except that the  
19                  plan documents may expressly provide that the  
20                  designated decision-maker is subject to the direc-  
21                  tion of a named fiduciary.

22                   “(B) *PROCEDURES.*—A designated decision-  
23                  maker shall—

24                           “(i) be a person who is named in the  
25                           plan or coverage documents, or who, pursu-

1            *ant to procedures specified in the plan or*  
2            *coverage documents, is identified as the des-*  
3            *ignated decision-maker by—*

4                    *“(I) a person who is an employer*  
5                    *or employee organization with respect*  
6                    *to the plan or issuer;*

7                    *“(II) a person who is such an em-*  
8                    *ployer and such an employee organiza-*  
9                    *tion acting jointly; or*

10                   *“(III) a person who is a named*  
11                   *fiduciary;*

12                   *“(ii) agree to accept appointment as a*  
13                   *designated decision-maker; and*

14                   *“(iii) be identified in the plan or cov-*  
15                   *erage documents as required under section*  
16                   *714(b)(14).*

17                   *“(C) QUALIFICATIONS.—To be appointed as*  
18                   *a designated decision-maker under this para-*  
19                   *graph, a person shall be—*

20                    *“(i) a plan sponsor;*

21                    *“(ii) a group health plan;*

22                    *“(iii) a health insurance issuer; or*

23                    *“(iv) any other person who can pro-*  
24                    *vide adequate evidence, in accordance with*

1 regulations promulgated by the Secretary, of  
2 the ability of the person to—

3 “(I) carry out the responsibilities  
4 set forth in the plan or coverage docu-  
5 ments;

6 “(II) carry out the applicable re-  
7 quirements of this subsection; and

8 “(III) meet other applicable re-  
9 quirements under this Act, including  
10 any financial obligation for liability  
11 under this subsection.

12 “(D) FLEXIBILITY IN ADMINISTRATION.—A  
13 group health plan, or health insurance issuer of-  
14 fering coverage in connection with a group  
15 health plan, may provide—

16 “(i) that any person or group of per-  
17 sons may serve in more than one capacity  
18 with respect to the plan or coverage (includ-  
19 ing service as a designated decision-maker,  
20 administrator, and named fiduciary); or

21 “(ii) that a designated decision-maker  
22 may employ one or more persons to provide  
23 advice with respect to any responsibility of  
24 such decision-maker under the plan or cov-  
25 erage.

1           “(E) *FAILURE TO DESIGNATE.*—*In any case*  
2           *in which a designated decision-maker is not ap-*  
3           *pointed under this paragraph, the group health*  
4           *plan (or health insurance issuer offering coverage*  
5           *in connection with the group health plan), the*  
6           *administrator, or the party or parties that bears*  
7           *the sole responsibility for making the final deter-*  
8           *mination under section 503A(b) (with respect to*  
9           *an internal review), or for approving coverage*  
10           *pursuant to the written determination of an*  
11           *independent medical reviewer under section*  
12           *503B, with respect to a denial of a claim for*  
13           *benefits shall be treated as the designated deci-*  
14           *sion-maker for purposes of liability under this*  
15           *section.*

16           “(3) *REQUIREMENT OF EXHAUSTION OF INDE-*  
17           *PENDENT MEDICAL REVIEW.*—*Paragraph (1) shall*  
18           *apply only if a final determination denying a claim*  
19           *for benefits under section 503A(b) has been referred*  
20           *for independent medical review under section 503B(d)*  
21           *and a written determination by an independent med-*  
22           *ical reviewer to reverse such final determination has*  
23           *been issued with respect to such review.*

24           “(4) *LIMITATIONS ON RECOVERY OF DAMAGES.*—

1           “(A) *MAXIMUM AWARD OF NONECONOMIC*  
2           *DAMAGES.—The aggregate amount of liability*  
3           *for noneconomic loss in an action under para-*  
4           *graph (1) may not exceed \$350,000.*

5           “(B) *INCREASE IN AMOUNT.—The amount*  
6           *referred to in subparagraph (A) shall be in-*  
7           *creased or decreased, for each calendar year that*  
8           *ends after December 31, 2001, by the same per-*  
9           *centage as the percentage by which the Consumer*  
10           *Price Index for All Urban Consumers (United*  
11           *States city average), published by the Bureau of*  
12           *Labor Statistics, for September of the preceding*  
13           *calendar year has increased or decreased from*  
14           *the such Index for September of 2001.*

15           “(C) *JOINT AND SEVERAL LIABILITY.—In*  
16           *the case of any action commenced pursuant to*  
17           *paragraph (1), the defendant shall be liable only*  
18           *for the amount of noneconomic damages attrib-*  
19           *utable to such defendant in direct proportion to*  
20           *such defendant’s share of fault or responsibility*  
21           *for the injury suffered by the participant or ben-*  
22           *eficiary. In all such cases, the liability of a de-*  
23           *fendant for noneconomic damages shall be several*  
24           *and not joint.*

1                   “(D) *TREATMENT OF COLLATERAL SOURCE*  
2                   *PAYMENTS.*—

3                   “(i) *IN GENERAL.*—*In the case of any*  
4                   *action commenced pursuant to paragraph*  
5                   *(1), the total amount of damages received by*  
6                   *a participant or beneficiary under such ac-*  
7                   *tion shall be reduced, in accordance with*  
8                   *clause (ii), by any other payment that has*  
9                   *been, or will be, made to such participant*  
10                   *or beneficiary to compensate such partici-*  
11                   *part or beneficiary for the injury that was*  
12                   *the subject of such action.*

13                   “(ii) *AMOUNT OF REDUCTION.*—*The*  
14                   *amount by which an award of damages to*  
15                   *a participant or beneficiary for an injury*  
16                   *shall be reduced under clause (i) shall be—*

17                   “(I) *the total amount of any pay-*  
18                   *ments (other than such award) that*  
19                   *have been made or that will be made to*  
20                   *such participant or beneficiary to pay*  
21                   *costs of or compensate such participant*  
22                   *or beneficiary for the injury that was*  
23                   *the subject of the action; less*

24                   “(II) *the amount paid by such*  
25                   *participant or beneficiary (or by the*

1 spouse, parent, or legal guardian of  
2 such participant or beneficiary) to se-  
3 cure the payments described in sub-  
4 clause (I).

5 “(iii) *DETERMINATION OF AMOUNTS*  
6 *FROM COLLATERAL SOURCES.*—*The reduc-*  
7 *tion required under clause (ii) shall be de-*  
8 *termined by the court in a pretrial pro-*  
9 *ceeding. At the subsequent trial no evidence*  
10 *shall be admitted as to the amount of any*  
11 *charge, payments, or damage for which a*  
12 *participant or beneficiary—*

13 “(I) *has received payment from a*  
14 *collateral source or the obligation for*  
15 *which has been assured by a third*  
16 *party; or*

17 “(II) *is, or with reasonable cer-*  
18 *tainty, will be eligible to receive from*  
19 *a collateral source which will, with*  
20 *reasonable certainty, be assumed by a*  
21 *third party.*

22 “(5) *AFFIRMATIVE DEFENSES.*—*In the case of*  
23 *any cause of action under paragraph (1), it shall be*  
24 *an affirmative defense that—*

1           “(A) the group health plan, or health insur-  
2           ance issuer offering health insurance coverage in  
3           connection with a group health plan, involved  
4           did not receive from the participant or bene-  
5           ficiary (or authorized representative) or the  
6           treating health care professional (if any), suffi-  
7           cient information regarding the medical condi-  
8           tion of the participant or beneficiary that was  
9           necessary to make a final determination on a  
10          claim for benefits under section 503A(b);

11          “(B) the participant or beneficiary (or au-  
12          thorized representative)—

13                 “(i) was in possession of facts that  
14                 were sufficient to enable the participant or  
15                 beneficiary (or authorized representative) to  
16                 know that an expedited review under sec-  
17                 tion 503A or 503B would have prevented  
18                 the harm that is the subject of the action;  
19                 and

20                 “(ii) failed to notify the plan or issuer  
21                 of the need for such an expedited review; or

22          “(C) the cause of action is based solely on  
23          the failure of a qualified external review entity  
24          or an independent medical reviewer to meet the  
25          timelines applicable under section 503B.

1       *Nothing in this paragraph shall be construed to limit*  
2       *the application of any other affirmative defense that*  
3       *may be applicable to the cause of action involved.*

4               “(6) *WAIVER OF INTERNAL REVIEW.—In the case*  
5       *of any cause of action under paragraph (1), the waiv-*  
6       *er or nonwaiver of internal review under section*  
7       *503A(b)(1)(D) by the group health plan, or health in-*  
8       *surance issuer offering health insurance coverage in*  
9       *connection with a group health plan, shall not be used*  
10       *in determining liability.*

11               “(7) *LIMITATIONS ON ACTIONS.—Paragraph (1)*  
12       *shall not apply in connection with any action that is*  
13       *commenced more than 1 year after—*

14                       “(A) *the date on which the last act occurred*  
15                       *which constituted a part of the failure referred to*  
16                       *in such paragraph; or*

17                       “(B) *in the case of an omission, the last*  
18                       *date on which the decision-maker could have*  
19                       *cured the failure.*

20               “(8) *LIMITATION ON RELIEF WHERE DEFEND-*  
21       *ANT’S POSITION PREVIOUSLY SUPPORTED UPON EX-*  
22       *TERNAL REVIEW.—In any case in which the court*  
23       *finds the defendant to be liable in an action under*  
24       *this subsection, to the extent that such liability is*  
25       *based on a finding by the court of a particular failure*

1 *described in paragraph (1) and such finding is con-*  
2 *trary to a previous determination by an independent*  
3 *medical reviewer under section 503B(d) with respect*  
4 *to such defendant, no relief shall be available under*  
5 *this subsection in addition to the relief otherwise*  
6 *available under subsection (a)(1)(B).*

7 “(9) *CONSTRUCTION.*—*Nothing in this subsection*  
8 *shall be construed as authorizing a cause of action*  
9 *under paragraph (1) for—*

10 “(A) *the failure of a group health plan or*  
11 *health insurance issuer to provide an item or*  
12 *service that is specifically excluded under the*  
13 *plan or coverage; or*

14 “(B) *any denial of a claim for benefits that*  
15 *was not eligible for independent medical review*  
16 *under section 503B(d).*

17 “(10) *FEDERAL JURISDICTION.*—*In the case of*  
18 *any action commenced pursuant to paragraph (1) the*  
19 *district courts of the United States shall have exclu-*  
20 *sive jurisdiction.*

21 “(11) *DEFINITIONS.*—*In this subsection:*

22 “(A) *AUTHORIZED REPRESENTATIVE.*—*The*  
23 *term ‘authorized representative’ has the meaning*  
24 *given such term in section 503B(i).*

1           “(B) *CLAIM FOR BENEFITS.*—*The term*  
2           *‘claim for benefits’ shall have the meaning given*  
3           *such term in section 503B(i), except that such*  
4           *term shall only include claims for prior author-*  
5           *ization determinations (as such term is defined*  
6           *in section 503B(i)).*

7           “(C) *GROUP HEALTH PLAN.*—*The term*  
8           *‘group health plan’ shall have the meaning given*  
9           *such term in section 733(a).*

10          “(D) *HEALTH INSURANCE COVERAGE.*—*The*  
11          *term ‘health insurance coverage’ has the meaning*  
12          *given such term in section 733(b)(1).*

13          “(E) *HEALTH INSURANCE ISSUER.*—*The*  
14          *term ‘health insurance issuer’ has the meaning*  
15          *given such term in section 733(b)(2) (including*  
16          *health maintenance organizations as defined in*  
17          *section 733(b)(3)).*

18          “(F) *ORDINARY CARE.*—*The term ‘ordinary*  
19          *care’ means the care, skill, prudence, and dili-*  
20          *gence under the circumstances prevailing at the*  
21          *time the care is provided that a prudent indi-*  
22          *vidual acting in a like capacity and familiar*  
23          *with the care being provided would use in pro-*  
24          *viding care of a similar character.*

1           “(G) *SUBSTANTIAL HARM.*—*The term ‘sub-*  
2           *stantial harm’ means the loss of life, loss or sig-*  
3           *nificant impairment of limb or bodily function,*  
4           *significant disfigurement, or severe and chronic*  
5           *physical pain.*”

6           “(12) *EFFECTIVE DATE.*—*The provisions of this*  
7           *subsection shall apply to acts and omissions occurring*  
8           *on or after the date of enactment of this subsection.”.*

9           (b) *IMMUNITY FROM LIABILITY FOR PROVISION OF IN-*  
10          *SURANCE OPTIONS.*—

11           (1) *IN GENERAL.*—*Section 502 of the Employee*  
12          *Retirement Income Security Act of 1974 (29 U.S.C.*  
13          *1132), as amended by subsection (a), is further*  
14          *amended by adding at the end the following:*

15          “(o) *IMMUNITY FROM LIABILITY FOR PROVISION OF*  
16          *INSURANCE OPTIONS.*—

17           “(1) *IN GENERAL.*—*No liability shall arise under*  
18          *subsection (n) with respect to a participant or bene-*  
19          *ficiary against a group health plan (other than a*  
20          *fully insured group health plan) if such plan offers*  
21          *the participant or beneficiary the coverage option de-*  
22          *scribed in paragraph (2).*”

23           “(2) *COVERAGE OPTION.*—*The coverage option*  
24          *described in this paragraph is one under which the*  
25          *group health plan (other than a fully insured group*

1 health plan), at the time of enrollment or as provided  
2 for in paragraph (3), provides the participant or ben-  
3 eficiary with the option to—

4 “(A) enroll for coverage under a fully in-  
5 sured health plan; or

6 “(B) receive an individual benefit payment,  
7 in an amount equal to the amount that would be  
8 contributed on behalf of the participant or bene-  
9 ficiary by the plan sponsor for enrollment in the  
10 group health plan, for use by the participant or  
11 beneficiary in obtaining health insurance cov-  
12 erage in the individual market.

13 “(3) *TIME OF OFFERING OF OPTION.*—The cov-  
14 erage option described in paragraph (2) shall be of-  
15 fered to a participant or beneficiary—

16 “(A) during the first period in which the  
17 individual is eligible to enroll under the group  
18 health plan; or

19 “(B) during any special enrollment period  
20 provided by the group health plan after the date  
21 of enactment of the Patients’ Bill of Rights Plus  
22 Act for purposes of offering such coverage op-  
23 tion.”.

24 (2) *AMENDMENTS TO INTERNAL REVENUE*  
25 *CODE.*—

1           (A) *EXCLUSION FROM INCOME.*—Section  
2           106 of the Internal Revenue Code of 1986 (relat-  
3           ing to contributions by employer to accident and  
4           health plans) is amended by adding at the end  
5           the following:

6           “(d) *TREATMENT OF CERTAIN COVERAGE OPTION*  
7           *UNDER SELF-INSURED PLANS.*—No amount shall be in-  
8           cluded in the gross income of an individual by reason of—

9           “(1) the individual’s right to elect a coverage op-  
10          tion described in section 502(o)(2) of the Employee  
11          Retirement Income Security Act of 1974, or

12          “(2) the receipt by the individual of an indi-  
13          vidual benefit payment described in section  
14          502(o)(2)(A) of such Act.”

15          (B) *NONDISCRIMINATION RULES.*—Section  
16          105(h) of such Code (relating to self-insured  
17          medical expense reimbursement plans) is amend-  
18          ed by adding at the end the following:

19          “(11) *TREATMENT OF CERTAIN COVERAGE OP-*  
20          *TIONS.*—If a self-insured medical reimbursement plan  
21          offers the coverage option described in section  
22          502(o)(2) of the Employee Retirement Income Secu-  
23          rity Act of 1974, employees who elect such option  
24          shall be treated as eligible to benefit under the plan



1       (c) *EFFECTIVE DATE.*—

2           (1) *IN GENERAL.*—*The amendments made by*  
3 *this section shall apply to all civil actions that are*  
4 *filed on or after the date of enactment of this Act.*

5           (2) *PENDING CIVIL ACTIONS.*—*Notwithstanding*  
6 *section 502(p) of the Employee Retirement Income*  
7 *Security Act of 1974 and section 1964(c)(2) of title*  
8 *18, United States Code, such sections 502(p) and*  
9 *1964(c)(2) shall apply to civil actions that are pend-*  
10 *ing and have not been finally determined by judg-*  
11 *ment or settlement prior to the date of enactment of*  
12 *this Act if such actions are substantially similar in*  
13 *nature to the claims or causes of actions referred to*  
14 *in such sections 502(p) and 1964(c)(2).*

15 **SEC. 2233. SEVERABILITY.**

16       *If any provision of this subtitle, an amendment made*  
17 *by this subtitle, or the application of such provision or*  
18 *amendment to any person or circumstance is held to be un-*  
19 *constitutional, the remainder of this subtitle, the amend-*  
20 *ments made by this subtitle, and the application of the pro-*  
21 *visions of such to any person or circumstance shall not be*  
22 *affected thereby.*

1     **TITLE XXIII—WOMEN’S HEALTH**  
2                     **AND CANCER RIGHTS**

3     **SEC. 2301. WOMEN’S HEALTH AND CANCER RIGHTS.**

4             (a) *SHORT TITLE.*—*This section may be cited as the*  
5     *“Women’s Health and Cancer Rights Act of 2000”.*

6             (b) *FINDINGS.*—*Congress finds that—*

7                 (1) *the offering and operation of health plans af-*  
8     *fect commerce among the States;*

9                 (2) *health care providers located in a State serve*  
10     *patients who reside in the State and patients who re-*  
11     *side in other States; and*

12                 (3) *in order to provide for uniform treatment of*  
13     *health care providers and patients among the States,*  
14     *it is necessary to cover health plans operating in 1*  
15     *State as well as health plans operating among the*  
16     *several States.*

17             (c) *AMENDMENTS TO ERISA.*—

18                 (1) *IN GENERAL.*—*Subpart B of part 7 of sub-*  
19     *title B of title I of the Employee Retirement Income*  
20     *Security Act of 1974, as amended by section 2211(a),*  
21     *is further amended by adding at the end the fol-*  
22     *lowing:*

1 **“SEC. 715. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**  
2 **STAY FOR MASTECTOMIES AND LYMPH NODE**  
3 **DISSECTIONS FOR THE TREATMENT OF**  
4 **BREAST CANCER AND COVERAGE FOR SEC-**  
5 **ONDARY CONSULTATIONS.**

6 *“(a) INPATIENT CARE.—*

7 *“(1) IN GENERAL.—A group health plan, and a*  
8 *health insurance issuer providing health insurance*  
9 *coverage in connection with a group health plan, that*  
10 *provides medical and surgical benefits shall ensure*  
11 *that inpatient coverage with respect to the treatment*  
12 *of breast cancer is provided for a period of time as*  
13 *is determined by the attending physician, in consulta-*  
14 *tion with the patient, to be medically necessary and*  
15 *appropriate following—*

16 *“(A) a mastectomy;*

17 *“(B) a lumpectomy; or*

18 *“(C) a lymph node dissection for the treat-*  
19 *ment of breast cancer.*

20 *“(2) EXCEPTION.—Nothing in this section shall*  
21 *be construed as requiring the provision of inpatient*  
22 *coverage if the attending physician and patient deter-*  
23 *mine that a shorter period of hospital stay is medi-*  
24 *cally appropriate.*

25 *“(b) PROHIBITION ON CERTAIN MODIFICATIONS.—In*  
26 *implementing the requirements of this section, a group*

1 *health plan, and a health insurance issuer providing health*  
2 *insurance coverage in connection with a group health plan,*  
3 *may not modify the terms and conditions of coverage based*  
4 *on the determination by a participant or beneficiary to re-*  
5 *quest less than the minimum coverage required under sub-*  
6 *section (a).*

7       “(c) *NOTICE.—A group health plan, and a health in-*  
8 *surance issuer providing health insurance coverage in con-*  
9 *nection with a group health plan shall provide notice to*  
10 *each participant and beneficiary under such plan regarding*  
11 *the coverage required by this section in accordance with reg-*  
12 *ulations promulgated by the Secretary. Such notice shall*  
13 *be in writing and prominently positioned in any literature*  
14 *or correspondence made available or distributed by the plan*  
15 *or issuer and shall be transmitted—*

16               “(1) *in the next mailing made by the plan or*  
17 *issuer to the participant or beneficiary;*

18               “(2) *as part of any yearly informational packet*  
19 *sent to the participant or beneficiary; or*

20               “(3) *not later than January 1, 2001;*  
21 *whichever is earlier.*

22       “(d) *SECONDARY CONSULTATIONS.—*

23               “(1) *IN GENERAL.—A group health plan, and a*  
24 *health insurance issuer providing health insurance*  
25 *coverage in connection with a group health plan, that*

1        *provides coverage with respect to medical and sur-*  
2        *gical services provided in relation to the diagnosis*  
3        *and treatment of cancer shall ensure that full coverage*  
4        *is provided for secondary consultations by specialists*  
5        *in the appropriate medical fields (including pathol-*  
6        *ogy, radiology, and oncology) to confirm or refute*  
7        *such diagnosis. Such plan or issuer shall ensure that*  
8        *full coverage is provided for such secondary consulta-*  
9        *tion whether such consultation is based on a positive*  
10       *or negative initial diagnosis. In any case in which*  
11       *the attending physician certifies in writing that serv-*  
12       *ices necessary for such a secondary consultation are*  
13       *not sufficiently available from specialists operating*  
14       *under the plan with respect to whose services coverage*  
15       *is otherwise provided under such plan or by such*  
16       *issuer, such plan or issuer shall ensure that coverage*  
17       *is provided with respect to the services necessary for*  
18       *the secondary consultation with any other specialist*  
19       *selected by the attending physician for such purpose*  
20       *at no additional cost to the individual beyond that*  
21       *which the individual would have paid if the specialist*  
22       *was participating in the network of the plan.*

23                *“(2) EXCEPTION.—Nothing in paragraph (1)*  
24        *shall be construed as requiring the provision of sec-*

1        *ondary consultations where the patient determines not*  
2        *to seek such a consultation.*

3        “(e) *PROHIBITION ON PENALTIES OR INCENTIVES.—*  
4 *A group health plan, and a health insurance issuer pro-*  
5 *viding health insurance coverage in connection with a*  
6 *group health plan, may not—*

7                *“(1) penalize or otherwise reduce or limit the re-*  
8                *imbursement of a provider or specialist because the*  
9                *provider or specialist provided care to a participant*  
10               *or beneficiary in accordance with this section;*

11               *“(2) provide financial or other incentives to a*  
12               *physician or specialist to induce the physician or spe-*  
13               *cialist to keep the length of inpatient stays of patients*  
14               *following a mastectomy, lumpectomy, or a lymph*  
15               *node dissection for the treatment of breast cancer*  
16               *below certain limits or to limit referrals for secondary*  
17               *consultations; or*

18               *“(3) provide financial or other incentives to a*  
19               *physician or specialist to induce the physician or spe-*  
20               *cialist to refrain from referring a participant or bene-*  
21               *ficiary for a secondary consultation that would other-*  
22               *wise be covered by the plan or coverage involved*  
23               *under subsection (d).”.*

24               (2) *CLERICAL AMENDMENT.—The table of con-*  
25               *tents in section 1 of the Employee Retirement Income*

1       *Security Act of 1974 is amended by inserting after*  
 2       *the item relating to section 714 the following new*  
 3       *item:*

      “*Sec. 715. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.*”.

4       (d) *AMENDMENTS TO PHSA RELATING TO THE*  
 5       *GROUP MARKET.—Subpart 2 of part A of title XXVII of*  
 6       *the Public Health Service Act (42 U.S.C. 300gg–4 et seq.)*  
 7       *is amended by adding at the end the following new section:*

8       “**SEC. 2707. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**  
 9                   **STAY FOR MASTECTOMIES AND LYMPH NODE**  
 10                   **DISSECTIONS FOR THE TREATMENT OF**  
 11                   **BREAST CANCER AND COVERAGE FOR SEC-**  
 12                   **ONDARY CONSULTATIONS.**

13       “(a) *INPATIENT CARE.—*

14               “(1) *IN GENERAL.—A group health plan, and a*  
 15       *health insurance issuer providing health insurance*  
 16       *coverage in connection with a group health plan, that*  
 17       *provides medical and surgical benefits shall ensure*  
 18       *that inpatient coverage with respect to the treatment*  
 19       *of breast cancer is provided for a period of time as*  
 20       *is determined by the attending physician, in consulta-*  
 21       *tion with the patient, to be medically necessary and*  
 22       *appropriate following—*

23                   “(A) *a mastectomy;*

24                   “(B) *a lumpectomy; or*

1                   “(C) a lymph node dissection for the treat-  
2                   ment of breast cancer.

3                   “(2) *EXCEPTION.*—Nothing in this section shall  
4                   be construed as requiring the provision of inpatient  
5                   coverage if the attending physician and patient deter-  
6                   mine that a shorter period of hospital stay is medi-  
7                   cally appropriate.

8                   “(b) *PROHIBITION ON CERTAIN MODIFICATIONS.*—In  
9                   implementing the requirements of this section, a group  
10                  health plan, and a health insurance issuer providing health  
11                  insurance coverage in connection with a group health plan,  
12                  may not modify the terms and conditions of coverage based  
13                  on the determination by a participant or beneficiary to re-  
14                  quest less than the minimum coverage required under sub-  
15                  section (a).

16                  “(c) *NOTICE.*—A group health plan, and a health in-  
17                  surance issuer providing health insurance coverage in con-  
18                  nection with a group health plan shall provide notice to  
19                  each participant and beneficiary under such plan regarding  
20                  the coverage required by this section in accordance with reg-  
21                  ulations promulgated by the Secretary. Such notice shall  
22                  be in writing and prominently positioned in any literature  
23                  or correspondence made available or distributed by the plan  
24                  or issuer and shall be transmitted—

1           “(1) in the next mailing made by the plan or  
2 issuer to the participant or beneficiary;

3           “(2) as part of any yearly informational packet  
4 sent to the participant or beneficiary; or

5           “(3) not later than January 1, 2001;

6 whichever is earlier.

7           “(d) *SECONDARY CONSULTATIONS.*—

8           “(1) *IN GENERAL.*—A group health plan, and a  
9 health insurance issuer providing health insurance  
10 coverage in connection with a group health plan that  
11 provides coverage with respect to medical and sur-  
12 gical services provided in relation to the diagnosis  
13 and treatment of cancer shall ensure that full coverage  
14 is provided for secondary consultations by specialists  
15 in the appropriate medical fields (including pathol-  
16 ogy, radiology, and oncology) to confirm or refute  
17 such diagnosis. Such plan or issuer shall ensure that  
18 full coverage is provided for such secondary consulta-  
19 tion whether such consultation is based on a positive  
20 or negative initial diagnosis. In any case in which  
21 the attending physician certifies in writing that serv-  
22 ices necessary for such a secondary consultation are  
23 not sufficiently available from specialists operating  
24 under the plan with respect to whose services coverage  
25 is otherwise provided under such plan or by such

1        *issuer, such plan or issuer shall ensure that coverage*  
2        *is provided with respect to the services necessary for*  
3        *the secondary consultation with any other specialist*  
4        *selected by the attending physician for such purpose*  
5        *at no additional cost to the individual beyond that*  
6        *which the individual would have paid if the specialist*  
7        *was participating in the network of the plan.*

8            *“(2) EXCEPTION.—Nothing in paragraph (1)*  
9        *shall be construed as requiring the provision of sec-*  
10       *ondary consultations where the patient determines not*  
11       *to seek such a consultation.*

12          *“(e) PROHIBITION ON PENALTIES OR INCENTIVES.—*  
13 *A group health plan, and a health insurance issuer pro-*  
14 *viding health insurance coverage in connection with a*  
15 *group health plan, may not—*

16            *“(1) penalize or otherwise reduce or limit the re-*  
17        *imbursement of a provider or specialist because the*  
18        *provider or specialist provided care to a participant*  
19        *or beneficiary in accordance with this section;*

20            *“(2) provide financial or other incentives to a*  
21        *physician or specialist to induce the physician or spe-*  
22        *cialist to keep the length of inpatient stays of patients*  
23        *following a mastectomy, lumpectomy, or a lymph*  
24        *node dissection for the treatment of breast cancer*

1       *below certain limits or to limit referrals for secondary*  
 2       *consultations; or*

3               “(3) *provide financial or other incentives to a*  
 4       *physician or specialist to induce the physician or spe-*  
 5       *cialist to refrain from referring a participant or bene-*  
 6       *ficiary for a secondary consultation that would other-*  
 7       *wise be covered by the plan or coverage involved*  
 8       *under subsection (d).”.*

9       (e) *AMENDMENTS TO PHSA RELATING TO THE INDI-*  
 10       *VIDUAL MARKET.—The first subpart 3 of part B of title*  
 11       *XXVII of the Public Health Service Act (42 U.S.C. 300gg–*  
 12       *51 et seq.) (relating to other requirements) (42 U.S.C.*  
 13       *300gg–51 et seq.) is amended—*

14               (1) *by redesignating such subpart as subpart 2;*  
 15       *and*

16               (2) *by adding at the end the following:*

17       **“SEC. 2753. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**  
 18               **STAY FOR MASTECTOMIES AND LYMPH NODE**  
 19               **DISSECTIONS FOR THE TREATMENT OF**  
 20               **BREAST CANCER AND SECONDARY CON-**  
 21               **SULTATIONS.**

22               *“The provisions of section 2707 shall apply to health*  
 23       *insurance coverage offered by a health insurance issuer in*  
 24       *the individual market in the same manner as they apply*  
 25       *to health insurance coverage offered by a health insurance*

1 issuer in connection with a group health plan in the small  
2 or large group market.”.

3 (f) *AMENDMENTS TO THE IRC.*—

4 (1) *IN GENERAL.*—Subchapter B of chapter 100  
5 of the Internal Revenue Code of 1986, as amended by  
6 section 2202, is further amended by inserting after  
7 section 9813 the following:

8 **“SEC. 9814. REQUIRED COVERAGE FOR MINIMUM HOSPITAL**  
9 **STAY FOR MASTECTOMIES AND LYMPH NODE**  
10 **DISSECTIONS FOR THE TREATMENT OF**  
11 **BREAST CANCER AND COVERAGE FOR SEC-**  
12 **ONDARY CONSULTATIONS.**

13 “(a) *INPATIENT CARE.*—

14 “(1) *IN GENERAL.*—A group health plan that  
15 provides medical and surgical benefits shall ensure  
16 that inpatient coverage with respect to the treatment  
17 of breast cancer is provided for a period of time as  
18 is determined by the attending physician, in consulta-  
19 tion with the patient, to be medically necessary and  
20 appropriate following—

21 “(A) a mastectomy;

22 “(B) a lumpectomy; or

23 “(C) a lymph node dissection for the treat-  
24 ment of breast cancer.

1           “(2) *EXCEPTION.*—*Nothing in this section shall*  
2           *be construed as requiring the provision of inpatient*  
3           *coverage if the attending physician and patient deter-*  
4           *mine that a shorter period of hospital stay is medi-*  
5           *cally appropriate.*

6           “(b) *PROHIBITION ON CERTAIN MODIFICATIONS.*—*In*  
7           *implementing the requirements of this section, a group*  
8           *health plan may not modify the terms and conditions of*  
9           *coverage based on the determination by a participant or*  
10          *beneficiary to request less than the minimum coverage re-*  
11          *quired under subsection (a).*

12          “(c) *NOTICE.*—*A group health plan shall provide no-*  
13          *tice to each participant and beneficiary under such plan*  
14          *regarding the coverage required by this section in accord-*  
15          *ance with regulations promulgated by the Secretary. Such*  
16          *notice shall be in writing and prominently positioned in*  
17          *any literature or correspondence made available or distrib-*  
18          *uted by the plan and shall be transmitted—*

19                 *“(1) in the next mailing made by the plan to the*  
20                 *participant or beneficiary;*

21                 *“(2) as part of any yearly informational packet*  
22                 *sent to the participant or beneficiary; or*

23                 *“(3) not later than January 1, 2000;*  
24                 *whichever is earlier.*

25          “(d) *SECONDARY CONSULTATIONS.*—

1           “(1) *IN GENERAL.*—A group health plan that  
2           provides coverage with respect to medical and sur-  
3           gical services provided in relation to the diagnosis  
4           and treatment of cancer shall ensure that full coverage  
5           is provided for secondary consultations by specialists  
6           in the appropriate medical fields (including pathol-  
7           ogy, radiology, and oncology) to confirm or refute  
8           such diagnosis. Such plan or issuer shall ensure that  
9           full coverage is provided for such secondary consulta-  
10          tion whether such consultation is based on a positive  
11          or negative initial diagnosis. In any case in which  
12          the attending physician certifies in writing that serv-  
13          ices necessary for such a secondary consultation are  
14          not sufficiently available from specialists operating  
15          under the plan with respect to whose services coverage  
16          is otherwise provided under such plan or by such  
17          issuer, such plan or issuer shall ensure that coverage  
18          is provided with respect to the services necessary for  
19          the secondary consultation with any other specialist  
20          selected by the attending physician for such purpose  
21          at no additional cost to the individual beyond that  
22          which the individual would have paid if the specialist  
23          was participating in the network of the plan.

24           “(2) *EXCEPTION.*—Nothing in paragraph (1)  
25          shall be construed as requiring the provision of sec-

1        *ondary consultations where the patient determines not*  
2        *to seek such a consultation.*

3        “(e) *PROHIBITION ON PENALTIES.—A group health*  
4        *plan may not—*

5                “(1) *penalize or otherwise reduce or limit the re-*  
6                *imbursement of a provider or specialist because the*  
7                *provider or specialist provided care to a participant*  
8                *or beneficiary in accordance with this section;*

9                “(2) *provide financial or other incentives to a*  
10               *physician or specialist to induce the physician or spe-*  
11               *cialist to keep the length of inpatient stays of patients*  
12               *following a mastectomy, lumpectomy, or a lymph*  
13               *node dissection for the treatment of breast cancer*  
14               *below certain limits or to limit referrals for secondary*  
15               *consultations; or*

16               “(3) *provide financial or other incentives to a*  
17               *physician or specialist to induce the physician or spe-*  
18               *cialist to refrain from referring a participant or bene-*  
19               *ficiary for a secondary consultation that would other-*  
20               *wise be covered by the plan involved under subsection*  
21               *(d).”.*

22               (2) *CLERICAL AMENDMENT.—The table of con-*  
23               *tents for chapter 100 of such Code is amended by in-*  
24               *serting after the item relating to section 9813 the fol-*  
25               *lowing new item:*

*“Sec. 9814. Required coverage for minimum hospital stay for mastectomies and lymph node dissections for the treatment of breast cancer and coverage for secondary consultations.”.*

1                   **TITLE XXIV—GENETIC**  
 2                   **INFORMATION AND SERVICES**

3   **SEC. 2401. SHORT TITLE.**

4           *This title may be cited as the “Genetic Information*  
 5 *Nondiscrimination in Health Insurance Act of 2000”.*

6   **SEC. 2402. AMENDMENTS TO EMPLOYEE RETIREMENT IN-**  
 7                   **COME SECURITY ACT OF 1974.**

8           *(a) PROHIBITION OF HEALTH DISCRIMINATION ON*  
 9 *THE BASIS OF GENETIC INFORMATION OR GENETIC SERV-*  
 10 *ICES.—*

11                   *(1) NO ENROLLMENT RESTRICTION FOR GENETIC*  
 12 *SERVICES.—Section 702(a)(1)(F) of the Employee Re-*  
 13 *retirement Income Security Act of 1974 (29 U.S.C.*  
 14 *1182(a)(1)(F)) is amended by inserting before the pe-*  
 15 *riod the following: “(including information about a*  
 16 *request for or receipt of genetic services)”.*

17                   *(2) NO DISCRIMINATION IN GROUP PREMIUMS*  
 18 *BASED ON PREDICTIVE GENETIC INFORMATION.—Sub-*  
 19 *part B of part 7 of subtitle B of title I of the Em-*  
 20 *ployee Retirement Income Security Act of 1974, as*  
 21 *amended by section 2301(c), is further amended by*  
 22 *adding at the end the following:*

1 **“SEC. 716. PROHIBITING PREMIUM DISCRIMINATION**  
2 **AGAINST GROUPS ON THE BASIS OF PRE-**  
3 **DICTIVE GENETIC INFORMATION.**

4 *“A group health plan, or a health insurance issuer of-*  
5 *fering group health insurance coverage in connection with*  
6 *a group health plan, shall not adjust premium or contribu-*  
7 *tion amounts for a group on the basis of predictive genetic*  
8 *information concerning any individual (including a de-*  
9 *pendent) or family member of the individual (including in-*  
10 *formation about a request for or receipt of genetic serv-*  
11 *ices).”.*

12 (3) *CONFORMING AMENDMENTS.—*

13 (A) *IN GENERAL.—Section 702(b) of the*  
14 *Employee Retirement Income Security Act of*  
15 *1974 (29 U.S.C. 1182(b)) is amended by adding*  
16 *at the end the following:*

17 *“(3) REFERENCE TO RELATED PROVISION.—For*  
18 *a provision prohibiting the adjustment of premium or*  
19 *contribution amounts for a group under a group*  
20 *health plan on the basis of predictive genetic informa-*  
21 *tion (including information about a request for or re-*  
22 *ceipt of genetic services), see section 716.”.*

23 (B) *TABLE OF CONTENTS.—The table of*  
24 *contents in section 1 of the Employee Retirement*  
25 *Income Security Act of 1974, as amended by sec-*  
26 *tion 2301, is further amended by inserting after*

1           *the item relating to section 715 the following new*  
2           *item:*

          “Sec. 716. *Prohibiting premium discrimination against groups on the basis of predictive genetic information.*”.

3           **(b) LIMITATION ON COLLECTION OF PREDICTIVE GE-**  
4 **NETIC INFORMATION.**—*Section 702 of the Employee Retire-*  
5 *ment Income Security Act of 1974 (29 U.S.C. 1182) is*  
6 *amended by adding at the end the following:*

7           **“(c) COLLECTION OF PREDICTIVE GENETIC INFORMA-**  
8 **TION.**—

9                   **“(1) LIMITATION ON REQUESTING OR REQUIRING**  
10 **PREDICTIVE GENETIC INFORMATION.**—*Except as pro-*  
11 *vided in paragraph (2), a group health plan, or a*  
12 *health insurance issuer offering health insurance cov-*  
13 *erage in connection with a group health plan, shall*  
14 *not request or require predictive genetic information*  
15 *concerning any individual (including a dependent) or*  
16 *family member of the individual (including informa-*  
17 *tion about a request for or receipt of genetic services).*

18                   **“(2) INFORMATION NEEDED FOR DIAGNOSIS,**  
19 **TREATMENT, OR PAYMENT.**—

20                           **“(A) IN GENERAL.**—*Notwithstanding para-*  
21 *graph (1), a group health plan, or a health in-*  
22 *surance issuer offering health insurance coverage*  
23 *in connection with a group health plan, that*  
24 *provides health care items and services to an in-*

1           *dividual or dependent may request (but may not*  
2           *require) that such individual or dependent dis-*  
3           *close, or authorize the collection or disclosure of,*  
4           *predictive genetic information for purposes of di-*  
5           *agnosis, treatment, or payment relating to the*  
6           *provision of health care items and services to*  
7           *such individual or dependent.*

8           “(B) NOTICE OF CONFIDENTIALITY PRAC-  
9           TICES AND DESCRIPTION OF SAFEGUARDS.—As a  
10          part of a request under subparagraph (A), the  
11          group health plan, or a health insurance issuer  
12          offering health insurance coverage in connection  
13          with a group health plan, shall provide to the in-  
14          dividual or dependent a description of the proce-  
15          dures in place to safeguard the confidentiality,  
16          as described in subsection (d), of such predictive  
17          genetic information.

18          “(d) CONFIDENTIALITY WITH RESPECT TO PRE-  
19          DICTIVE GENETIC INFORMATION.—

20                 “(1) NOTICE OF CONFIDENTIALITY PRACTICES.—

21                         “(A) PREPARATION OF WRITTEN NOTICE.—

22                         A group health plan, or a health insurance  
23                         issuer offering health insurance coverage in con-  
24                         nection with a group health plan, shall post or  
25                         provide, in writing and in a clear and con-

1           *spicuous manner, notice of the plan or issuer's*  
2           *confidentiality practices, that shall include—*

3                   “(i) *a description of an individual's*  
4                   *rights with respect to predictive genetic in-*  
5                   *formation;*

6                   “(ii) *the procedures established by the*  
7                   *plan or issuer for the exercise of the individ-*  
8                   *ual's rights; and*

9                   “(iii) *the right to obtain a copy of the*  
10                  *notice of the confidentiality practices re-*  
11                  *quired under this subsection.*

12                  “(B) *MODEL NOTICE.—The Secretary, in*  
13                  *consultation with the National Committee on*  
14                  *Vital and Health Statistics and the National As-*  
15                  *sociation of Insurance Commissioners, and after*  
16                  *notice and opportunity for public comment, shall*  
17                  *develop and disseminate model notices of con-*  
18                  *fidentiality practices. Use of the model notice*  
19                  *shall serve as a defense against claims of receiv-*  
20                  *ing inappropriate notice.*

21                  “(2) *ESTABLISHMENT OF SAFEGUARDS.—A*  
22                  *group health plan, or a health insurance issuer offer-*  
23                  *ing health insurance coverage in connection with a*  
24                  *group health plan, shall establish and maintain ap-*  
25                  *propriate administrative, technical, and physical*

1       *safeguards to protect the confidentiality, security, ac-*  
2       *curacy, and integrity of predictive genetic informa-*  
3       *tion created, received, obtained, maintained, used,*  
4       *transmitted, or disposed of by such plan or issuer.”.*

5       (c) *DEFINITIONS.*—*Section 733(d) of the Employee Re-*  
6       *tirement Income Security Act of 1974 (29 U.S.C. 1191b(d))*  
7       *is amended by adding at the end the following:*

8               “(5) *FAMILY MEMBER.*—*The term ‘family mem-*  
9       *ber’ means with respect to an individual—*

10                       “(A) *the spouse of the individual;*

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

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

17               “(6) *GENETIC INFORMATION.*—*The term ‘genetic*  
18       *information’ means information about genes, gene*  
19       *products, or inherited characteristics that may derive*  
20       *from an individual or a family member (including*  
21       *information about a request for or receipt of genetic*  
22       *services).*

23               “(7) *GENETIC SERVICES.*—*The term ‘genetic*  
24       *services’ means health services provided to obtain, as-*  
25       *sess, or interpret genetic information for diagnostic*

1 *and therapeutic purposes, and for genetic education*  
2 *and counseling.*

3 “(8) *PREDICTIVE GENETIC INFORMATION.*—

4 “(A) *IN GENERAL.*—*The term ‘predictive ge-*  
5 *netic information’ means, in the absence of*  
6 *symptoms, clinical signs, or a diagnosis of the*  
7 *condition related to such information—*

8 “(i) *information about an individual’s*  
9 *genetic tests;*

10 “(ii) *information about genetic tests of*  
11 *family members of the individual; or*

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

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

16 “(i) *information about the sex or age of*  
17 *the individual;*

18 “(ii) *information derived from phys-*  
19 *ical tests, such as the chemical, blood, or*  
20 *urine analyses of the individual including*  
21 *cholesterol tests; and*

22 “(iii) *information about physical*  
23 *exams of the individual.*

24 “(9) *GENETIC TEST.*—*The term ‘genetic test’*  
25 *means the analysis of human DNA, RNA, chro-*

1        *mosomes, proteins, and certain metabolites, including*  
2        *analysis of genotypes, mutations, phenotypes, or*  
3        *karyotypes, for the purpose of predicting risk of dis-*  
4        *ease in asymptomatic or undiagnosed individuals.*  
5        *Such term does not include physical tests, such as the*  
6        *chemical, blood, or urine analyses of the individual*  
7        *including cholesterol tests, and physical exams of the*  
8        *individual, in order to detect symptoms, clinical*  
9        *signs, or a diagnosis of disease.”.*

10        *(d) EFFECTIVE DATE.—Except as provided in this sec-*  
11        *tion, this section and the amendments made by this section*  
12        *shall apply with respect to group health plans for plan*  
13        *years beginning 1 year after the date of the enactment of*  
14        *this Act.*

15        **SEC. 2403. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**

16                                **ACT.**

17        *(a) AMENDMENTS RELATING TO THE GROUP MAR-*  
18        *KET.—*

19                                *(1) PROHIBITION OF HEALTH DISCRIMINATION*  
20        *ON THE BASIS OF GENETIC INFORMATION IN THE*  
21        *GROUP MARKET.—*

22                                *(A) NO ENROLLMENT RESTRICTION FOR GE-*  
23        *NETIC SERVICES.—Section 2702(a)(1)(F) of the*  
24        *Public Health Service Act (42 U.S.C. 300gg-*  
25        *1(a)(1)(F)) is amended by inserting before the*

1           *period the following: “(including information*  
2           *about a request for or receipt of genetic serv-*  
3           *ices)”.*

4           (B) *NO DISCRIMINATION IN PREMIUMS*  
5           *BASED ON PREDICTIVE GENETIC INFORMATION.—*  
6           *Subpart 2 of part A of title XXVII of the Public*  
7           *Health Service Act (42 U.S.C. 300gg–4 et seq.),*  
8           *as amended by section 2301(d), is amended by*  
9           *adding at the end the following new section:*

10       **“SEC. 2708. PROHIBITING PREMIUM DISCRIMINATION**  
11                       **AGAINST GROUPS ON THE BASIS OF PRE-**  
12                       **DICTIVE GENETIC INFORMATION IN THE**  
13                       **GROUP MARKET.**

14           *“A group health plan, or a health insurance issuer of-*  
15           *fering group health insurance coverage in connection with*  
16           *a group health plan shall not adjust premium or contribu-*  
17           *tion amounts for a group on the basis of predictive genetic*  
18           *information concerning any individual (including a de-*  
19           *pendent) or family member of the individual (including in-*  
20           *formation about a request for or receipt of genetic serv-*  
21           *ices).”.*

22           (C) *CONFORMING AMENDMENT.—Section*  
23           *2702(b) of the Public Health Service Act (42*  
24           *U.S.C. 300gg–1(b)) is amended by adding at the*  
25           *end the following:*

1           “(3) *REFERENCE TO RELATED PROVISION.*—*For*  
2           *a provision prohibiting the adjustment of premium or*  
3           *contribution amounts for a group under a group*  
4           *health plan on the basis of predictive genetic informa-*  
5           *tion (including information about a request for or re-*  
6           *ceipt of genetic services), see section 2708.”.*

7                         *(D) LIMITATION ON COLLECTION AND DIS-*  
8                         *CLOSURE OF PREDICTIVE GENETIC INFORMA-*  
9                         *TION.*—*Section 2702 of the Public Health Service*  
10                        *Act (42 U.S.C. 300gg–1) is amended by adding*  
11                        *at the end the following:*

12           “(c) *COLLECTION OF PREDICTIVE GENETIC INFORMA-*  
13           *TION.*—

14                        “(1) *LIMITATION ON REQUESTING OR REQUIRING*  
15                        *PREDICTIVE GENETIC INFORMATION.*—*Except as pro-*  
16                        *vided in paragraph (2), a group health plan, or a*  
17                        *health insurance issuer offering health insurance cov-*  
18                        *erage in connection with a group health plan, shall*  
19                        *not request or require predictive genetic information*  
20                        *concerning any individual (including a dependent) or*  
21                        *a family member of the individual (including infor-*  
22                        *mation about a request for or receipt of genetic serv-*  
23                        *ices).*

24                        “(2) *INFORMATION NEEDED FOR DIAGNOSIS,*  
25                        *TREATMENT, OR PAYMENT.*—

1           “(A) *IN GENERAL.*—Notwithstanding para-  
2           graph (1), a group health plan, or a health in-  
3           surance issuer offering health insurance coverage  
4           in connection with a group health plan, that  
5           provides health care items and services to an in-  
6           dividual or dependent may request (but may not  
7           require) that such individual or dependent dis-  
8           close, or authorize the collection or disclosure of,  
9           predictive genetic information for purposes of di-  
10          agnosis, treatment, or payment relating to the  
11          provision of health care items and services to  
12          such individual or dependent.

13           “(B) *NOTICE OF CONFIDENTIALITY PRAC-*  
14          *TICES AND DESCRIPTION OF SAFEGUARDS.*—As a  
15          part of a request under subparagraph (A), the  
16          group health plan, or a health insurance issuer  
17          offering health insurance coverage in connection  
18          with a group health plan, shall provide to the in-  
19          dividual or dependent a description of the proce-  
20          dures in place to safeguard the confidentiality,  
21          as described in subsection (d), of such predictive  
22          genetic information.

23           “(d) *CONFIDENTIALITY WITH RESPECT TO PRE-*  
24          *DICTIVE GENETIC INFORMATION.*—

25           “(1) *NOTICE OF CONFIDENTIALITY PRACTICES.*—

1           “(A) *PREPARATION OF WRITTEN NOTICE.*—  
2           *A group health plan, or a health insurance*  
3           *issuer offering health insurance coverage in con-*  
4           *nection with a group health plan, shall post or*  
5           *provide, in writing and in a clear and con-*  
6           *spicuous manner, notice of the plan or issuer’s*  
7           *confidentiality practices, that shall include—*

8                     “(i) *a description of an individual’s*  
9                     *rights with respect to predictive genetic in-*  
10                    *formation;*

11                   “(ii) *the procedures established by the*  
12                    *plan or issuer for the exercise of the individ-*  
13                    *ual’s rights; and*

14                   “(iii) *the right to obtain a copy of the*  
15                    *notice of the confidentiality practices re-*  
16                    *quired under this subsection.*

17           “(B) *MODEL NOTICE.*—*The Secretary, in*  
18           *consultation with the National Committee on*  
19           *Vital and Health Statistics and the National As-*  
20           *sociation of Insurance Commissioners, and after*  
21           *notice and opportunity for public comment, shall*  
22           *develop and disseminate model notices of con-*  
23           *fidentiality practices. Use of the model notice*  
24           *shall serve as a defense against claims of receiv-*  
25           *ing inappropriate notice.*

1           “(2) *ESTABLISHMENT OF SAFEGUARDS.*—A  
2           *group health plan, or a health insurance issuer offer-*  
3           *ing health insurance coverage in connection with a*  
4           *group health plan, shall establish and maintain ap-*  
5           *propriate administrative, technical, and physical*  
6           *safeguards to protect the confidentiality, security, ac-*  
7           *curacy, and integrity of predictive genetic informa-*  
8           *tion created, received, obtained, maintained, used,*  
9           *transmitted, or disposed of by such plan or issuer.”.*

10           (2) *DEFINITIONS.*—Section 2791(d) of the Public  
11           *Health Service Act (42 U.S.C. 300gg–91(d)) is*  
12           *amended by adding at the end the following:*

13           “(15) *FAMILY MEMBER.*—The term ‘family mem-  
14           *ber’ means, with respect to an individual—*

15                   “(A) *the spouse of the individual;*

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

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

22           “(16) *GENETIC INFORMATION.*—The term ‘ge-  
23           *netic information’ means information about genes,*  
24           *gene products, or inherited characteristics that may*  
25           *derive from an individual or a family member (in-*

1 *cluding information about a request for or receipt of*  
2 *genetic services).*

3 “(17) *GENETIC SERVICES.*—*The term ‘genetic*  
4 *services’ means health services provided to obtain, as-*  
5 *sess, or interpret genetic information for diagnostic*  
6 *and therapeutic purposes, and for genetic education*  
7 *and counseling.*

8 “(18) *PREDICTIVE GENETIC INFORMATION.*—

9 “(A) *IN GENERAL.*—*The term ‘predictive ge-*  
10 *netic information’ means, in the absence of*  
11 *symptoms, clinical signs, or a diagnosis of the*  
12 *condition related to such information—*

13 “(i) *information about an individual’s*  
14 *genetic tests;*

15 “(ii) *information about genetic tests of*  
16 *family members of the individual; or*

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

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

21 “(i) *information about the sex or age of*  
22 *the individual;*

23 “(ii) *information derived from phys-*  
24 *ical tests, such as the chemical, blood, or*

1                    *urine analyses of the individual including*  
2                    *cholesterol tests; and*

3                    *“(iii) information about physical*  
4                    *exams of the individual.*

5                    *“(19) GENETIC TEST.—The term ‘genetic test’*  
6                    *means the analysis of human DNA, RNA, chro-*  
7                    *mosomes, proteins, and certain metabolites, including*  
8                    *analysis of genotypes, mutations, phenotypes, or*  
9                    *karyotypes, for the purpose of predicting risk of dis-*  
10                   *ease in asymptomatic or undiagnosed individuals.*  
11                   *Such term does not include physical tests, such as the*  
12                   *chemical, blood, or urine analyses of the individual*  
13                   *including cholesterol tests, and physical exams of the*  
14                   *individual, in order to detect symptoms, clinical*  
15                   *signs, or a diagnosis of disease.”.*

16                   *(e) AMENDMENTS TO PHSA RELATING TO THE INDI-*  
17                   *VIDUAL MARKET.—The first subpart 3 of part B of title*  
18                   *XXVII of the Public Health Service Act (42 U.S.C. 300gg–*  
19                   *51 et seq.) (relating to other requirements) (42 U.S.C.*  
20                   *300gg–51 et seq.), as amended by section 2301(e), is further*  
21                   *amended by adding at the end the following:*

1 **“SEC. 2754. PROHIBITION OF HEALTH DISCRIMINATION ON**  
2 **THE BASIS OF PREDICTIVE GENETIC INFOR-**  
3 **MATION.**

4 “(a) *PROHIBITION ON PREDICTIVE GENETIC INFORMA-*  
5 *TION AS A CONDITION OF ELIGIBILITY.*—A health insurance  
6 issuer offering health insurance coverage in the individual  
7 market may not use predictive genetic information as a  
8 condition of eligibility of an individual to enroll in indi-  
9 vidual health insurance coverage (including information  
10 about a request for or receipt of genetic services).

11 “(b) *PROHIBITION ON PREDICTIVE GENETIC INFORMA-*  
12 *TION IN SETTING PREMIUM RATES.*—A health insurance  
13 issuer offering health insurance coverage in the individual  
14 market shall not adjust premium rates for individuals on  
15 the basis of predictive genetic information concerning such  
16 an individual (including a dependent) or a family member  
17 of the individual (including information about a request  
18 for or receipt of genetic services).

19 “(c) *COLLECTION OF PREDICTIVE GENETIC INFORMA-*  
20 *TION.*—

21 “(1) *LIMITATION ON REQUESTING OR REQUIRING*  
22 *PREDICTIVE GENETIC INFORMATION.*—Except as pro-  
23 vided in paragraph (2), a health insurance issuer of-  
24 fering health insurance coverage in the individual  
25 market shall not request or require predictive genetic  
26 information concerning any individual (including a

1       *dependent) or a family member of the individual (in-*  
2       *cluding information about a request for or receipt of*  
3       *genetic services).*

4               “(2) *INFORMATION NEEDED FOR DIAGNOSIS,*  
5       *TREATMENT, OR PAYMENT.—*

6               “(A) *IN GENERAL.—Notwithstanding para-*  
7       *graph (1), a health insurance issuer offering*  
8       *health insurance coverage in the individual mar-*  
9       *ket that provides health care items and services*  
10       *to an individual or dependent may request (but*  
11       *may not require) that such individual or de-*  
12       *pendent disclose, or authorize the collection or*  
13       *disclosure of, predictive genetic information for*  
14       *purposes of diagnosis, treatment, or payment re-*  
15       *lating to the provision of health care items and*  
16       *services to such individual or dependent.*

17               “(B) *NOTICE OF CONFIDENTIALITY PRAC-*  
18       *TICES AND DESCRIPTION OF SAFEGUARDS.—As a*  
19       *part of a request under subparagraph (A), the*  
20       *health insurance issuer offering health insurance*  
21       *coverage in the individual market shall provide*  
22       *to the individual or dependent a description of*  
23       *the procedures in place to safeguard the con-*  
24       *fidentiality, as described in subsection (d), of*  
25       *such predictive genetic information.*

1       “(d) *CONFIDENTIALITY WITH RESPECT TO PRE-*  
2 *DICTIVE GENETIC INFORMATION.*—

3               “(1) *NOTICE OF CONFIDENTIALITY PRACTICES.*—

4                       “(A) *PREPARATION OF WRITTEN NOTICE.*—

5                       *A health insurance issuer offering health insur-*  
6 *ance coverage in the individual market shall post*  
7 *or provide, in writing and in a clear and con-*  
8 *spicuous manner, notice of the issuer’s confiden-*  
9 *tiality practices, that shall include—*

10                               “(i) *a description of an individual’s*  
11 *rights with respect to predictive genetic in-*  
12 *formation;*

13                               “(ii) *the procedures established by the*  
14 *issuer for the exercise of the individual’s*  
15 *rights; and*

16                               “(iii) *the right to obtain a copy of the*  
17 *notice of the confidentiality practices re-*  
18 *quired under this subsection.*

19                       “(B) *MODEL NOTICE.*—*The Secretary, in*  
20 *consultation with the National Committee on*  
21 *Vital and Health Statistics and the National As-*  
22 *sociation of Insurance Commissioners, and after*  
23 *notice and opportunity for public comment, shall*  
24 *develop and disseminate model notices of con-*  
25 *fidentiality practices. Use of the model notice*

1           *shall serve as a defense against claims of receiv-*  
2           *ing inappropriate notice.*

3           “(2) *ESTABLISHMENT OF SAFEGUARDS.—A*  
4           *health insurance issuer offering health insurance cov-*  
5           *erage in the individual market shall establish and*  
6           *maintain appropriate administrative, technical, and*  
7           *physical safeguards to protect the confidentiality, se-*  
8           *curity, accuracy, and integrity of predictive genetic*  
9           *information created, received, obtained, maintained,*  
10          *used, transmitted, or disposed of by such issuer.”.*

11          “(c) *EFFECTIVE DATE.—The amendments made by this*  
12          *section shall apply with respect to—*

13                 (1) *group health plans, and health insurance*  
14                 *coverage offered in connection with group health*  
15                 *plans, for plan years beginning after 1 year after the*  
16                 *date of enactment of this Act; and*

17                 (2) *health insurance coverage offered, sold,*  
18                 *issued, renewed, in effect, or operated in the indi-*  
19                 *vidual market after 1 year after the date of enactment*  
20                 *of this Act.*

21 **SEC. 2404. AMENDMENTS TO THE INTERNAL REVENUE**

22                         **CODE OF 1986.**

23           “(a) *PROHIBITION OF HEALTH DISCRIMINATION ON*  
24           *THE BASIS OF GENETIC INFORMATION OR GENETIC SERV-*  
25           *ICES.—*

1           (1) *NO ENROLLMENT RESTRICTION FOR GENETIC*  
2           *SERVICES.*—Section 9802(a)(1)(F) of the Internal  
3           Revenue Code of 1986 is amended by inserting before  
4           the period the following: “(including information  
5           about a request for or receipt of genetic services)”.

6           (2) *NO DISCRIMINATION IN GROUP PREMIUMS*  
7           *BASED ON PREDICTIVE GENETIC INFORMATION.*—

8           (A) *IN GENERAL.*—Subchapter B of chapter  
9           100 of the Internal Revenue Code of 1986, as  
10           amended by section 2301(f), is further amended  
11           by adding at the end the following:

12       **“SEC. 9815. PROHIBITING PREMIUM DISCRIMINATION**  
13               **AGAINST GROUPS ON THE BASIS OF PRE-**  
14               **DICTIVE GENETIC INFORMATION.**

15           “A group health plan shall not adjust premium or con-  
16           tribution amounts for a group on the basis of predictive  
17           genetic information concerning any individual (including  
18           a dependent) or a family member of the individual (includ-  
19           ing information about a request for or receipt of genetic  
20           services).”.

21           (B) *CONFORMING AMENDMENT.*—Section  
22           9802(b) of the Internal Revenue Code of 1986 is  
23           amended by adding at the end the following:

24           “(3) *REFERENCE TO RELATED PROVISION.*—For  
25           a provision prohibiting the adjustment of premium or

1        *contribution amounts for a group under a group*  
2        *health plan on the basis of predictive genetic informa-*  
3        *tion (including information about a request for or the*  
4        *receipt of genetic services), see section 9815.”.*

5                    (C) *AMENDMENT TO TABLE OF SECTIONS.—*  
6                    *The table of sections for subchapter B of chapter*  
7                    *100 of the Internal Revenue Code of 1986, as*  
8                    *amended by section 2301(f), is further amended*  
9                    *by adding at the end the following:*

                  “*Sec. 9815. Prohibiting premium discrimination against groups on the basis of*  
                  *predictive genetic information.*”.

10            (b) *LIMITATION ON COLLECTION OF PREDICTIVE GE-*  
11 *NETIC INFORMATION.—Section 9802 of the Internal Rev-*  
12 *enue Code of 1986 is amended by adding at the end the*  
13 *following:*

14            “(d) *COLLECTION OF PREDICTIVE GENETIC INFORMA-*  
15 *TION.—*

16            “(1) *LIMITATION ON REQUESTING OR REQUIRING*  
17 *PREDICTIVE GENETIC INFORMATION.—Except as pro-*  
18 *vided in paragraph (2), a group health plan shall not*  
19 *request or require predictive genetic information con-*  
20 *cerning any individual (including a dependent) or a*  
21 *family member of the individual (including informa-*  
22 *tion about a request for or receipt of genetic services).*

23            “(2) *INFORMATION NEEDED FOR DIAGNOSIS,*  
24 *TREATMENT, OR PAYMENT.—*

1           “(A) *IN GENERAL.*—Notwithstanding para-  
2           graph (1), a group health plan that provides  
3           health care items and services to an individual  
4           or dependent may request (but may not require)  
5           that such individual or dependent disclose, or  
6           authorize the collection or disclosure of, pre-  
7           dictive genetic information for purposes of diag-  
8           nosis, treatment, or payment relating to the pro-  
9           vision of health care items and services to such  
10          individual or dependent.

11          “(B) *NOTICE OF CONFIDENTIALITY PRAC-*  
12          *TICES; DESCRIPTION OF SAFEGUARDS.*—As a  
13          part of a request under subparagraph (A), the  
14          group health plan shall provide to the individual  
15          or dependent a description of the procedures in  
16          place to safeguard the confidentiality, as de-  
17          scribed in subsection (e), of such predictive ge-  
18          netic information.

19          “(e) *CONFIDENTIALITY WITH RESPECT TO PREDICTIVE*  
20          *GENETIC INFORMATION.*—

21                 “(1) *NOTICE OF CONFIDENTIALITY PRACTICES.*—

22                         “(A) *PREPARATION OF WRITTEN NOTICE.*—  
23                         A group health plan shall post or provide, in  
24                         writing and in a clear and conspicuous manner,

1           *notice of the plan’s confidentiality practices, that*  
2           *shall include—*

3                   “(i) *a description of an individual’s*  
4                   *rights with respect to predictive genetic in-*  
5                   *formation;*

6                   “(ii) *the procedures established by the*  
7                   *plan for the exercise of the individual’s*  
8                   *rights; and*

9                   “(iii) *the right to obtain a copy of the*  
10                  *notice of the confidentiality practices re-*  
11                  *quired under this subsection.*

12                  “(B) *MODEL NOTICE.—The Secretary, in*  
13                  *consultation with the National Committee on*  
14                  *Vital and Health Statistics and the National As-*  
15                  *sociation of Insurance Commissioners, and after*  
16                  *notice and opportunity for public comment, shall*  
17                  *develop and disseminate model notices of con-*  
18                  *fidentiality practices. Use of the model notice*  
19                  *shall serve as a defense against claims of receiv-*  
20                  *ing inappropriate notice.*

21                  “(2) *ESTABLISHMENT OF SAFEGUARDS.—A*  
22                  *group health plan shall establish and maintain ap-*  
23                  *propriate administrative, technical, and physical*  
24                  *safeguards to protect the confidentiality, security, ac-*  
25                  *curacy, and integrity of predictive genetic informa-*

1        *tion created, received, obtained, maintained, used,*  
2        *transmitted, or disposed of by such plan.”.*

3        (c) *DEFINITIONS.*—Section 9832(d) of the Internal  
4 *Revenue Code of 1986 is amended by adding at the end*  
5 *the following:*

6            “(6) *FAMILY MEMBER.*—The term ‘family mem-  
7        *ber’ means, with respect to an individual—*

8            “(A) *the spouse of the individual;*

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

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

15            “(7) *GENETIC INFORMATION.*—The term ‘genetic  
16        *information’ means information about genes, gene*  
17        *products, or inherited characteristics that may derive*  
18        *from an individual or a family member (including*  
19        *information about a request for or receipt of genetic*  
20        *services).*

21            “(8) *GENETIC SERVICES.*—The term ‘genetic  
22        *services’ means health services provided to obtain, as-*  
23        *sess, or interpret genetic information for diagnostic*  
24        *and therapeutic purposes, and for genetic education*  
25        *and counseling.*

1           “(9) *PREDICTIVE GENETIC INFORMATION.*—

2                   “(A) *IN GENERAL.*—*The term ‘predictive ge-*  
3                   *netic information’ means, in the absence of*  
4                   *symptoms, clinical signs, or a diagnosis of the*  
5                   *condition related to such information—*

6                           “(i) *information about an individual’s*  
7                           *genetic tests;*

8                           “(ii) *information about genetic tests of*  
9                           *family members of the individual; or*

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

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

14                           “(i) *information about the sex or age of*  
15                           *the individual;*

16                           “(ii) *information derived from phys-*  
17                           *ical tests, such as the chemical, blood, or*  
18                           *urine analyses of the individual including*  
19                           *cholesterol tests; and*

20                           “(iii) *information about physical*  
21                           *exams of the individual.*

22                   “(10) *GENETIC TEST.*—*The term ‘genetic test’*  
23                   *means the analysis of human DNA, RNA, chro-*  
24                   *mosomes, proteins, and certain metabolites, including*  
25                   *analysis of genotypes, mutations, phenotypes, or*

1       *karyotypes, for the purpose of predicting risk of dis-*  
2       *ease in asymptomatic or undiagnosed individuals.*  
3       *Such term does not include physical tests, such as the*  
4       *chemical, blood, or urine analyses of the individual*  
5       *including cholesterol tests, and physical exams of the*  
6       *individual, in order to detect symptoms, clinical*  
7       *signs, or a diagnosis of disease.”.*

8       *(d) EFFECTIVE DATE.—Except as provided in this sec-*  
9       *tion, this section and the amendments made by this section*  
10       *shall apply with respect to group health plans for plan*  
11       *years beginning after 1 year after the date of the enactment*  
12       *of this Act.*

13       ***TITLE XXV—PATIENT SAFETY***  
14       ***AND ERRORS REDUCTION***

15       ***SEC. 2501. SHORT TITLE.***

16       *This title may be cited as the “Patient Safety and Er-*  
17       *rors Reduction Act”.*

18       ***SEC. 2502. PURPOSES.***

19       *It is the purpose of this title to—*

20                (1) *promote the identification, evaluation, and*  
21                *reporting of medical errors;*

22                (2) *raise standards and expectations for im-*  
23                *provements in patient safety;*

1           (3) *reduce deaths, serious injuries, and other*  
2           *medical errors through the implementation of safe*  
3           *practices at the delivery level;*

4           (4) *develop error reduction systems with legal*  
5           *protections to support the collection of information*  
6           *under such systems;*

7           (5) *extend existing confidentiality and peer re-*  
8           *view protections to the reports relating to medical er-*  
9           *rors that are reported under such systems that are de-*  
10          *veloped for safety and quality improvement purposes;*  
11          *and*

12          (6) *provide for the establishment of systems of*  
13          *information collection, analysis, and dissemination to*  
14          *enhance the knowledge base concerning patient safety.*

15 **SEC. 2503. AMENDMENT TO PUBLIC HEALTH SERVICE ACT.**

16          *Title IX of the Public Health Service Act (42 U.S.C.*  
17          *299 et seq.) is amended—*

18                 (1) *by redesignating part C as part D;*

19                 (2) *by redesignating sections 921 through 928, as*  
20                 *sections 931 through 938, respectively;*

21                 (3) *in section 938(1) (as so redesignated), by*  
22                 *striking “921” and inserting “931”; and*

23                 (4) *by inserting after part B the following:*

1 **“PART C—REDUCING ERRORS IN HEALTH CARE**

2 **“SEC. 921. DEFINITIONS.**

3 *“In this part:*

4 *“(1) ADVERSE EVENT.—The term ‘adverse event’*  
5 *means, with respect to the patient of a provider of*  
6 *services, an untoward incident, therapeutic misadven-*  
7 *ture, or iatrogenic injury directly associated with the*  
8 *provision of health care items and services by a health*  
9 *care provider or provider of services.*

10 *“(2) CENTER.—The term ‘Center’ means the*  
11 *Center for Quality Improvement and Patient Safety*  
12 *established under section 922(b).*

13 *“(3) CLOSE CALL.—The term ‘close call’ means,*  
14 *with respect to the patient of a provider of services,*  
15 *any event or situation that—*

16 *“(A) but for chance or a timely interven-*  
17 *tion, could have resulted in an accident, injury,*  
18 *or illness; and*

19 *“(B) is directly associated with the provi-*  
20 *sion of health care items and services by a pro-*  
21 *vider of services.*

22 *“(4) EXPERT ORGANIZATION.—The term ‘expert*  
23 *organization’ means a third party acting on behalf of,*  
24 *or in conjunction with, a provider of services to col-*  
25 *lect information about, or evaluate, a medical event.*

1           “(5) *HEALTH CARE OVERSIGHT AGENCY*.—*The*  
2           *term ‘health care oversight agency’ means an agency,*  
3           *entity, or person, including the employees and agents*  
4           *thereof, that performs or oversees the performance of*  
5           *any activities necessary to ensure the safety of the*  
6           *health care system.*

7           “(6) *HEALTH CARE PROVIDER*.—*The term*  
8           *‘health care provider’ means—*

9                   “(A) *any provider of services (as defined in*  
10                   *section 1861(u) of the Social Security Act); and*

11                   “(B) *any person furnishing any medical or*  
12                   *other health care services as defined in section*  
13                   *1861(s)(1) and (2) of such Act through, or under*  
14                   *the authority of, a provider of services described*  
15                   *in subparagraph (A).*

16           “(7) *PROVIDER OF SERVICES*.—*The term ‘pro-*  
17           *vider of services’ means a hospital, skilled nursing fa-*  
18           *cility, comprehensive outpatient rehabilitation facil-*  
19           *ity, home health agency, renal dialysis facility, ambu-*  
20           *latory surgical center, or hospice program, and any*  
21           *other entity specified in regulations promulgated by*  
22           *the Secretary after public notice and comment.*

23           “(8) *PUBLIC HEALTH AUTHORITY*.—*The term*  
24           *‘public health authority’ means an agency or author-*  
25           *ity of the United States, a State, a territory, a polit-*

1        *ical subdivision of a State or territory, and an In-*  
2        *dian tribe that is responsible for public health matters*  
3        *as part of its official mandate.*

4            “(9) *MEDICAL EVENT*.—*The term ‘medical event’*  
5        *means, with respect to the patient of a provider of*  
6        *services, any sentinel event, adverse event, or close*  
7        *call.*

8            “(10) *MEDICAL EVENT ANALYSIS ENTITY*.—*The*  
9        *term ‘medical event analysis entity’ means an entity*  
10       *certified under section 923(a).*

11           “(11) *ROOT CAUSE ANALYSIS*.—

12            “(A) *IN GENERAL*.—*The term ‘root cause*  
13        *analysis’ means a process for identifying the*  
14        *basic or contributing causal factors that underlie*  
15        *variation in performance associated with med-*  
16        *ical events that—*

17            “(i) *has the characteristics described in*  
18        *subparagraph (B);*

19            “(ii) *includes participation by the*  
20        *leadership of the provider of services and in-*  
21        *dividuals most closely involved in the proc-*  
22        *esses and systems under review;*

23            “(iii) *is internally consistent; and*

24            “(iv) *includes the consideration of rel-*  
25        *evant literature.*

1           “(B) *CHARACTERISTICS.*—*The characteristics*  
2           *described in this subparagraph include the*  
3           *following:*

4                   “(i) *The analysis is interdisciplinary*  
5                   *in nature and involves those individuals*  
6                   *who are responsible for administering the*  
7                   *reporting systems.*

8                   “(ii) *The analysis focuses primarily on*  
9                   *systems and processes rather than indi-*  
10                   *vidual performance.*

11                   “(iii) *The analysis involves a thorough*  
12                   *review of all aspects of the process and all*  
13                   *contributing factors involved.*

14                   “(iv) *The analysis identifies changes*  
15                   *that could be made in systems and proc-*  
16                   *esses, through either redesign or development*  
17                   *of new processes or systems, that would im-*  
18                   *prove performance and reduce the risk of*  
19                   *medical events.*

20                   “(12) *SENTINEL EVENT.*—*The term ‘sentinel*  
21                   *event’ means, with respect to the patient of a provider*  
22                   *of services, an unexpected occurrence that—*

23                           “(A) *involves death or serious physical or*  
24                           *psychological injury (including loss of a limb);*  
25                           *and*

1                   “(B) is directly associated with the provi-  
2                   sion of health care items and services by a health  
3                   care provider or provider of services.

4   **“SEC. 922. RESEARCH TO IMPROVE THE QUALITY AND SAFE-**  
5                   **TY OF PATIENT CARE.**

6                   “(a) *IN GENERAL.*—To improve the quality and safety  
7 of patient care, the Director shall—

8                   “(1) conduct and support research, evaluations  
9                   and training, support demonstration projects, provide  
10                  technical assistance, and develop and support part-  
11                  nerships that will identify and determine the causes  
12                  of medical errors and other threats to the quality and  
13                  safety of patient care;

14                  “(2) identify and evaluate interventions and  
15                  strategies for preventing or reducing medical errors  
16                  and threats to the quality and safety of patient care;

17                  “(3) identify, in collaboration with experts from  
18                  the public and private sector, reporting parameters to  
19                  provide consistency throughout the errors reporting  
20                  system;

21                  “(4) identify approaches for the clinical manage-  
22                  ment of complications from medical errors; and

23                  “(5) establish mechanisms for the rapid dissemi-  
24                  nation of interventions and strategies identified under

1        *this section for which there is scientific evidence of ef-*  
2        *fectiveness.*

3        “(b) *CENTER FOR QUALITY IMPROVEMENT AND PA-*  
4        *TIENT SAFETY.*—

5                “(1) *ESTABLISHMENT.*—*The Director shall estab-*  
6        *lish a center to be known as the Center for Quality*  
7        *Improvement and Patient Safety to assist the Direc-*  
8        *tor in carrying out the requirements of subsection (a).*

9                “(2) *MISSION.*—*The Center shall—*

10                “(A) *provide national leadership for re-*  
11        *search and other initiatives to improve the qual-*  
12        *ity and safety of patient care;*

13                “(B) *build public-private sector partner-*  
14        *ships to improve the quality and safety of pa-*  
15        *tient care; and*

16                “(C) *serve as a national resource for re-*  
17        *search and learning from medical errors.*

18                “(3) *DUTIES.*—

19                “(A) *IN GENERAL.*—*In carrying out this*  
20        *section, the Director, acting through the Center,*  
21        *shall consult and build partnerships, as appro-*  
22        *priate, with all segments of the health care in-*  
23        *dustry, including health care practitioners and*  
24        *patients, those who manage health care facilities,*  
25        *systems and plans, peer review organizations,*

1           *health care purchasers and policymakers, and*  
2           *other users of health care research.*

3           “(B) *REQUIRED DUTIES.*—*In addition to*  
4           *the broad responsibilities that the Director may*  
5           *assign to the Center for research and related ac-*  
6           *tivities that are designed to improve the quality*  
7           *of health care, the Director shall ensure that the*  
8           *Center—*

9                     “(i) *builds scientific knowledge and*  
10                    *understanding of the causes of medical er-*  
11                    *rors in all health care settings and identi-*  
12                    *fies or develops and validates effective inter-*  
13                    *ventions and strategies to reduce errors and*  
14                    *improve the safety and quality of patient*  
15                    *care;*

16                    “(ii) *promotes public and private sec-*  
17                    *tor research on patient safety by—*

18                             “(I) *developing a national patient*  
19                             *safety research agenda;*

20                             “(II) *identifying promising op-*  
21                             *portunities for preventing or reducing*  
22                             *medical errors; and*

23                             “(III) *tracking the progress made*  
24                             *in addressing the highest priority re-*

1 search questions with respect to patient  
2 safety;

3 “(iii) facilitates the development of vol-  
4 untary national patient safety goals by con-  
5 vening all segments of the health care indus-  
6 try and tracks the progress made in meeting  
7 those goals;

8 “(iv) analyzes national patient safety  
9 data for inclusion in the annual report on  
10 the quality of health care required under  
11 section 913(b)(2);

12 “(v) strengthens the ability of the  
13 United States to learn from medical errors  
14 by—

15 “(I) developing the necessary tools  
16 and advancing the scientific techniques  
17 for analysis of errors;

18 “(II) providing technical assist-  
19 ance as appropriate to reporting sys-  
20 tems; and

21 “(III) entering into contracts to  
22 receive and analyze aggregate data  
23 from public and private sector report-  
24 ing systems;

1                   “(vi) supports dissemination and com-  
2                   munication activities to improve patient  
3                   safety, including the development of tools  
4                   and methods for educating consumers about  
5                   patient safety; and

6                   “(vii) undertakes related activities that  
7                   the Director determines are necessary to en-  
8                   able the Center to fulfill its mission.

9                   “(C) *LIMITATION.*—Aggregate data gathered  
10                  for the purposes described in this section shall  
11                  not include specific patient, health care provider,  
12                  or provider of service identifiers.

13               “(c) *LEARNING FROM MEDICAL ERRORS.*—

14               “(1) *IN GENERAL.*—To enhance the ability of the  
15               health care community in the United States to learn  
16               from medical events, the Director shall—

17               “(A) carry out activities to increase sci-  
18               entific knowledge and understanding regarding  
19               medical error reporting systems;

20               “(B) carry out activities to advance the sci-  
21               entific knowledge regarding the tools and tech-  
22               niques for analyzing medical events and deter-  
23               mining their root causes;

24               “(C) carry out activities in partnership  
25               with experts in the field to increase the capacity

1           *of the health care community in the United*  
2           *States to analyze patient safety data;*

3           *“(D) develop a confidential national safety*  
4           *database of medical event reports;*

5           *“(E) conduct and support research, using*  
6           *the database developed under subparagraph (D),*  
7           *into the causes and potential interventions to de-*  
8           *crease the incidence of medical errors and close*  
9           *calls; and*

10           *“(F) ensure that information contained in*  
11           *the national database developed under subpara-*  
12           *graph (D) does not include specific patient,*  
13           *health care provider, or provider of service iden-*  
14           *tifiers.*

15           *“(2) NATIONAL PATIENT SAFETY DATABASE.—*  
16           *The Director shall, in accordance with paragraph*  
17           *(1)(D), establish a confidential national safety data-*  
18           *base (to be known as the National Patient Safety*  
19           *Database) of reports of medical events that can be*  
20           *used only for research to improve the quality and*  
21           *safety of patient care. In developing and managing*  
22           *the National Patient Safety Database, the Director*  
23           *shall—*

24           *“(A) ensure that the database is only used*  
25           *for its intended purpose;*

1           “(B) ensure that the database is only used  
2 by the Agency, medical event analysis entities,  
3 and other qualified entities or individuals as de-  
4 termined appropriate by the Director and in ac-  
5 cordance with paragraph (3) or other criteria  
6 applied by the Director;

7           “(C) ensure that the database is as com-  
8 prehensive as possible by aggregating data from  
9 Federal, State, and private sector patient safety  
10 reporting systems;

11           “(D) conduct and support research on the  
12 most common medical errors and close calls,  
13 their causes, and potential interventions to re-  
14 duce medical errors and improve the quality and  
15 safety of patient care;

16           “(E) disseminate findings made by the Di-  
17 rector, based on the data in the database, to cli-  
18 nicians, individuals who manage health care fa-  
19 cilities, systems, and plans, patients, and other  
20 individuals who can act appropriately to im-  
21 prove patient safety; and

22           “(F) develop a rapid response capacity to  
23 provide alerts when specific health care practices  
24 pose an imminent threat to patients or health

1           *care practitioners, or other providers of health*  
2           *care items or services.*

3           “(3) *CONFIDENTIALITY AND PEER REVIEW PRO-*  
4           *TECTIONS.—Notwithstanding any other provision of*  
5           *law any information (including any data, reports,*  
6           *records, memoranda, analyses, statements, and other*  
7           *communications) developed by or on behalf of a health*  
8           *care provider or provider of services with respect to*  
9           *a medical event, that is contained in the National Pa-*  
10          *tient Safety Database shall be confidential in accord-*  
11          *ance with section 925.*

12          “(4) *PATIENT SAFETY REPORTING SYSTEMS.—*  
13          *The Director shall identify public and private sector*  
14          *patient safety reporting systems and build scientific*  
15          *knowledge and understanding regarding the most*  
16          *effective—*

17                  “(A) *components of patient safety reporting*  
18                  *systems;*

19                  “(B) *incentives intended to increase the rate*  
20                  *of error reporting;*

21                  “(C) *approaches for undertaking root cause*  
22                  *analyses;*

23                  “(D) *ways to provide feedback to those fil-*  
24                  *ing error reports;*

1           “(E) techniques and tools for collecting, in-  
2           tegrating, and analyzing patient safety data;  
3           and

4           “(F) ways to provide meaningful informa-  
5           tion to patients, consumers, and purchasers that  
6           will enhance their understanding of patient safe-  
7           ty issues.

8           “(5) TRAINING.—The Director shall support  
9           training initiatives to build the capacity of the health  
10          care community in the United States to analyze pa-  
11          tient safety data and to act on that data to improve  
12          patient safety.

13          “(d) EVALUATION.—The Director shall recommend  
14          strategies for measuring and evaluating the national  
15          progress made in implementing safe practices identified by  
16          the Center through the research and analysis required under  
17          subsection (b) and through the voluntary reporting system  
18          established under subsection (c).

19          “(e) IMPLEMENTATION.—In implementing strategies to  
20          carry out the functions described in subsections (b), (c), and  
21          (d), the Director may contract with public or private enti-  
22          ties on a national or local level with appropriate expertise.

23          **“SEC. 923. MEDICAL EVENT ANALYSIS ENTITIES.**

24          “(a) IN GENERAL.—The Director, based on informa-  
25          tion collected under section 922(c), shall provide for the cer-

1 *tification of entities to collect and analyze information on*  
2 *medical errors, and to collaborate with health care providers*  
3 *or providers of services in collecting information about, or*  
4 *evaluating, certain medical events.*

5       “(b) *COMPATIBILITY OF COLLECTED DATA.*—*To en-*  
6 *sure that data reported to the National Patient Safety*  
7 *Database under section 922(c)(2) concerning medical errors*  
8 *and close calls are comparable and useful on an analytic*  
9 *basis, the Director shall require that the entities described*  
10 *in subsection (c) follow the recommendations regarding a*  
11 *common set of core measures for reporting that are devel-*  
12 *oped by the National Forum for Health Care Quality Meas-*  
13 *urement and Reporting, or other voluntary private stand-*  
14 *ard-setting organization that is designated by the Director*  
15 *taking into account existing measurement systems and in*  
16 *collaboration with experts from the public and private sec-*  
17 *tor.*

18       “(c) *DUTIES OF CERTIFIED ENTITIES.*—

19               “(1) *IN GENERAL.*—*An entity that is certified*  
20 *under subsection (a) shall collect and analyze infor-*  
21 *mation, consistent with the requirement of subsection*  
22 *(b), provided to the entity under section 924(a)(4) to*  
23 *improve patient safety.*

24               “(2) *INFORMATION TO BE REPORTED TO THE EN-*  
25 *TITY.*—*A medical event analysis entity shall, on a*

1       *periodic basis and in a format that is specified by the*  
2       *Director, submit to the Director a report that*  
3       *contains—*

4               “(A) *a description of the medical events*  
5               *that were reported to the entity during the pe-*  
6               *riod covered under the report;*

7               “(B) *a description of any corrective action*  
8               *taken by providers of services with respect to*  
9               *such medical events or any other measures that*  
10              *are necessary to prevent similar events from oc-*  
11              *curring in the future; and*

12              “(C) *a description of the systemic changes*  
13              *that entities have identified, through an analysis*  
14              *of the medical events included in the report, as*  
15              *being needed to improve patient safety.*

16              “(3) *COLLABORATION.—A medical event analysis*  
17              *entity that is collaborating with a health care pro-*  
18              *vider or provider of services to address close calls and*  
19              *adverse events may, at the request of the health care*  
20              *provider or provider of services—*

21              “(A) *provide expertise in the development of*  
22              *root cause analyses and corrective action plan*  
23              *relating to such close calls and adverse events; or*

1           “(B) collaborate with such provider of serv-  
2           ices to identify on-going risk reduction activities  
3           that may enhance patient safety.

4           “(d) CONFIDENTIALITY AND PEER REVIEW PROTEC-  
5 TIONS.—Notwithstanding any other provision of law, any  
6 information (including any data, reports, records, memo-  
7 randa, analyses, statements, and other communications)  
8 collected by a medical event analysis entity or developed  
9 by or on behalf of such an entity under this part shall be  
10 confidential in accordance with section 925.

11          “(e) TERMINATION AND RENEWAL.—

12           “(1) IN GENERAL.—The certification of an entity  
13 under this section shall terminate on the date that is  
14 3 years after the date on which such certification was  
15 provided. Such certification may be renewed at the  
16 discretion of the Director.

17           “(2) NONCOMPLIANCE.—The Director may ter-  
18 minate the certification of a medical event analysis  
19 entity if the Director determines that such entity has  
20 failed to comply with this section.

21          “(f) IMPLEMENTATION.—In implementing strategies to  
22 carry out the functions described in subsection (c), the Di-  
23 rector may contract with public or private entities on a  
24 national or local level with appropriate expertise.

1 **“SEC. 924. PROVIDER OF SERVICES SYSTEMS FOR REPORT-**  
2 **ING MEDICAL EVENTS.**

3 *“(a) INTERNAL MEDICAL EVENT REPORTING SYS-*  
4 *TEMS.—Each provider of services that elects to participate*  
5 *in a medical error reporting system under this part shall—*

6 *“(1) establish a system for—*

7 *“(A) identifying, collecting information*  
8 *about, and evaluating medical events that occur*  
9 *with respect to a patient in the care of the pro-*  
10 *vider of services or a practitioner employed by*  
11 *the provider of services, that may include—*

12 *“(i) the provision of a medically coher-*  
13 *ent description of each event so identified;*

14 *“(ii) the provision of a clear and thor-*  
15 *ough accounting of the results of the inves-*  
16 *tigation of such event under the system; and*

17 *“(iii) a description of all corrective*  
18 *measures taken in response to the event; and*

19 *“(B) determining appropriate follow-up ac-*  
20 *tions to be taken with respect to such events;*

21 *“(2) establish policies and procedures with re-*  
22 *spect to when and to whom such events are to be re-*  
23 *ported;*

24 *“(3) take appropriate follow-up action with re-*  
25 *spect to such events; and*

1           “(4) submit to the appropriate medical event  
2           analysis entity information that contains descriptions  
3           of the medical events identified under paragraph  
4           (1)(A).

5           “(b) *PROMOTING IDENTIFICATION, EVALUATION, AND*  
6           *REPORTING OF CERTAIN MEDICAL EVENTS.—*

7           “(1) *IN GENERAL.—Notwithstanding any other*  
8           *provision of law any information (including any*  
9           *data, reports, records, memoranda, analyses, state-*  
10           *ments, and other communications) developed by or on*  
11           *behalf of a provider of services with respect to a med-*  
12           *ical event pursuant to a system established under sub-*  
13           *section (a) shall be privileged in accordance with sec-*  
14           *tion 925.*

15           “(2) *RULES OF CONSTRUCTION.—Nothing in this*  
16           *subsection shall be construed as prohibiting—*

17                   “(A) *disclosure of a patient’s medical record*  
18                   *to the patient;*

19                   “(B) *a provider of services from complying*  
20                   *with the requirements of a health care oversight*  
21                   *agency or public health authority; or*

22                   “(C) *such an agency or authority from dis-*  
23                   *closing information transferred by a provider of*  
24                   *services to the public in a form that does not*

1           *identify or permit the identification of the health*  
2           *care provider or provider of services or patient.*

3   **“SEC. 925. CONFIDENTIALITY.**

4           **“(a) CONFIDENTIALITY AND PEER REVIEW PROTEC-**  
5   **TIONS.—Notwithstanding any other provision of law—**

6           **“(1) any information (including any data, re-**  
7           **ports, records, memoranda, analyses, statements, and**  
8           **other communications) developed by or on behalf of a**  
9           **health care provider or provider of services with re-**  
10          **spect to a medical event, that is contained in the Na-**  
11          **tional Patient Safety Database, collected by a medical**  
12          **event analysis entity, or developed by or on behalf of**  
13          **such an entity, or collected by a health care provider**  
14          **or provider or services for use under systems that are**  
15          **developed for safety and quality improvement pur-**  
16          **poses under this part—**

17                  **“(A) shall be privileged, strictly confiden-**  
18                  **tial, and may not be disclosed by any other per-**  
19                  **son to which such information is transferred**  
20                  **without the authorization of the health care pro-**  
21                  **vider or provider of services; and**

22                  **“(B) shall—**

23                          **“(i) be protected from disclosure by**  
24                          **civil, criminal, or administrative subpoena;**

1           “(ii) not be subject to discovery or oth-  
2           erwise discoverable in connection with a  
3           civil, criminal, or administrative pro-  
4           ceeding;

5           “(iii) not be subject to disclosure pur-  
6           suant to section 552 of title 5, United States  
7           Code (the Freedom of Information Act) and  
8           any other similar Federal or State statute  
9           or regulation; and

10           “(iv) not be admissible as evidence in  
11           any civil, criminal, or administrative pro-  
12           ceeding;

13           without regard to whether such information is  
14           held by the provider or by another person to  
15           which such information was transferred;

16           “(2) the transfer of any such information by a  
17           provider of services to a health care oversight agency,  
18           an expert organization, a medical event analysis enti-  
19           ty, or a public health authority, shall not be treated  
20           as a waiver of any privilege or protection established  
21           under paragraph (1) or established under State law.

22           “(b) *PENALTY.*—It shall be unlawful for any person  
23           to disclose any information described in subsection (a) other  
24           than for the purposes provided in such subsection. Any per-  
25           son violating the provisions of this section shall, upon con-

1 *viction, be fined in accordance with title 18, United States*  
2 *Code, and imprisoned for not more than 6 months, or both.*

3       “(c) *APPLICATION OF PROVISIONS.—The protections*  
4 *provided under subsection (a) and the penalty provided for*  
5 *under subsection (b) shall apply to any information (in-*  
6 *cluding any data, reports, memoranda, analyses, state-*  
7 *ments, and other communications) collected or developed*  
8 *pursuant to research, including demonstration projects,*  
9 *with respect to medical error reporting supported by the*  
10 *Director under this part.*

11 **“SEC. 926. AUTHORIZATION OF APPROPRIATIONS.**

12       *“There is authorized to be appropriated to carry out*  
13 *this part, \$50,000,000 for fiscal year 2001, and such sums*  
14 *as may be necessary for subsequent fiscal years.”.*

15 **SEC. 2504. EFFECTIVE DATE.**

16       *The amendments made by section 2503 shall become*  
17 *effective on the date of the enactment of this Act.*

18       *This Act may be cited as the “Departments of Labor,*  
19 *Health and Human Services, and Education, and Related*  
20 *Agencies Appropriations Act, 2001”.*

Attest:

*Secretary.*

106TH CONGRESS  
2D SESSION

**H. R. 4577**

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**AMENDMENT**