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

PROGRAM

Mr. MCCAIN. For the information of all Senators, under the previous order there will be a rollcall vote on Tuesday at 2:15 p.m. on the motion to invoke cloture on the campaign finance reform bill. If cloture is invoked, the Senate would be expected to continue consideration of S. 1219. If cloture is not invoked, the Senate will resume consideration of the Defense authorization bill, or possibly any other items cleared for action. Additional rollcall votes will therefore occur during Tuesday's session. A cloture motion was filed this evening on the defense bill, with that vote to occur on Wednesday. Under the provisions of rule XXII, first-degree amendments to the DOD bill must be filed by 12:30 on Tuesday.

ORDER FOR ADJOURNMENT

Mr. MCCAIN. If there is no further business to come before the Senate, I now ask the Senate stand in adjournment under the previous order, following the remarks of Senator KENNEDY.

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

The Senator from Massachusetts is recognized.

TRIBUTE TO GABRIEL LEWIS OF PANAMA

Mr. KENNEDY. Mr. President, I was distressed to learn recently that a serious illness has required a valiant champion of human rights and democracy and a great friend of the United States to withdraw from his high position as Foreign Minister of the Republic of Panama. Foreign Minister Gabriel Lewis is well known to many of us in Congress and he is especially warmly remembered for his determined, persuasive, and eloquent opposition to the dictatorship of Manuel Noriega in Panama.

Few, if any, individuals were more responsible for the return of democracy and respect for human rights in Panama than Mr. Lewis. He championed the cause of his fellow Panamanians in a way that makes him a profile in courage for our time.

The President of Panama has recently appointed Mr. Lewis to be his senior counsel with cabinet rank. I know that all friends of Mr. Lewis in the United States and many other countries wish him a speedy recovery. We need his continuing leadership to advance the close ties between our two countries, and to enhance the cause of democracy throughout the Americas.

MINIMUM WAGE

Mr. KENNEDY. Mr. President, 58 years ago today, on the eve of his signing into law the first Federal minimum wage, President Franklin Roosevelt gave a fireside chat. He warned the American people that they would hear ''Calamity howling business executives with incomes of $1,000 a day, claim that the new minimum wage of $11 a week will have a disastrous effect on all American industry.'' It was not true then and it is not true today.

The minimum wage will not hurt business, cause job loss, or cause inflation. It will, however, provide a pay raise for 112 million hard-working Americans who deserve a living wage. Tomorrow, Senator DASCHLE, I, and others will seek to add the minimum wage as an amendment to the DOD authorization bill. This is not the course we would prefer to take, but the Republican leadership of the Senate leaves us no choice.

More than a year ago, I joined Senator DASCHLE in introducing S. 413, a bill that would have raised the minimum wage by 45 cents in July 1995 and again this July for a total raise of 90 cents, bringing the minimum wage up to $5.15 an hour. We could not get a hearing on S. 413 in the Labor Committee, so on July 31, I offered a sense-of-the-Senate resolution calling on the Senate to consider the minimum wage increase before the end of the year. The resolution was defeated 48 to 49.

In October, unable to have so much as a hearing on the minimum wage, we tried again. Senator KERRY, my colleague, offered a sense-of-the-Senate resolution again, which was blocked by a Republican procedural maneuver. But we got a majority in favor, 51 to 48. We finally got a hearing in December, but no markup was scheduled. Finally, with the real value of the minimum wage continuing to fall and no relief for low-wage workers in sight, we offered an amendment to raise the minimum wage on the parks bill this past April and filed cloture; 55 Senators voted for cloture and 45 against.

It is clear from that vote, and the one last October, that a majority of Senators want to see the minimum wage increased, but they have been frustrated by the Republican leadership. Time after time, we have tried to bring up this critical legislation, but the Republican leadership has been willing to tie up the Senate for 10 days at a time to prevent it. Then on May 23, the House passed a minimum wage increase by a huge margin, 266 to 162. That bill came over from the House, and the majority leader—then Bob Dole, and now Senator LOTT—has refused to allow its consideration as a clean bill.

This is now our last opportunity to have the minimum wage increase considered before the day it is supposed to take effect, July 4. If the Senate does not act now, it will be turning its back on 12 million Americans, who are counting on the Congress to do the right thing for them and their families.

Tomorrow, June 25, marks the 58th anniversary of Franklin Roosevelt's signing of the first minimum wage bill. The minimum wage in the bill President Roosevelt signed established the wage at 25 cents an hour. In 1938, as today, Republicans were opposed to the minimum wage. But, ultimately, the good sense of the Congress prevailed.

It is entirely fitting that, tomorrow, Senator DASCHLE, our Democratic leader, will seek, once again, to bring the minimum wage increase to the floor, and I hope the Republican leadership will not block that effort. If it does, we will not give up. We will seek to offer the minimum wage to every bill on the Senate floor and, ultimately, I believe we will prevail, as Franklin Roosevelt did 58 years ago.

HEALTH CARE REFORM

Mr. KENNEDY. Mr. President, I will address the Senate for a few moments this evening on an issue that is before the Senate, and really before the country, and that is a question of where we are in our health care debate and discussion.

I thought this evening I would just make some brief comments to follow those of last Friday about what some of the dangers are with medical savings accounts and, in particular, what has been the record of the Golden Rule Insurance Co., which is the principal insurance company that sells medical savings accounts at the present time. I will review, briefly, what the record of that company has been over the period of the last couple of years because there have been those who have questioned whether we have been giving a fair and accurate reflection of this insurance company.

I will include in the RECORD, Mr. President, the Indianapolis Star article of June 22, just a few days ago. This is the Indianapolis Star, the home newspaper for the Golden Rule Insurance Co. I think for those that are familiar with the Indianapolis Star, there is no one here that would suggest that that was considered to be a liberal newspaper, or even a moderate newspaper. It has been one of the newspapers that have been part of the Pullian family and has prided itself in supporting very conservative candidates, with a very conservative editorial policy. This is the hometown newspaper. This is not the Democrats, who are opposed, or Republicans who are opposed to medical savings accounts. This is their hometown newspaper, blowing the whistle, so to speak, on the Golden Rule Insurance Co.

I ask unanimous consent that this article be printed in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Indianapolis Star, June 22, 1996]

GOLDEN RULE HAS A KEEN INTEREST IN INSURANCE BILL

INCLUSION OF TAX-FREE MEDICAL SAVINGS ACCOUNTS WOULD BE A SIGNIFICANT AID TO THE FIRM'S PROFITABILITY

(By Larry MacIntyre)

If you ran an insurance business and discovered that fewer and fewer people were

buying your policies, you'd probably welcome a federal law that would have the effect of paying some families a $2,000 or more bonus to buy them.

A law like that could turn sinking sales into skyrocketing sales almost overnight.

In a sense, that is what's at stake for the Indianapolis-based Golden Rule Insurance Co. as it watches the White House and Congressional Republicans haggle over putting tax-free medical savings accounts—known as MSAs—into a health-insurance reform bill jointly sponsored by Sens. Ted Kennedy, D–Mass., and Nancy Kassebaum, R–Kan.

The bill is aimed at making it easier for employees to keep health insurance when they change jobs. Until this month, President Clinton had vowed to veto it if it included MSAs, a concept that Golden Rule's former chairman, Pat Rooney, has been lobbying for tirelessly for years.

Congressional Republicans, who received more than $1 million in campaign contributions from Golden Rule and its executives before the last election, are touting MSAs as a way to bring free-market forces to bear on rising health-care costs.

Opponents of MSAs predict the device will shrink the amount of money needed for health insurance pools by instead giving it to people who stay healthy—or at least don't visit the doctor. Kennedy says MSAs will drive insurance premiums ''through the roof,'' and he singled out Golden Rule as being the ''worst abuser'' of the current system.

The prospect of MSAs appeared to be at a stalemate until two weeks ago, when the White House signaled it would be willing to include a trial program for small businesses. Now, Clinton's aides and Congressional staffers are trying to agree on how big a population would be served by the trial program.

FUTURE IN QUESTION

The answers they come up with will determine the future of Golden Rule, which is seeing steadily declining sales of individual health-insurance policies in the face of mounting competition from managed-care plans.

The company's profitability is also being squeezed as it shifts into the highly competitive group health-insurance market, which is now dominated by managed-care plans.

In its required annual report to the state, Golden Rule cited reduced revenue from health policies as the reason its net gain after taxes fell to $25.8 million in 1995—down 29 percent from the previous year.

Company officials did not return phone calls from The Indianapolis Star and The Indianapolis News seeking comment.

One reason managed-care plans are growing in popularity is that, unlike holders of Golden Rule's traditional fee-for-service policies, users of managed-care plans don't have to pay a $500 or $1,000 deductible out of pocket before the policy kicks in. Most managed-care policies provide what is known as first-dollar coverage.

The attraction of medical savings accounts is that they go one step better. People who stay healthy would get money back.

The plan pushed by Congressional Republicans calls for a three-year test. It would allow self-employed individuals and employers with 100 or fewer workers to establish tax-exempt MSAs of up to $2,000 per individual or $4,000 per family.

The catch is that money in the MSA would be tax exempt only if a companion health-insurance policy for catastrophic illness is also purchased. Deductibles for these policies could be as high as $5,000 for individuals and $7,500 for families. Choose own doctors

MSA holders could choose their own doctors and spend as much or as little as necessary from the account. At the end of the year, any money left in the MSA could be either rolled over or paid to the employee as taxable income.

At the end of the three-year test, Congress would vote on whether to expand MSAs to the rest of the nation's workers.

A RAND Corp. study published in the Journal of the American Medical Association last month estimated that 57 percent of the nation's families would choose MSAs over traditional fee-for-service policies or managed care.

If that estimate were to hold true, it would translate into a potential market of more than 50 million new customers for Golden Rule and other insurers offering catastrophic-care policies.

Last year, Blue Cross & Blue Shield of Ohio analyzed a year's worth of health claims for 38,729 family policyholders and determined that 68 percent would have qualified for money back if they had MSAs.

Assuming they had all started with $3,000 in their MSAs, their average payback would have been $2,039.

But the Ohio insurer isn't a supporter of MSAs. In fact, John Burry Jr., its chairman and chief executive officer, is one of the most outspoken and active opponents of MSAs.

Burry says the Ohio study—which he presented to the House Ways and Means Committee last year—show that MSAs have the potential to bankrupt the nation's health-care system.

''They are tailor-made for identifying healthy persons who may be profitably insured. It makes no sense for a sick person to utilize an MSA,'' Burry said in testimony to the committee.

The reason is that all the money that healthy people would get back from their MSAs—more than $50 million in the Ohio group—represents money that under current health plans is being paid into the insurance pool for their group coverage.

$50 MILLION SHORTFALL

If that money were taken out of their pool, it would create a shortfall of $50 million needed to cover the health expenses of the 32 percent of families that didn't stay healthy.

Some of those families spent in excess of $300,000 each for treatment of cancer, preterm infants or coronary problems.

While the unhealthy families represented less than a third of the study group, they accounted for 84 percent of the $159.3 million health-care costs. But under an MSA plan, the study calculated there would have been only $109 million available to cover those health costs.

Thus, the study concluded, employers would ultimately have to pay higher premiums, or sick people would have to pay more of their own costs to make up that $50 million shortfall.

Extend that economic model across the entire nation, says Burris, and the shortfall could reach $80 billion a year.

Burris' arguments have not dampened the enthusiasm among Congressional Republicans.

''MSAs deserve to become the law of the land because they represent a commonsensical, sound policy for health care,'' says Sen. Dan Coats, R-Ind. Coats is a Republican conferee pushing to keep MSAs in the health-care bill.

Supporters of MSAs range from the American Medical Association to Rush Limbaugh.

The most ardent opponent of MSAs in the Senate has been Ted Kennedy, who recently singled out Golden Rule for criticism in his written response explaining why he would not support the MSA amendment to his bill.

''It is no accident that the leading proponents of medical savings accounts are insurance companies like Golden Rule, which have been the worst abusers of the current system,'' he wrote, ''They have given millions of dollars to political candidates to try to get this business opportunity into law.''

Last fall, the nonpartisan American Academy of Actuaries, which studies insurance policy issues, also chimed in with a call for caution on MSAs.

Its report concluded: ''The greatest savings will be for the employees who have little or no health care expenditures. The greatest losses will be for the employees with substantial health care expenses. Those with high expenditures are primarily older employees and pregnant women.''

Mr. President, in the last Congress, health care reform became a highly partisan issue—and no progress was made. In this Congress, we have an opportunity to avoid the failures of the past by moving to address some of these problems on a bipartisan basis, even in this election year. The Kassebaum-Kennedy bill passed the Senate by a vote of 100 to 0. It had 66 cosponsors—with almost equal numbers from both parties. If we could send it to the President today, it would be signed by him tomorrow.

But the House Republican leadership is insisting that any health reform must be their way or no way. This nonnegotiable approach is an insult to millions of Americans who want insurance reform. It is time for the Republican leadership to stopped trying to turn a bipartisan bill that the American people need into a partisan proposal that will never be signed into law.

The Kassebaum-Kennedy insurance reform bill eliminates many of the worst abuses of the current system. It will benefit an estimated 25 million Americans a year. Today, millions of Americans are forced to pass up jobs that would improve their standard of living or offer them greater opportunities, because they are afraid they will lose their health insurance or face unacceptable exclusions for preexisting conditions. Many other Americans abandon the goal of starting their own business, because health insurance would be unavailable to them or members of their families. Still other Americans lose their health insurance because they become sick or lose their job or change their job, even when they have paid their insurance premiums for many years.

The Kassebaum-Kennedy bill addresses each of these problems. Insurance companies are limited in their power to impose exclusions for preexisting conditions. No exclusion can last for more than 12 months. Once persons have been covered for 12 months, no new exclusion can be imposed as long as there is no gap in coverage, even if they change their job, lose their job, or change insurance companies.

No workers wishing to participate in an insurance plan offered by their employer can be turned down or made to pay higher premiums because they are in poor health. If someone no longer has access to on-the-job insurance because they have lost their job or gone to work for an employer who does not

offer coverage, they cannot be denied individual insurance coverage or face exclusions for preexisting conditions when they buy a policy. The same protection is provided for children who exceed the maximum age when they can still be covered under their parents' plan.

The Kassebaum-Kennedy bill will not solve all the problems of the current system. But it will make a significant difference in increased health security for millions of Americans.

The only opposition to the Kassebaum-Kennedy bill came from those who profit from the abuses in the current system. That is why it passed the Senate unanimously. An amendment by Senators Dole and Roth that added assistance for small business, strengthened antifraud provisions—and included other useful proposals was also adopted with overwhelming bipartisan support.

But now the bill is stalled, because some Republicans insist on adding a partisan poison bill—medical savings accounts. Such accounts are a bad idea that will make our insurance system worse instead of better. They are too controversial to be included in any consensus bill.

A compromise is possible if our Republican friends are willing to have a legitimate test of the idea first, without imposing it full-blown on the country. But the so-called compromise now being offered on medical savings accounts is nothing of this kind. It is a capitulation to House Republicans, who are more interested in creating an issue and serving a special interest constituency than in passing a needed health reform bill.

Discussions are ongoing to see whether a genuine compromise can be reached. If not, we should simply pass the bipartisan bill already unanimously approved by the Senate, and consider medical savings accounts on separate legislation.

Most people do not understand what a medical savings account is, or why special interest groups are so anxious to see them included in this bill. Medical savings accounts have two parts. The first is a catastrophic, high-deductible insurance policy that requires people to incur substantial medical costs out of their own pocket before insurance kicks in. Supporters of medical savings accounts usually mean policies with deductibles of about $1,500 to $2,000 per person. There is nothing that keeps businesses and individuals from buying such policies today.

The second part of a medical savings account is a tax-free savings account that is established by an individual or an employer to pay for part of the costs that the insurance does not cover. In theory, the lower premium cost for such a policy will make savings available to put in these accounts. Proponents of medical savings accounts often present this part of the plan as if the premium savings will cover almost the whole cost of the deductible. But that's not necessarily the case.

Medical savings accounts sound too good to be true—and they are. The American Academy of Actuaries and the Urban Institute estimate that the savings will be only a fraction of the deductible—leaving families exposed to high costs they simply cannot pay.

Last week, I challenged the supporters of medical savings accounts to answer some simple questions, so that the American people can understand what the flawed Republican proposal really means. Those questions have still not been answered, because the Republicans know that their medical savings account plan cannot stand the truth in advertising test. Here's what their plan provides.

First, the Republican plan allows deductibles as high as $5,000 per individual and $7,500 per family. A family needing medical care must spend $7,500 out of their own pocket before their insurance pays a dime. I ask my Republican friends how many families can afford to pay this much for medical care, and why in the world would you give a special tax break for a policy providing such minimal protection?

Medical savings accounts are described by the advocates as providing catastrophic protection. Once you hit the cap, they say you have complete protection. Actually, almost all conventional insurance policies already have a feature like this, called a stop-loss, which caps the policyholder's out-of-pocket spending for covered services. Even among policies offered by small businesses, which are typically less generous than those provided by large companies, 90 percent have a stop-loss. And for virtually all of these plans, the stop-loss is less than $2,000.

Contrast that to the Republican plan. Protection does not even start until you have spent $5,000, and there is no stop-loss. None whatsoever. The plan allows the insurer to charge a 30-percent copayment for charges in excess of the deductible. A $40,000 doctor and hospital bill is not unusual for a significant illness or surgery. A person needing such care would owe $15,500 for bills the policy would not pay. Under the conventional plan, their costs would be limited to $2,000 or less.

Can the Republicans explain to the American people why their plan has no stop-loss provision? Can they describe the logic that says it is all right to make a family pay $7,500 before their insurance covers them at all—and then leave them exposed to unlimited additional expenses even after they have paid the first $7,500? When you ask these questions, the Republicans have no answer.

The Republicans claim that people can cover these huge gaps in their insurance protection out of their medical savings accounts. Perhaps the wealthy, who get the bulk of the tax breaks under this plan, will be able to afford high medical costs—but how are working families to set aside the $5,000, $10,000, $20,000, or more that they would need for protection in the event of a serious illness?

There is nothing in the Republican plan that requires employers to contribute even one thin dime to a medical savings account for their employees. I've asked the Republican sponsors of this provision if their plan requires employers to make any contribution to the medical savings accounts of their employees, but there has been no answer—because a truthful answer is too embarrassing.

The Republican plan has other basic flaws. Today, most insurance companies have fee schedules limiting the amount that doctors and hospitals can charge for covered services. These fee schedules generally pay less—sometimes only half as much—as the actual charges. But providers generally accept these reduced fees as payment in full.

Under a medical savings account there is no such protection. In fact, patients could find themselves in the situation of having spent $9,000 on physician and hospital care and still not have met their $5,000 deductible, because the charges the patient has to pay are higher than the insurance company's fee schedule. No wonder some doctors and hospitals love the idea of medical savings accounts.

The driving force behind medical savings accounts is the Golden Rule Insurance Co. It made more than $1 million in campaign contributions before the last election alone. In October 1994, Golden Rule delivered $416,000 in soft money to the GOP. Only two other companies gave more to Republicans during the last election cycle. Golden Rule has contributed lavishly to NEWT GINGRICH's GOPAC political action fund. No one should be under any illusions. If it were not for Golden Rule, its chairman, Patrick Rooney, and its lavish contributions, medical savings accounts would not be an issue before this Congress—and it would not be the poison pill that threatens to sink health reform legislation again.

Why does the Golden Rule Insurance Co. want this legislation? The answer is simple. Golden Rule profits by abusing the current system. They make their money by insuring the healthy and avoiding those who need coverage the most. The company is notorious for offering policies with inadequate coverage, for dropping people when they get sick, for excluding parts of the body most likely to result in an illness, and for invoking exclusions for preexisting conditions when costly claims are filed.

Insurance reform that forces companies like Golden Rule to compete fairly by providing good services at a reasonable price would put them out of business. As the Indianapolis Star said on Saturday, ''[MSAs] will determine the future of Golden Rule, which is seeing steadily declining sales of individual health insurance policies * * * In its required annual report to the State, Golden Rule cited reduced revenue

from health policies as the reason its net gain after taxes fell to $25.8 million in 1995—down 29% from the previous year.''

Golden Rule knows that its future depends on a multibillion dollar tax giveaway in the form of medical savings accounts. That is why their Republican friends in Congress are trying to force this partisan special interest proposal into the health reform bill—even at the risk of sinking the bill.

Let's look at the dishonor roll of Golden Rule policies. Like the Republican plan, MSA policies sound good until you read the fine print. Here is a policy offered by Golden Rule in Massachusetts through Americans for Tax Reform. It has no coverage for prenatal care or postnatal care. It has no coverage for most preventive services. It does not cover an emergency room visit unless you are admitted to the hospital. It does not even cover outpatient physician services, except for outpatient surgery. It does not cover outpatient prescription drugs. It does not even cover diagnostic tests unless the patient is hospitalized within 3 days.

Here is another Golden Rule policy, from Virginia. It has all the exclusions in the Massachusetts policy and adds even more gaps. There is no coverage for mental health. There is no coverage for substance abuse. There is no coverage for pregnancy and delivery—none at all. All routine and preventive care is excluded.

But even worse than the things Golden Rule explicitly does not cover is the things that it will not cover for you if they think you might get sick—or if you actually do. Here is what the policy says on page 6 of the Massachusetts policy under the heading ''pre-existing conditions.'' It says ''Pre-existing conditions will not be covered during the first 12 months after an individual becomes a covered person.'' This sounds reasonable. But listen to the fine print. ''This exclusion will not apply to conditions which are both: (a) fully disclosed to Golden Rule in the individual's application; and (b) not excluded or limited by our underwriters.''

What does this mean? It means that if, in the judgment of Golden Rule, you have not disclosed a pre-existing condition, they are not obligated to cover it after 12 months, and they reserve the option to exclude a condition from coverage forever—not just for 12 months. What does that mean in practice? It means that the protection Golden Rule promises is often a sham.

Let me read some of the cases of consumers who bought Golden Rule policies, faithfully paid their premiums, and then were told their insurance did not cover them, just when they needed it the most.

Daniel Brokaw of Roanoke, VA, was covered under a Golden Rule policy, although the policy excluded any coverage for care related to Mr. Brokaw's Tourette's disorder. Golden Rule also refused to cover Mr. Brokaw's 4-year-old son, even with a similar exclusion, because he occasionally shook his fist. Golden Rule canceled even this limited coverage when Mr. Brokaw submitted a claim for a broken arm.

Louise Mampe of suburban Chicago was diagnosed with breast cancer after having been covered by Golden Rule for 11 months. Golden Rule denied payment for $60,000 of bills and canceled her policy, saying that the breast cancer was a pre-existing condition. Mrs. Mampe had felt a ''bump'' but did not get treatment for years because she did not think it was anything serious—she had been getting similar bumps for years. Golden Rule wrote to Mrs. Mampe's widowed husband, Howard, that ''Obviously, Mrs. Mampe was the author of her own misfortune.'' Pat Rooney, head of Golden Rule, himself stated that, ''If my sister applied for her own insurance and she knew that she had felt a lump in her breast, she is not an insurable risk.''

Gwendolyn Hughes of Utah had claims relating to injuries suffered in an automobile accident denied because she had failed to list a digestive problem on her Golden Rule insurance application.

James Clark of Keithville, LA, was forced to pay for his heart by-pass surgery after Golden Rule denied his claim, saying he had not disclosed cholesterol and triglyceride levels on his insurance application.

Linda Shafer of Ramsey, IN, had her Golden Rule policy canceled after she was diagnosed with Parkinson's. The Golden Rule underwriter said Ms. Shafer failed to disclose on her application that her hands sometimes shook. Ms. Shafer said she thought this was due to the stress of going through a divorce, not ''a disorder of the nervous system such as epilepsy, convulsion, frequent headaches or mental or nervous disorders'' as listed on the application. ''Since I am not in the medical profession and could not diagnose my symptoms, I didn't even consider that I had any type of nervous disorder,'' she wrote.

Sharon Tate of Kansas City, MO, had her claim for removal of a sinus cyst denied because Golden Rule said she had to have known about the problem before taking out her policy. A court ruled against Golden Rule when it found that the company's doctor had not even looked at Ms. Tate's x-ray, although that was supposedly the justification for the claim denial.

Ana Painter of Chesterfield, IL, had her hospital bill relating to stem-cell infusion treatment for malignant ovarian cancer rejected on grounds that the treatment was ''experimental.'' Golden Rule filed a suit against Ms. Painter 5 days later—without even waiting for her to appeal the decision—asking for a legal ruling that the company did not have to pay the bill. Ms. Painter had to retain a lawyer.

James Anderle of Milwaukee, WI, had his claim for medical bills resulting from a stroke denied by Golden Rule. Golden Rule claimed Mr. Anderle had a pre-existing condition—the flu.

Carol Schreul of Aurora, IL, suffered a brain tumor, resulting in medical bills of $39,000. Golden Rule refused to pay, claiming that Ms. Schreul misrepresented her health status by listing her weight as 190 pounds when it was actually 210.

Harry Baglayan had his claim for the $49,000 in costs for heart by-pass rejected. Golden Rule argued that Mr. Baglayan had failed to disclose that he had nausea four months earlier, a pre-existing condition.

Golden Rule has adamantly opposed insurance reforms, because they know they cannot compete on a level playing field where these abusive practices are outlawed. In Vermont, they vigorously and tenaciously opposed insurance reform—and then pulled out of the State when reform was finally enacted. Golden Rule refuses to give information on their experience with MSA's that they currently offer—and it's no wonder, given what turned up in Vermont.

Here is how the State insurance commissioner described what they found when Golden Rule turned over its policies to the Blue Cross plan, which assumed responsibility for Golden Rule policyholders when it pulled out of the State.

What are the tools of an aggressive underwriter [like Golden Rule]? The first is the initial application form filled out by the consumer. Let me briefly review its scope. Item 15 of the application asks for information about health status over a 10 year period. The questions asked are very broad and refer to any disorder that the applicant may have had. How many of us have not had a headache or diarrhea or a bad stomach ache over the past ten years?

Another tool used more aggressively by Golden Rule than by other insurers is the exclusion. This is a limitation placed on the policy to exclude coverage for a particular individual, condition, disease, etc. When Golden Rule withdrew from Vermont, most of its insured elected to become members of Blue Cross and Blue Shield of Vermont under the safety net program I discussed earlier. As a result, the safety-net program allows unique access to information about the Golden Rule Policies.

Of the approximately 5,000 Vermont Golden Rule policyholders who joined the safety-net, approximately 25 percent had some type of exclusion under their Golden Rule policies. In the initial study done by Blue Cross and Blue Shield, 1,024 Golden Rule policies have 1,245 separate exclusions added to their policies.

Blue Cross and Blue Shield also compiled a list of more than 81 exclusions used by Golden Rule. These include the exclusion of whole body parts, such as arms, backs, breasts, knees, legs, hands, skin.

A particularly disturbing practice of Golden Rule was to selectively underwrite newborn children of individuals holding individual rather than family policies. After providing the 30 day coverage of newborn children mandated by Vermont law, Golden Rule would only extend coverage if the newborn was healthy.

Mr. President, I ask that the full text of this letter be entered in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

STATE OF VERMONT,
DEPARTMENT OF BANKING,
INSURANCE AND SECURITIES.

[Memorandum]

To: John D. Dingell, Chairman, Subcommittee on Oversight and Investigations.
From: Thomas R. Van Cooper, Director of Insurance Regulation.
Date: June 27, 1994.
Subject: Vermont Health Care Reform Initiatives.

INTRODUCTION

Good morning. My name is Thomas Van Cooper. I am the Director of Insurance Regulation for the state of Vermont. I want to thank you, Mr. Chairman and members of the subcommittee, for the opportunity to discuss Vermont's health insurance reforms. In particular, the requirements that health insurers use community rating and that they guarantee acceptance of all applicants, in the small group (1–49 employees) market as of July 1, 1992, and in the individual market as of July 1, 1993. I understand that the committee is interested in Golden Rule Insurance Company. Many of the issues surrounding Golden Rule, regarding both its conduct and its positions on health insurance, can probably be best addressed by reviewing more generally the issues Vermont faced in its individual and small group markets.

An important finance issue that Vermont confronted in its effort to obtain health care reform involved the impact of insurers employing aggressive underwriting techniques that either explicitly excluded some Vermonters from the marketplace or effectively did so by pricing such individuals out of the marketplace. The cost of care for individuals forced out of the marketplace is borne by other taxpayers and insureds, whether through tax based social programs or by less easily identified shifts of uninsured and underinsured costs to the private insurance marketplace. Since Vermont had a social contract to provide health care to all citizens regardless of their ability to pay, it needed a fair insurance mechanism for financing health care.

* * * * *

Did insurers leave the state as a result of the reforms? Sure, some chose to leave, including Golden Rule. However, other insurers took their place, recognizing the opportunity to do business and make a fair profit in Vermont. Today Vermont has 17 carriers competing in the small group market and 9 carriers in the individual market. Now that may not sound like a lot, but Vermont only has 560,000 citizens and in fact, we now have more carriers actively competing for business than before the reform measures. More significantly, we now have much more capacity, since every one of these carriers will take all comers. I have attached a list of the companies doing business and some of the prices for products they are selling. See Attachment D.

In sum, the reforms in Vermont have been a success. The consumer can have confidence in a stable and rationale marketplace in which coverage is guaranteed and available at a fair price. In fact, prices are low, and competition among insurers for business is high. During the legislative debate, the HIAA and Golden Rule rolled out their actuaries and experts to explain why the reforms would not work. But rather than fall prey to the numbers game in which one actuary battles another, we relied on common sense and looked to the definition of insurance for guidance. Insurance is not about risk avoidance. It is about the pooling of risk.

GOLDEN RULE

Before discussing Golden Rule and its behavior in Vermont, I want to state that the company did not violate any Vermont laws by its conduct. I believe that its underwriting practices, however, were instrumental in creating the support that led to the passage of reform legislation in Vermont that rendered its type of underwriting illegal.

What are the tools of an aggressive underwriter? The first is the initial application form filled out by a consumer. I have attached a copy of a Golden Rule form. See Attachment E. Let me briefly review its scope. Item 15 of the application asks for information about health status over a ten-year period. The questions asked are very broad and refer to any disorder that the applicant may have had. How many of us have not had a headache or diarrhea or a bad stomach ache over the past ten years?

Another tool used more extensively by Golden Rule than by other insurers is the exclusion. This is a limitation placed on the policy to exclude coverage for a particular individual, condition, disease, etc. When Golden Rule withdrew from Vermont, most of its insureds elected to become members of Blue Cross and Blue Shield of Vermont under the safety-net program I discussed earlier. As a result, the safety-net program allows unique access to information about Golden Rule policies.

Of the approximately 5,000 Vermont Golden Rule coverage policyholders who joined the safety-net, approximately 25 percent of them had some type of exclusion under their Golden Rule policies. In an initial study done by Blue Cross and Blue Shield, 1,024 Golden Rule policyholders had 1,245 separate exclusions added to their policies. I have attached some examples of these policy exclusions. See Attachment F. I will review a few of them.

Subscriber B applied for health insurance from Golden Rule on September 18, 1991. The subscriber had been treated by a physician in June of 1991 for bumps on the skin that were determined to be fatty deposits of no concern. Golden Rule excluded any loss incurred resulting from any form of tumor or tumorous growth, including complications therefrom or operation therefor. The exclusion was in force at the time Golden Rule terminated coverage on November 1, 1992.

Subscriber C also treated with aspiration of fluid in benign cysts located in breasts. Golden Rule excluded any loss incurred resulting from any disease or disorder of the breasts, including complications therefor. This included any reconstructive surgery or complications of reconstruction surgery. The exclusion was in force at the time Golden Rule terminated coverage on July 19, 1993.

Subscriber F applied for health insurance from Golden Rule on January 15, 1992. The subscriber, a self-employed commercial painting contractor, indicated no experience with back problems. Golden Rule excluded any loss incurred resulting from any injury to, disease or disorder of the spinal column, including vertebrae, intervertebral discs, spinal cord, nerves, surrounding ligaments and muscles, including complications therefrom or operation therefor. The exclusion was in force at the time Golden Rule terminated coverage on March 1, 1993.

Blue Cross and Blue Shield also compiled a list of more than 81 exclusions used by Golden Rule. These include the exclusion of whole body parts, such as arms, backs, breasts, hips, knees, legs, hands, skin, testes and so on. I think the list speaks for itself. See Attachment G.

A particularly disturbing practice of Golden Rule was to selectively underwrite newborn children of individuals holding individual rather than family policies. After providing the 30 day coverage of newborn children mandated by Vermont law, Golden Rule would only extend coverage if the newborn was healthy.

SUMMARY

Community rating and guarantee issuance represent good social policy, good insurance policy and good business policy. The Vermont legislature quickly saw through the self-interested doomsday prophesies of the commercial industry about radical price increases and the destruction of Vermont's insurance market, and instead recognized that there was no reason insurers could not make a fair profit playing on a level playing field, where they could compete on the quality of service they provided and the management of costs rather than the avoidance of risk. Vermont consumers need no longer worry about whether they will be able to have access to this essential product.

Mr. KENNEDY. Mr. President, these shameful practices are not unique to Vermont. In Kentucky, consumer complaints against Golden Rule were twice as high as against other companies. In New Hampshire, where no systematic survey was done, a State legislator reported his son had a foot injury as a small child and Golden Rule's coverage of him as a young adult excludes everything on the right leg before the knee. In Florida, the insurance department reported that Golden Rule's rate increases exceeded those of other carriers by a wide margin. People were insured at a low rate when they were healthy, and then their premiums were raised through the roof when they became sick. And Consumer Reports ranked Golden Rule near the bottom in a nationwide survey of insurance companies.

No wonder Golden Rule wants medical savings accounts. They can only compete when the rules of the game are rigged against consumers. They can only profit by perverting insurance into a method of taking premium dollars from the healthy and avoiding paying benefits to the sick. The American public is coming to understand why a company like Golden Rule favors medical savings accounts, and why they have no place in legislation that is designed to make health insurance work better for consumers, not worse.

I have placed into the RECORD editorials from a number of leading newspapers around the country pointing out the dangers of medical savings accounts and urging the passage of a bipartisan insurance reform bill without this poison pill. The editorials included the Washington Post, May 8, 1996, ''Dubious Crusade for Medical Savings Accounts''; the Los Angeles Times, June 6, 1996, ''U.S. Deserves This Health Reform''; the New York Times, May 30, 1996, ''Mr. Dole's Health-Care Task''; the Dallas Morning News, April 21, 1996, ''No Cure-All, Medical savings accounts present a flawed solution''; the Baltimore Sun, April 25, 1996, ''Another Chance for health care reform''; the Washington Post, June 3, 1996, ''Senator Dole's Final Business''; the News Tribune (Tacoma, WA), June 13, 1996, Stick to Basics in New Health Bill''; the San Francisco Chronicle, June 10, 1996, ''Health Care Reform/Key Test for Dole''; the Harrisburg Patriot, April 3, 1996, ''Too Much Reform''; the Columbus Dispatch, June 12, 1996, '''Clean'

Health Bill; Get Rid of Those Two Killer Amendments''.

Today, I would like to place additional editorials in the RECORD demonstrating the broad public opposition to MSA's and the desire for people across the country for passage of a clean, bipartisan insurance reform bill.

There being no objection, the editorials were ordered to be printed in the RECORD, as follows:

[From the Seattle Times, June 17, 1996]

POINTLESS STALEMATE HALTS HEALTH-INSURANCE REFORM

The near demise of the Kennedy-Kassebaum health-insurance bill shows how little Congress now cares about solving the real-life problems of millions of working Americans.

The Kennedy-Kassebaum bill, a modest piece of legislation, would allow people moving from one job to another the right to transfer their insurance coverage and provide more protection for individuals with pre-existing medical conditions. It is an incremental step toward broadening and stabilizing health care access.

At one time, the bill's enactment was cheered on by both Democrats and Republicans. President Clinton endorsed the bill in his State of the Union address. The Senate passed it unanimously; the House's version sailed through too.

Now, this plan is about to be sacrificed to politics of the crassest sort. Both Sens. Edward Kennedy and Nancy Kassebaum were adamant from the beginning that their bill would win passage only if it were limited to the noncontroversial portability and pre-existing provisions. And yet, both Senate and House versions were eventually loaded with dubious amendments.

After weeks of negotiations, most of those add-ons have been stripped off. Now, medical savings accounts (MSAs) allowed in the House version but not in the Senate bill remain the heart of the controversy.

Kennedy, a strong opponent of the MSA concept, will agree only to a pilot program to test the impact of MSAs on health-insurance rates. The Republicans, however, insist on making MSAs available immediately to roughly 30 million Americans working in small businesses, with all others becoming eligible in 2000 unless Congress votes to stop the expansion. The Clinton administration opposes immediate, broad MSA implementation.

The MSA issue is highly controversial and has nothing to do with insurance reform. Some claim these tax-free savings accounts will help control overall health-care spending. Others argue MSAs would siphon healthy people out of the traditional insurance market, thereby leaving sicker people with higher insurance premiums.

Congress will have every opportunity to wrestle with MSAs in coming months; the issue could even pop up in the presidential campaign. If MSAs are good innovations, Congress can pass them on a separate track.

There is absolutely no reason to hold the Kennedy-Kassebaum bill hostage to MSAs. Let a good, widely supported insurance-reform measure pass standing alone.

[From the St. Louis Post-Dispatch, June 1, 1996]

REVIVE THE HEALTH INSURANCE DEBATE

President Bill Clinton's promise to put health insurance issues back on the national agenda, perhaps during his re-election campaign, is welcome. Since Congress killed his initial health-care proposal, the president has shied away from the issue even though the ranks of uninsured Americans have eclipsed the 40-million mark.

Voter concern about health costs is high, judging from findings of a Louis Harris survey commissioned by the Robert Wood Johnson Foundation. The survey included separate polls in 15 cities, including St. Louis, as well as a national poll.

Though giving managed care high marks for containing medical costs, 90 percent of St. Louisians predict nevertheless that their own out-of-pocket costs for medical expenses will continue to rise. Moreover, they expect taxpayers to pay more than they do now to cover medical costs for the elderly and the indigent. Another 44 percent express worry about being hit with expensive medical bills that their health insurance won't cover.

Overall, the views of the 300 St. Louis households in the survey mirrored those of the 605 households in the national sample. St. Louisians did have more misgivings about health care in some key areas. Only 40 percent, compared to 48 percent in the national sample, felt that managed care would improve the quality of health care. Another 45 percent reported worrying that they won't be able to pay for nursing-home care when they or a family member needed it, compared with 38 percent in the national sample.

Some of these numbers suggest that Congress is tackling the wrong health-insurance issues. The Kennedy-Kassebaum bill to protect health benefits of workers who change jobs or face a serious illness is a good one. A House bill also includes these provisions, along with the misguided plan to give Americans the choice of opening so-called medical savings accounts to cover some of their health expenses.

In fact, these accounts generally would give tax breaks to wealthy Americans, who need them least; moreover, the accounts would do nothing to help the uninsured, notwithstanding claims by GOP leaders. If many working Americans are too poor to buy health insurance, what makes the party think these workers would be able to put aside money for a medical savings account?

The Harris poll results show that voters deserve some plausible answers to this question. They also deserve to know what each party intends to do not only to protect the health benefits of the insured but to extend benefits to those who are not.

[From the Pittsburgh Post-Gazette, May 7, 1996]

MODEST OR REVOLUTIONARY? THE KENNEDY-KASSEBAUM HEALTH LEGISLATION MAY BE BOTH

Depending on who is doing the talking, the Kennedy-Kassebaum health reform proposal is either so minimalist it is meaningless, or so enormous it's revolutionary.

Both assertions may be true.

On the face of it, the bill makes it legally possible for people to change jobs or lose their job and still maintain health coverage. The bill, separate versions of which have passed the House and Senate, ensures that workers who change jobs will not have to wait around for years before being covered under their new employers' insurer.

Gone would be exclusions based on pre-existing medical conditions. Also, workers who lose their jobs or move to new jobs without health benefits would be guaranteed the opportunity to purchase an individual policy through their previous insurer.

The bill does not cap premiums, however, so it is possible that the individual coverage that is legally available may be financially out of reach, particularly for people with a pre-existing condition.

The Kennedy-Kassebaum tinkering could free millions of people who are currently in job-lock because of their dependence on health coverage. And it opens up the insurance pool to millions more who are now closed out due to some illness. But because of the costs involved, it seems unlikely that it would have much of an impact on the 40 million Americans without coverage.

That's why many analysts consider it all but insignificant.

Those who believe the contrary, that this proposal is revolutionary, do not think the bill itself will turn the world upside down. Rather, they believe that it will lead inexorably to massive government involvement in writing the rules for health care.

In their scenario, throwing coverage open to sick people will learn to sharply higher premiums and result in a public backlash. Voters will turn up the heat on Congress to further regulate the insurance market. What started out as a piecemeal reform will, in the long-run, lead to systemic change.

We do not imagine that the 100 senators who voted in favor of the bill foresee revolution as a consequence. But even if that analysis is on target, it does not argue against the proposal.

Everyone agrees that being sick should not preclude an individual from obtaining health coverage. Indeed, sick people have the most immediate need for insurance. If it is impossible for the nation's health-care system to extend coverage to that group, then there is something deeply wrong with the system.

If the bill sponsored by Kansas Republican Nancy Kassebaum and Massachusetts Democrat Edward M. Kennedy plugs the hole, great. If it exposes a more widespread problem. Congress should be grateful for the knowledge and then move to fix it.

All that said, and despite the massive bipartisan support for the bill, it is not a sure thing. The conference committee must first deal with three potential deal-breakers.

The House version includes tax-exemption for Medical Savings Accounts, which are sort of a health-care IRA, and for a cap on medical malpractice awards. If these measures find their way into the final bill, President Clinton has threatened a veto. The Senate version includes a requirement to raise the caps on mental health treatment to provide the same lifetime limits as other forms of treatment. Many in the business community fear the cost ramifications of this proposal.

We have mixed feelings about the three proposals—thumbs down on Medical Savings Accounts, proceed cautiously with malpractice reform, thumbs up for treatment parity—but we don't believe any of them should be allowed to block passage of the more modest first step originally promised by Kennedy-Kassebaum.

Whether it's a revolution or a tentative first step, it's the most Congress has been able to manage and the least the American public deserves.

[From the New York Times, June 22, 1996]

WHITE HOUSE WAFFLING ON HEALTH

The White House and Congressional Republicans are negotiating over the G.O.P.'s demand to include medical savings accounts as part of healthcare reform. The White House once threatened to veto a bill that included these accounts. But now it is merely quibbling over details. The Administration needs to regain its sense of principle. The fight over medical savings accounts goes to the heart of the health-care debate. No one can say for sure what damage the accounts would cause. But they threaten to divide rich from poor, healthy from sick, young from old.

The Republicans propose to permit families who buy catastrophic coverage—policies with high deductibles—to make tax-free deposits to a savings account. The account

would be used to pay routine bills. Savings could be withdrawn after age 59½ and taxed as ordinary income.

Proponents say the accounts would discourage waste because initial outlays would come from personal savings. The accounts would also provide coverage without herding people into managed care or government coverage. But critics point out that the accounts will appeal mostly to wealthy people because they can afford steep deductibles, and healthy people because they can expect to save money on a tax-free basis. The accounts would encourage healthy people to split off from traditional coverage, leaving the chronically ill to buy coverage at sky-high rates.

Yet good health can be transitory, giving holders of medical savings accounts a false security. Once they become ill, they may regret having given up traditional coverage. Indeed, they may try to manipulate the system by hopping back into traditional coverage when they expect large bills. The better alternative is for all Americans to buy coverage together, creating a vast pool of customers that will guarantee affordable premiums for everyone regardless of medical condition.

The Administration understands the problem, but wants to walk into November having signed a health-care bill. It is covering its tracks by saying that all it is negotiating is a pilot program. But the Republicans plan to offer the accounts to tens of millions of employees at small businesses. After three years, Congress will be asked to make the accounts permanent and universal.

It is thus highly likely that today's experiment will become tomorrow's permanent program. The vast majority of Americans are healthy. Because they will profit from a medical savings account, at least in the short term, they will resist any effort by Congress to strip them of their tax-free benefit. A true test of the savings accounts would be limited in size and require at least six years—enough time to observe what happens when sizable numbers of account-holders become chronically ill. A valid test would also experiment with different formulations in order to test what plan works best.

In 1993, the White House stood for the principle of covering every American through common insurance pools. That was a fine principle, even if the legislation it proposed proved to be a medical monstrosity and a political albatross. Now the Administration seems to be heading in the opposite direction, where fortunate individuals take care of themselves and leave others to do as best they can.

Mr. KENNEDY. The Seattle Times stated on June 17,

> There is absolutely no reason to hold the Kennedy-Kassebaum bill hostage to MSAs. Let a good widely supported insurance reform measure pass standing alone.

The St. Louis Post-Dispatch said on June 1,

> The Kennedy-Kassebaum bill to protect health benefits of workers who change jobs or face a serious illness is a good one. A House bill also includes these provisions, along with the misguided plan to give Americans the choice of opening so-called medical savings accounts to cover some of their health expenses. In fact, these accounts would give tax breaks to wealthy Americans, who need them least; moreover, the accounts would do nothing to help the uninsured, notwithstanding claims by GOP leaders. If many working Americans are too poor to buy health insurance, what makes the party think these workers would be able to put aside money for a medical savings account?

The Pittsburgh Post-Gazette said on May 7,

> Thumbs down on Medical Savings accounts . . . [They] should not be allowed to block passage of . . . Kennedy-Kassebaum.''

The Star-Ledger of Newark, NJ, said on May 29,

> Kennedy-Kassebaum was supposed to guarantee that workers can take their employee health benefits with them when they are downsized, out-sourced, or otherwise put out of a job. Since then, a horde of amendments have been added . . . Some are bad, such as the proposal for medical savings accounts, a new tax shelter for the wealthy. None of them . . . should have been tagged on to the Kennedy-Kassebaum bill, and you have to wonder whether some of those supporting these add-ons might not be out to sink the measure under the weight of the amendments.

The St. Petersburg Times said on June 11,

> Dole claims to support the major provisions of the Kassebaum-Kennedy legislation . . . However, Dole and other Republicans have insisted on weighing the bill down with a provision that would create tax-deductible Medical Savings Accounts—a radical plan to subsidize wealthy taxpayers that could threaten the solvency of insurance plans for less affluent Americans.

And just last Saturday, the New York Times wrote,

> The fight over medical savings accounts goes to the heart of the health care debate. No one can say for sure what damage the accounts would cause. But they are threatening to divide rich from poor, healthy from sick, young from old.

These editorials are just a sampling of commentary around the Nation. There is no clamor for medical savings accounts, except from the special interests who see yet another opportunity to profit at the expense of people who need medical care. Indeed, responsible voices throughout the country urge rejection of this dangerous and untested idea. It is time for Republicans to stop playing special interest politics with health insurance reform. The Kassebaum-Kennedy bill passed by a bipartisan vote of 100 to 0. It should not be blocked because some Republicans want to line the pockets of their campaign contributors. Health insurance reform is too important to become just another election year casualty of extremist Republican political tactics.

Mr. President, the MSA's are a golden lifeboat for Golden Rule's sinking ship. If we have ever had a classic bailout for private special interests, this is it. This is not what I am saying here tonight. It is what the hometown newspaper of Golden Rule, a conservative newspaper, has described it as, and in the meantime, the Republican leadership is refusing to let us get what has been agreed on, a bipartisan program signed by the President of the United States into law, because we are being held hostage to Golden Rule Insurance Co. That is the fact of the matter. Of course, they want their hand in the Federal Treasury. Of course, they want the American taxpayers to bail them out. Who would not, with declining sales in this market, and you can understand why they have declining sales.

It is time for Republicans to stop playing special interest politics with health insurance reform. The Kassebaum-Kennedy bill passed by a bipartisan vote of 100 to nothing. It should not be blocked because some Republicans want to line their pockets with campaign contributions. Health insurance reform is too important to become just another election year issue.

Mr. President, I hope that we are going to be able to see that this legislation is passed. We welcome the opportunity, as we did last Friday and this evening, to point out the flaws both of the companies that have been receiving and would receive the benefits from this effective tax giveaway.

The Joint Economic Committee estimated that if there was going to be a million Americans who were going to participate in this program, the costs to the Federal Treasury in 10 years is $3 billion—for 1 million people. And you have 120 million Americans who are working and you have their family members. The Republican proposals would include all the companies with employees of less than 100, some 47 million working, a third of all Americans, in a program that is untested, untried. You can imagine what that would mean in terms of opening up the Federal Treasury.

There is no justification, there is no rationale, there is no reason, there is no meaning to deny 25 million Americans who have these preexisting conditions the protection that they need and their families deserve. We have a responsibility to do it. We have developed bipartisan legislation. Release the hold that these insurance companies have on the Republican leadership and let us do something decent for the American people and for hard-working families across this country.

Mr. President, I yield the floor.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate is adjourned until 9:30 a.m., Tuesday, June 25.

Thereupon, at 6:58 p.m., the Senate adjourned until Tuesday, June 25, 1996, at 9:30 a.m.