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House of Representatives

The House met at 10 a.m. and was called to order by the Speaker pro tempore [Mr. HEFLEY].

DESIGNATION OF THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC,
July 31, 1996.

I hereby designate the Honorable JOEL HEFLEY to act as Speaker pro tempore on this day.

NEWT GINGRICH,
Speaker of the House of Representatives.

PRAYER

The Chaplain, Rev. James David Ford, D.D., offered the following prayer:

As the rain waters the grass and the crops bring forth their fruit, and the light of the Sun makes clear the path and Your Spirit, O God, flows from on high, so nourish our spirits and make clear our path this day. Without Your light, O gracious God, and without the nurture of Your abiding presence, how will we know the way and the truth. So we pray, O God, that Your blessings will abound in our hearts and minds and spirits that we will be Your people and do those good things that honor You and serve people in their need. This is our earnest prayer. Amen.

THE JOURNAL

The SPEAKER pro tempore. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

Mrs. SCHROEDER. Mr. Speaker, pursuant to clause 1, rule I, I demand a vote on agreeing to the Speaker's approval of the Journal.

The SPEAKER pro tempore. The question is on the Chair's approval of the Journal.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mrs. SCHROEDER. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 302, nays 85, answered ''present'' 1, not voting 45, as follows:

[Roll No. 373]

YEAS—302

Allard
Andrews
Archer
Armey
Bachus
Baesler
Baker (CA)
Baker (LA)
Ballenger
Barcia
Barr
Barrett (NE)
Barrett (WI)
Bartlett
Barton
Bass
Bateman
Beilenson
Bentsen
Bereuter
Berman
Bevill
Bilbray
Bilirakis
Bishop
Bliley
Blumenauer
Blute
Boehlert
Boehner
Bonilla
Borski
Boucher
Brewster
Browder
Bryant (TN)
Bryant (TX)
Bunning
Burr
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cardin
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clement
Clinger
Coble
Coburn
Collins (GA)
Combest
Condit
Conyers
Cooley
Cox
Cramer
Crane
Crapo
Cremeans
Cubin
Cummings
Cunningham
Danner
Davis
de la Garza
DeLay
Dellums
Deutsch
Dickey
Dicks
Dingell
Dixon
Doggett
Dooley
Doolittle
Dreier
Duncan
Dunn
Edwards
Ehlers
Ehrlich
Eshoo
Ewing
Farr
Fawell
Fields (LA)
Fields (TX)
Flanagan
Foley
Forbes
Fowler
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Frost
Furse
Gallegly
Ganske
Gejdenson
Gekas
Gilchrest
Gilman
Goodlatte
Goodling
Gordon
Goss
Graham
Greene (UT)
Greenwood
Hall (TX)
Hamilton
Hancock
Hansen
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hobson
Hoekstra
Hoke
Holden
Hostettler
Houghton
Hoyer
Hyde
Inglis
Jackson-Lee (TX)
Johnson (CT)
Johnson (SD)
Johnson, E. B.
Johnson, Sam
Johnston
Kaptur
Kasich
Kelly
Kennedy (MA)
Kennelly
Kildee
Kim
King
Kingston
Kleczka
Klink
Klug
Knollenberg
Kolbe
LaHood
Lantos
Largent
LaTourette
Laughlin
Lazio
Leach
Lewis (CA)
Lightfoot
Linder
Lipinski
LoBiondo
Lofgren
Lucas
Luther
Manton
Manzullo
Markey
Martinez
Martini
Mascara
Matsui
McCarthy
McCollum
McHale
McHugh
McInnis
McIntosh
McKeon
McKinney
Meek
Metcalf
Meyers
Mica
Millender-McDonald
Miller (CA)
Miller (FL)
Minge
Mink
Moakley
Molinari
Mollohan
Montgomery
Morella
Murtha
Myers
Myrick
Nadler
Nethercutt
Neumann
Ney
Norwood
Nussle
Obey
Olver
Orton
Owens
Oxley
Packard
Parker
Pastor
Paxon
Payne (VA)
Peterson (FL)
Peterson (MN)
Petri
Porter
Portman
Pryce
Quillen
Quinn
Radanovich
Rahall
Rangel
Reed
Regula
Rivers
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Roukema
Roybal-Allard
Royce
Salmon
Sanford
Sawyer
Saxton
Scarborough
Schaefer
Schiff
Schumer
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Skeen
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Solomon
Souder
Spence
Stark
Stearns
Stenholm
Stokes
Studds
Stump
Stupak
Tanner
Tate
Tauzin
Tejeda
Thomas
Thornberry
Thornton
Thurman
Tiahrt
Torres
Towns
Traficant
Upton
Velazquez
Vucanovich
Walker
Walsh
Wamp
Watt (NC)
Waxman
Weldon (FL)
Weldon (PA)
White
Whitfield

☐ This symbol represents the time of day during the House proceedings, e.g., ☐ 1407 is 2:07 p.m.
Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

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Wicker	Wilson	Wynn
Williams	Woolsey	Zeliff

NAYS—85

Abercrombie	Gibbons	Payne (NJ)
Baldacci	Green (TX)	Pickett
Becerra	Gutierrez	Pomeroy
Bonior	Gutknecht	Poshard
Brown (CA)	Hall (OH)	Ramstad
Brown (FL)	Hastings (FL)	Rose
Brown (OH)	Hefner	Rush
Bunn	Heineman	Sabo
Clay	Hilliard	Sanders
Clyburn	Hinchey	Schroeder
Collins (IL)	Hutchinson	Scott
Costello	Jackson (IL)	Skaggs
Deal	Jacobs	Stockman
DeFazio	Jefferson	Taylor (MS)
DeLauro	Jones	Thompson
Doyle	Kennedy (RI)	Torkildsen
Durbin	LaFalce	Vento
English	Latham	Visclosky
Ensign	Levin	Volkmer
Evans	Lewis (GA)	Ward
Everett	Lewis (KY)	Waters
Fattah	Lowey	Watts (OK)
Fazio	Maloney	Weller
Filner	McDermott	Wise
Foglietta	McNulty	Wolf
Fox	Menendez	Yates
Funderburk	Neal	Zimmer
Gephardt	Oberstar	
Geren	Pallone	

ANSWERED ''PRESENT''—1

Harman

NOT VOTING—45

Ackerman	Gillmor	Moran
Bono	Gonzalez	Ortiz
Brownback	Gunderson	Pelosi
Burton	Hilleary	Pombo
Chapman	Horn	Richardson
Clayton	Hunter	Riggs
Coleman	Istook	Roth
Collins (MI)	Kanjorski	Serrano
Coyne	Lincoln	Sisisky
Diaz-Balart	Livingston	Spratt
Dornan	Longley	Talent
Engel	McCrery	Taylor (NC)
Flake	McDade	Torricelli
Ford	Meehan	Young (AK)
Frank (MA)	Moorhead	Young (FL)

□ 1021

So the Journal was approved.

The result of the vote was announced as above recorded.

PLEDGE OF ALLEGIANCE

The SPEAKER pro tempore (Mr. HEFLEY). Will the gentleman from Ohio [Mr. CHABOT] come forward and lead the House in the Pledge of Allegiance.

Mr. CHABOT led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Lundregan, one of its clerks, announced that the Senate had passed without amendment a bill of the House of the following title:

H.R. 3663. An act to amend the District of Columbia Self-Government and Governmental Reorganization Act to permit the Council of the District of Columbia to authorize the issuance of revenue bonds with respect to water and sewer facilities, and for other purposes.

The message also announced that the Senate had passed, with an amendment in which the concurrence of the House is requested, a bill of the House of the following title:

H.R. 3816. An act making appropriations for energy and water development for the fiscal year ending September 30, 1997, and for other purposes.

The message also announced that the Senate insists upon its amendment to the bill (H.R. 3816) ''An act making appropriations for energy and water development for the fiscal year ending September 30, 1997, and for other purposes,'' requests a conference with the House on the disagreeing votes of the two Houses thereon, and appoints Mr. DOMENICI, Mr. HATFIELD, Mr. COCHRAN, Mr. GORTON, Mr. MCCONNELL, Mr. BENNETT, Mr. BURNS, Mr. JOHNSTON, Mr. BYRD, Mr. HOLLINGS, Mr. REID, Mr. KERREY, and Mrs. MURRAY to be conferees on the part of the Senate.

The message also announced that the Senate disagrees to the amendments of the House to the bill (S. 1260) ''An act to reform and consolidate the public and assisted housing programs of the United States, and to redirect primary responsibility for these programs from the Federal Government to States and localities, and for other purposes,'' agrees to a conference asked by the House of Representatives on the disagreeing votes of the two Houses thereon, and appoints Mr. D'AMATO, Mr. MACK, Mr. FAIRCLOTH, Mr. BOND, Mr. SARBANES, Mr. KERRY, and Ms. MOSELEY-BRAUN to be the conferees on the part of the Senate.

PERSONAL EXPLANATION

Mr. NADLER. Mr. Speaker, on rollcall vote 359 I was incorrectly recorded as voting ''no.'' I intended to vote ''aye.''

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will entertain fifteen 1-minutes per side.

REFORM WELFARE NOW

(Mr. CHABOT asked and was given permission to address the House for 1 minute.)

Mr. CHABOT. Mr. Speaker, in 1992, Bill Clinton portrayed himself as a new Democrat. One of the things that was supposed to set him apart from the old Democrats was the belief shared by many people of goodwill that the welfare system was a mess, that it was broken and needed to be fixed.

After two vetoes, we are now told that Bill Clinton may finally be prepared to sign a welfare reform package. If that is true, it is a very positive development. America needs, no, Americans demand serious, genuine welfare reform, and I frankly do not care who gets the credit. I do not care if it is the Republican Party or the new Democrats or the old Democrats or the blue dogs or the yellow dogs or the man on the moon. That part of it does not matter and does not change the fact that we desperately need to change welfare so that it honors family and it honors work. Mr. Speaker, reforming welfare is the right thing to do, it is the commonsense thing to do, and I say let us get it done now, no matter who gets credit for it.

COMMEMORATING THE F–111

(Mr. PETE GEREN of Texas asked and was given permission to address the House for 1 minute.)

Mr. PETE GEREN of Texas. Mr. Speaker, I rise to commemorate the end of an era in U.S. aviation history. This past weekend at a ceremony in Fort Worth, TX, the F–111 was retired and officially named the ''Aardvark,'' the nickname given it by the pilots that flew it. This ceremony commemorated the accomplishments of this great aircraft from its first flight in 1964 to its honorable service in the gulf war and its revolutionary impact on military aviation technology around the world.

The F–111 served this Nation in the war in Vietnam, the bombing of terrorist targets in Libya, and during Operation Desert Storm. In November 1966, the F–111 set a record for the longest low-level supersonic flight, and it was the first tactical aircraft to fly across the Atlantic Ocean without refueling.

Additionally, the F–111 was the first plane equipped with swing wing technology that allowed it to take off and land on a short 2,000-foot runway while still being able to reach supersonic speeds at a variety of altitudes with wings swept back.

Mr. Speaker and my colleagues, join me in celebrating the men and women who built this great aircraft, a bird that served our Nation and the free world for over 30 years and now takes its place among other great Texas built military aircraft like the B–24 Liberator and the B–58 Hustler.

PRESIDENT SHOULD SIGN WELFARE REFORM BILL

(Mr. CHRYSLER asked and was given permission to address the House for 1 minute.)

Mr. CHRYSLER. Mr. Speaker, welfare cases in Michigan are down significantly, but more importantly, parents are working to provide for their own families in setting examples for their children to follow. Currently the State of Michigan is waiting on 76 additional waivers from the President to fully implement their welfare plan.

The enactment of the Personal Responsibility and Work Opportunity Act would largely end the need for these waivers and allow Michigan to proceed with their reforms, truly helping the disabled and the people that need our help in restoring the basic human dignity and pride that comes from bringing home a paycheck and providing care for your family.

However, if the President fails to approve these reforms for the third time, it is the children who will suffer and

these children should not be left hostage any longer to elected officials breaking their promises.

Mr. Speaker, I urge the President to sign the welfare reform today and truly end welfare as we know it.

PRESIDENTIAL CANDIDATES SHOULD FOCUS ON REAL ISSUES, NOT NEGATIVE CAMPAIGN ADS

(Mr. SANDERS asked and was given permission to address the House for 1 minute.)

Mr. SANDERS. Mr. Speaker, at a time when this country has the lowest voter turnout of any major country and millions of Americans are giving up on the political process, it is imperative that the presidential candidates in this election focus their attention on the real issues facing the middle class and the working families and not devote their energy to negative 30-second television ads.

□ 1030

This country has some terribly serious problems, and the American people want to hear those problems discussed. For example, why does this Nation have the most unfair distribution of wealth and income of all industrialized nations on Earth? Why is the gap between the rich and the poor growing wider while the middle class continues to shrink?

What do we do to reverse the trend by which real wages for working people continue to decline and today are 16 percent less than they were 20 years ago with workers now working longer and longer hours just to provide for their families?

What do we do about the reality that most of the new jobs that are being created are poverty level jobs? Let us talk about the real issues.

CHILDREN ARE WAITING FOR WELFARE REFORM

(Mr. BARTLETT of Maryland asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BARTLETT of Maryland. Mr. Speaker, how much longer should America wait before we rescue the millions of children who are trapped in poverty by the current welfare system?

Shouldn't we be encouraging work, marriage, and family instead of discouraging them?

How many more children, communities, and cities must we lose to poverty and violence before we say enough is enough?

When it comes to welfare reform, President Clinton has become the maybe man.

Maybe he'll end welfare as we know it and maybe he won't.

Should we trust what the President has said?

Or should we judge the President by what he's done?

The President's record on welfare is two vetoes and delays and denials of waivers for States to pursue innovative solutions.

This week Congress will pass welfare reform for the third time.

Will the third time prove the charm . . . or will the President strike out? The children are waiting.

A NEW WAR ON TERRORISM

(Mrs. SCHROEDER asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Mrs. SCHROEDER. Mr. Speaker, America's communities are being terrorized by lunatics. Our law enforcement officers are the ones who are on the front line trying to bring back some tranquility to America's public places. Our law enforcement officers today look like Wyatt Earp. They really do not have any more technology than Wyatt Earp had except they have a car instead of a horse. We could fix that.

We have all sorts of cold war technology taxpayers have paid for that should be opened up to law enforcement and move out there so we fight crime much smarter. If we could trace everything in the world, we ought to be able to trace explosives, and we know how to trace explosives.

It is outrageous that this Congress might think about going home before we deal with this issue. One of the primary reasons for the Congress, according to the Constitution, is to deal with the domestic tranquility. Let us deal with that before we adjourn. Let us open up that wonderful storehouse of research and development that we have paid for for the cold war for this new war on terrorism.

COMMONSENSE WELFARE REFORM

(Mrs. SEASTRAND asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Mrs. SEASTRAND. Mr. Speaker, when President Bill Clinton says that the welfare system is broken, he's absolutely right. Every year, the Government spends more and more money on welfare.

Today, Government spends 1,600 percent more on welfare than they did in 1950 while the population of this country has only increased 72 percent.

Mr. Speaker, it all boils down to common sense.

Common sense tells us that welfare has been a colossal failure—as President Clinton says, the system is broken. Common sense also tells that money is simply not the answer—welfare may give people money but it takes away something far more precious.

It is now time for this Government to exercise a little common sense of its own. Congress will soon give the President a genuine welfare reform package. It is real; it is common sense; and it honors the basic values of work, family, and personal responsibility.

We hope that Bill Clinton will do the right thing and sign commonsense welfare reform.

THE ISSUE OF TERRORISM

(Mr. PALLONE asked and was given permission to address the House for 1 minute.)

Mr. PALLONE. Mr. Speaker, this Friday Congress is scheduled to go into recess, but I do not think we should be recessing unless we address or until we address the issue of terrorism. I have to tell you that right now my constituents in the phone calls to my office are overwhelming that people are concerned and want the Congress and the President to get together on a bipartisan basis to address the issue.

It is not something that is just in other countries now. Clearly, because of the TWA crash, because of the explosion in Atlanta at the Olympics, people feel, and I think rightly so, that they cannot be safe and that we need to address the issue of terrorism.

Basically, the President this week convened a bipartisan leadership meeting to discuss the steps that are necessary to fight against terrorism. As was mentioned by some of the previous speakers, we do have certain tools at hand which we really have not used and we can use on the Federal basis to try to get at the problem.

Mentioned was the expanding the power to use wire tapping, also certain tracers or taggants, as they are called in explosives. These things need to be addressed, and we have to do them before we recess.

THE WELFARE REFORM BILL

(Mr. DUNCAN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. DUNCAN. Mr. Speaker, last night, each Member had the August 12 issue of the New Republic delivered to our offices.

As everyone knows, the New Republic is a very liberal magazine.

Yet this magazine had a lead editorial entitled ''Sign It,'' urging the President to sign the welfare reform bill.

The President earlier vetoed a welfare reform bill that passed the Senate 87 to 12.

The current bill passed the Senate 74 to 24 and passed by a very large margin in this House.

The New Republic says this bill ''will, finally, start the process by which America's underclass problem can be solved.''

The editors said the block grant structure of this bill ''is likely to point the way to ending the 'culture of poverty.'''

This is a really significant endorsement, Mr. Speaker.

The New Republic ended its editorial with these words:

The continuing agony of the underclass is destroying our cities, our race relations, our sense of civility, our faith in the possibilities of government. It's worth taking some risks to end it.

I urge the President to sign the welfare reform bill.

TERRORISM

(Mr. DURBIN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. DURBIN. Mr. Speaker, the image of terrorism are ingrained in our minds. What was often seen as someone else's problem is now our problem.

If America is being terrorized without and within, this Congress should not be terrorized by special interest groups opposed to legislation which would protect us. When Congress passed its antiterrorism bill, the gun lobby opposed a provision which would have required tracer particles in explosives so that law enforcement could track the source of terrorist bombs. Sadly, more than 200 Members of Congress bowed to the NRA and voted to deny the FBI this important tool to fight terrorism.

Now we are being asked to pass additional antiterrorism legislation in light of the recent tragedies. But the gun lobby has once again made it clear that it will oppose any effort to put tracers in explosives.

As America would not be intimidated by terrorists, this Congress should not be intimidated by the gun lobby. Before we go home this week, let us pass an antiterrorism bill that will protect American families, not protect special interest groups.

LEGITIMATE WELFARE REFORM

(Mr. ENSIGN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. ENSIGN. Mr. Speaker, using common sense, would we set up a welfare system that told a pregnant teenage mom, Listen, do not live with your parents; we will get you an apartment; do not get a job; do not save any money; you can have any man live with you except for the father of the child and, by the way, if you want more money, have another child out of wedlock?

Let us put party politics aside here. Let us let the American people win for the first time in a long time. Let us pass this legitimate welfare reform bill that we have on the House floor today.

If you are an able-bodied American, you are going to be required to work. We are going to provide child care money for you to transition from welfare to work, and we are going to provide job training.

We have a program in Las Vegas called Opportunity Village. It is a program for mentally disabled people. We have enough compassion in Las Vegas to help people that are mentally disabled get into a job. Let us have enough compassion on welfare recipients to help them get into a job.

THE NRA

(Mr. MILLER of California asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MILLER of California. Mr. Speaker, if you are involved in a hit-and-run accident today, the police can trace the paint on your car to the exact day it was painted, to where it was painted, to the gallon of paint used and where that car was sold and who owns it.

Today if you use your phone in the commission of a crime, they can trace your calls back to that. But if you blow up the World Trade Center or you blow up the TWA airline or you blow up the park in Atlanta, the NRA will not let them trace the powder in those explosives back to the point of purchase and manufacture to expedite the investigation of who those people were that engaged in this terrorism against American cities and against American citizens. That is an outrage.

A few months ago, 200 Members in this Congress voted to deny the alcohol, tobacco bureau the efforts to make that investigation, the FBI to make those investigations. We should now understand that these tools should be available to the FBI. They should be available to the alcohol, tobacco bureau. They should be available for the investigation to protect American lives.

PRESIDENT CLINTON ON WELFARE REFORM

(Mr. BAKER of California asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BAKER of California. Mr. Speaker, speaking to the National Governor's Association 2 weeks ago, Bill Clinton sounded like a Republican. He talked about getting tough on irresponsible fathers; he talked about cutting red-tape; he talked about work; he talked about strong families; he even talked about imposing time limits on welfare benefits.

This week, Congress will send the White House the third welfare reform bill that addresses all the concerns raised by the President. It will have real work requirements and real time limits. It is genuine welfare reform; it is common sense; and it will move people from dependence to work and independence.

As Bill Clinton said in one of his radio addresses: ''No challenge is more important than replacing our broker welfare system.'' Mr. Speaker, he's right. But changing something as big and as entrenched as the welfare system requires commitment, it requires honesty, and it requires that politicians keep their promises. We can only hope Bill Clinton will do the right thing and sign the bill.

A POLITICAL ANSWER TO TERRORISM

(Mr. SCHUMER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SCHUMER. Mr. Speaker, the No. 1 question I was asked when I talked to my constituents on the phone last night and this morning is, why the heck would anyone oppose putting taggants, little tracers in explosives so that we can find those who commit terrorism.

There is no good answer. There is no good substantive answer. There is a political answer.

The reason this House is not going to address the issue of putting taggants, tracers explosives is three letters: NRA.

We all know it is the right thing to do. In fact, at all the hearings our committee held, there were only two groups of people who were against putting these taggants in explosives. Those were either explosive manufacturers or the gun lobby. But the NRA is making a serious mistake here.

The average gun owner does not agree with it. The average gun owner, who has a few hunting rifles or, in the city, carries a gun around for self-defense, they do not see that it is the NRA's business that explosives are tagged so we can find terrorists.

Congress, get with it. Stand up to the NRA and let our law enforcement be able to trace explosives with taggants.

GENUINE WELFARE REFORM

(Mr. BALLENGER asked and was given permission to address the House for 1 minute.)

Mr. BALLENGER. Mr. Speaker, liberal Democrats love to portray themselves as the great champions of America's children. The President has even threatened to veto welfare reform for the third time unless, and I quote, it ''protects children.''

For the last year, Bill Clinton has stood in the way of genuine welfare reform. He seems incapable of showing any determined leadership on any of the pressing social or economic issues facing this Nation. When he does act, he always hides behind children or some other alleged victim.

If Bill Clinton were truly concerned about children and those in need, he would have kept the promises he made in his campaign. He would have kept his promise to end welfare as we know it. He would have kept his promise to balance the budget in 5 years. The list of broken promises goes on and on.

The children of America don't need pandering they need a President who is willing to stand by his word, do the

right thing, and sign commonsense welfare reform.

THE SPIRIT OF THE OLYMPICS

(Mr. LEWIS of Georgia asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. LEWIS of Georgia. Mr. Speaker, yesterday I attended the reopening of the Olympic Centennial Park in Atlanta. Tens of thousands of people, from all over the country and the world, turned out for a memorial service in honor of those killed and injured in the bomb blast that exploded early Saturday morning, shattering the tranquility of the Olympic games. They also turned out to demonstrate that they will not bow to the fear and intimidation of terrorism.

Mr. Speaker, the Olympic games represent the best of the human spirit, and in many ways the response of the people in Atlanta to this vicious act truly represented the Olympic spirit. Yesterday, the people of Atlanta, of Georgia, of our Nation, and the world came together in prayer and solidarity. It was a beautiful and moving experience to be in a crowd representing the true brotherhood of nations.

Mr. Speaker, I want to take this opportunity to commend the many people who acted heroically in the wake of this terrorist attack: the medical personnel, the law enforcement officials and the thousands of volunteers who averted an even greater disaster.

Make no mistake, Mr. Speaker, the person who carried out this hideous crime will be found and prosecuted to the full extent of the law. In the meantime, we in the Congress should do everything in our power to pass legislation that will protect our citizens from such attacks in the future.

□ 1045

WELFARE SHOULD NOT BE A WAY OF LIFE

(Mr. BASS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BASS. Mr. Speaker, between 1965 and 1994 $5.4 trillion has been spent on welfare. Federal, State, and local welfare spending rose from $158 billion in 1975 to $324 billion in 1993.

Now, my colleagues may think that welfare is thought of as providing short-term relief. Well, the fact is that the average stay on welfare today is 13 years.

Now, since 1950 the population of the United States has increased 72 percent, from 151 million to 260 million. At the same time, total welfare spending by Federal, State, and local governments has increased by 1,623 percent.

Mr. Speaker, today the House will pass a historic welfare reform bill that requires work and personal responsibility and lifts families from lives of despair and hopelessness.

Mr. Speaker, welfare should not be a way of life. Commonsense welfare reform will help end the vicious cycle of welfare dependency.

Mr. Speaker, I urge the President to sign this historic welfare proposal.

LET US DO THE JOB RIGHT ON ANTITERRORISM LEGISLATION

(Ms. MCKINNEY asked and was given permission to address the House for 1 minute.)

Ms. MCKINNEY. Mr. Speaker, as a Member of Congress from the Metro-Atlanta area I, like the rest of the Nation, was horrified by the senseless bombing of innocent civilians at the Olympic Park.

As Americans, we have had a false sense of security that we are somehow immune to terrorism on our soil. However, Mr. Speaker, we have always had terrorist acts committed against Americans in the United States—we just did not call it terrorism.

Whether it was lynchings, church burnings, abortion clinic bombings, and now attacks by antigovernment groups, terrorism has, unfortunately, always been with us.

Mr. Speaker, it is time now that we dealt with all terrorist acts head on. Although the House passed the President's antiterrorism bill, it was watered-down to the point where it is almost ineffectual.

Now we have an opportunity to reintroduce the antiterrorism tools stripped from the legislation. Let us do the job right this time.

THIS IS THE SPIRIT OF THE OLYMPICS

(Mr. MANZULLO asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MANZULLO. Mr. Speaker, Theodore Roosevelt once said the credit belongs to the one who is actually in the arena and who spends time in a worthy cause. This is the spirit of the Olympics.

Shining examples of this indomitable spirit are Judy Wilmarth from Leaf River, IL, and Stephanie Brooks from Algonquin, IL. Judy helped carry the Olympic torch in Illinois, chosen because of her devotion to service to the needy and distribution of food. Fourteen-year old Stephanie Brooks is competing in the Paralympics in Atlanta. She is qualified for the 50- and the 100-meter free style and the 50-meter butterfly swimming events. She competes in these games as an elite athlete. These accomplishments stand in the face of the fact that Stephanie was born with spina bifida which has caused her to lose the use of her legs.

Mr. Speaker, let me take this opportunity to salute these two Olympic champions: Judy Wilmarth and Stephanie Brooks.

FOLLOWING THE ORDERS OF THE NATIONAL RIFLE ASSOCIATION MUST STOP

(Mrs. LOWEY asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Mrs. LOWEY. Mr. Speaker, it is time to give law enforcement officials the tools they need to prevent terrorist attacks in America. The Republican leadership must schedule a vote immediately on stronger measures to fight terrorism.

These proposals—requiring taggants in explosives and enhanced wiretapping authority—are absolutely critical in the war against terrorism.

These provisions should already be law, but were dropped from the original antiterrorism bill that Congress passed earlier this year.

They were dropped because this Republican Congress followed the orders of the National Rifle Association and took them out.

That was unacceptable then and it is unacceptable now.

Speaker GINGRICH must not allow the NRA to hold up swift passage of tough antiterrorism legislation. The Republican leadership must choose the safety and welfare of the American people over the objections of the NRA. This Republican Congress has spent the last 17 months following the orders of the NRA and it must stop.

Congress must take a united stand against terrorism both foreign and domestic now. We must make it very clear that we will use all the resources at our disposal to prevent and punish acts of terror.

NOT ONE LOGICAL REASON FOR THE PRESIDENT NOT TO SIGN CONGRESS' THIRD WELFARE REFORM BILL

(Mr. SMITH of Texas asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. SMITH of Texas. Mr. Speaker, our children are our country's most precious resource. They are the hope of the future. But today many children will grow up in a cycle of poverty and dependence, and that is a tragedy, Mr. Speaker.

Many of us came to Congress on a promise to do something about the failed welfare state. We want to end dependency, we want to encourage personal responsibility, we want to honor work so that welfare does not become a way of life.

President Clinton has already vetoed two welfare reform bills despite the promise during his campaign to, ''end welfare as we know it.'' the jury is still out on whether or not the President will sign Congress' third effort to reform the welfare system. Personally, I cannot imagine one logical reason why Mr. Clinton would not sign the current bill.

Mr. Speaker, it is a good bill. It is based on common sense. It honors work, family, and personal responsibility.

WE MUST NOT LEAVE FOR AUGUST RECESS WITHOUT PROVIDING ANTITERRORISM LEGISLATION

(Ms. DELAURO asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. DELAURO. Mr. Speaker, I was in Atlanta this past weekend, and I felt the aftershocks of the pipe bomb explosion in Centennial Park. The true spirit of the games, the athletes, and the spectators shone through, and everyone agreed that the games must go on and that we should not bow to hostile acts of terror; but people also felt equally strongly that Congress must act to prevent this violence.

The American people do not feel safe, and part of that is because we are good at catching criminals after the fact, but we are not good at preventing them from acting.

The American people want the Government to have the tools that it needs to prevent these bombings. President Clinton has asked the Congress this week to act on much-needed antiterrorism proposals like putting tracers in explosives, in gunpowder, a tool that is needed to be able to prevent acts of terror; but the NRA is opposed to these tracers. Their opposition is wrong.

We cannot in good faith leave for the August recess without passing legislation that will give the Federal Government the tools that it needs to stop terrorism in this country. We need and we must act in good faith. We must leave in August and provide people with the peace of mind that they need so that we can keep this country free of terrorism.

CONGRESS PROVIDED ANTITERRORISM RESOURCES; THE ADMINISTRATION SITS ON ITS HANDS

(Mr. MICA asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MICA. Mr. Speaker, I was absolutely astounded this morning to learn that this administration was provided $80 million within the last 2 years to establish a terrorism center, and it has sat on its hands for the last 24 months and not done anything to institute action against terrorism. This Congress has already provided resources; this administration has not done a thing about this. I was stunned to find this out.

Now, the FBI can find time and resources to hand over and provide files on Republicans. The FBI, as I learned in shock last weekend when the gentleman from Pennsylvania [Mr. CLINGER] came to the floor, can send agents to harass our witnesses in congressional hearings, but they cannot find the time and the resources that this Congress gave them to fight terrorism.

We must act together to fight terrorism and we have provided the resources.

WE SHOULD NOT RECESS UNTIL WE ACT ON TERRORISM

(Mrs. MALONEY asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Mrs. MALONEY. Mr. Speaker, domestic terrorism is becoming the greatest threat to our domestic tranquility. It marred the Olympics, it horrified us in Oklahoma City and with the World Trade Center, and it may have destroyed TWA Flight 800.

That tragedy touched me deeply and personally. Three nights before the tragedy I spent the evening with my neighbor and friend Judith Connelly Delouvier, who was on that flight. Three days later she was dead. She will never see her two children and husband again.

Her family deserves action now. We should not recess until we take legislative action on tracing explosives; we must take on the NRA; we must work on programmatic changes.

Mr. Speaker, we should not recess until we act on terrorism. We cannot wait until September.

IN FIGHTING ANTITERRORISM WE MUST ALSO PROTECT OUR CIVIL LIBERTIES

(Mr. MCINTOSH asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MCINTOSH. Mr. Speaker, let me rise and say I agree we need to take action in order to address antiterrorism in this country. We have all been horrified by the bombing at the Olympics and among our civil aeronautics. I want to urge the President to go ahead and spend that $80 million and build the antiterrorism center at the FBI so that Americans can be safer in our travel.

Second, we need to also protect civil liberties in this country, and I am troubled by President Clinton's request for secret wiretap authority. As my colleagues know when the President has 900 FBI files in the White House basement on his political opponents and still refuses to release the list of 200,000 Americans that he keeps track of in his big brother database, I am not sure that we can trust him with more authority to wiretap Americans who may be innocent of any crime.

We need to work to fight terrorism, but we also need to protect civil liberties in this country and make sure that we are not giving our Government authority to harass innocent Americans.

SUPPORT H.R. 43, THE BOMBING PREVENTION ACT

(Ms. SLAUGHTER asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. SLAUGHTER. Mr. Speaker, the United States suffered a terrible loss with the recent bombing in Centennial Park in Atlanta. We lost our innocence and our faith it will never happen here. It is becoming increasingly probable that black or smokeless powder was involved in the construction of this deadly pipe bomb.

I have introduced legislation during the last two Congresses that would help identify the perpetrators of this act. The Bombing Prevention Act, H.R. 43, would avert future deaths, save lives, and prevent families and our Nation as a whole from going through the anguish that terrorism leaves in its wake.

Specifically, my bill would require every person who purchases explosives including more than five pounds of black or smokeless powder to hold a Federal permit. They would have to provide their name and address to the vendor, and indicate the purpose of the explosives purchase. This information would be invaluable to law enforcement officials investigating terrorism. Under current law, any purchase of less than 50 pounds of black powder is exempt from Federal oversight. This is crazy—50 pounds can unleash dreadful destruction.

It would be a crime in itself if this Congress were to adjourn on Friday and go home without addressing this issue that has terrified every American from sea to shining sea.

ANTITERRORISM IS A BIPARTISAN MATTER

(Mr. KINGSTON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KINGSTON. Mr. Speaker, as my colleagues know, last Friday I was on my way to Atlanta, and I was told to go see Tom Davis who was the FBI agent in charge of Centennial Park because his father-in-law, Floyd Thaxton, works for us in our State's Bureau office. Well, needless to say something dramatically changed in the early hours of the morning, and I was unable to see Mr. Davis, who was one of the heroes and was injured by the bomb, but led the successful evacuation of many, many people.

□ 1100

Mr. Speaker, Mr. Davis is a hero to us. In his honor, I have to refute some of the things that are going on on this terrorism discussion today. I have the vote list on the terrorism bill, and many of the speakers today from the Democratic side voted against the only terrorism bill we had.

To my knowledge, none of them offered amendments. There may have

been a few, but it is kind of interesting to hear these people talking about we need a terrorist bill by the end of the week, and yet they had their chance. For a year and a half we debated this, and most of them did not offer amendments. Just about all of them voted no. I have a copy of the vote list, it is kind of interesting, it is almost rollcall, from the people we have been hearing from.

We have to work on a bipartisan basis. We want to continue working with the President. We want to solve this problem. We owe it to the Tom Davises of the world.

MEDICARE AND MEDICAID HAS DRASTICALLY REDUCED THE POVERTY RATE FOR AMERICA'S SENIOR CITIZENS

(Mr. GENE GREEN of Texas asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. GENE GREEN of Texas. In quick response, Mr. Speaker, to my colleague, the gentleman from Georgia, he knows who controls the rules on the floor. If we could have submitted amendments we probably would, but the Committee on Rules typically has closed rules, and the gentleman's colleague from Georgia prohibited them with his amendment, most of them.

What I am really here to talk about this week, we are celebrating the 31st anniversary of Medicare. We are looking back on a time that has seen drastic reductions in the number of seniors in poverty. As a result of Medicare, the poverty rate among America's senior citizens has dropped from 30 percent in 1966 to 12 percent in 1993. Before 1966 only 51 percent of American seniors had health insurance. Today, thanks to Medicare, 99 percent of America's seniors have health car.

This is a program that America needs, not only in 1965, but today and tomorrow. Contrary to sentiments expressed by my Republican colleagues, Medicare should not be allowed to wither on the vine or be limited to pay for tax cuts, or, as one of our former colleagues said, ''I was there fighting the fight voting against Medicare, 1 out of 12, because we knew it would not work in 1965.''

Celebrating Medicare's 31st birthday this week, we as Democrats are taking actions to ensure its success in the future.

REQUEST FOR PERMISSION TO ADDRESS THE HOUSE FOR 1 MINUTE AND TO USE EXHIBIT

Mr. DOGGETT. Mr. Speaker, I ask unanimous consent to address the House 1 minute and for use of this chart.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

Mr. VOLKMER. Mr. Speaker, pursuant to rule XXX, I object to the gentleman's use of the exhibit.

The SPEAKER pro tempore (Mr. HEFLEY). This objection is not debatable.

Pursuant to rule XXX, the question is: Shall the gentleman from Texas [Mr. DOGGETT] be permitted to use the exhibit?

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. VOLKMER. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 386, nays 28, answered ''present'' 2, not voting 17, as follows:

[Roll No. 374]

YEAS—386

Abercrombie	Conyers	Gephardt
Andrews	Cooley	Gibbons
Archer	Costello	Gilchrest
Armey	Cox	Gillmor
Bachus	Coyne	Gilman
Baesler	Cramer	Gonzalez
Baker (CA)	Crane	Goodlatte
Baker (LA)	Crapo	Goodling
Baldacci	Cremeans	Gordon
Ballenger	Cubin	Goss
Barcia	Cummings	Graham
Barr	Cunningham	Green (TX)
Barrett (NE)	Danner	Greenwood
Barrett (WI)	Davis	Gutierrez
Bartlett	de la Garza	Gutknecht
Barton	DeFazio	Hall (OH)
Bass	DeLay	Hall (TX)
Bateman	Dellums	Hamilton
Becerra	Deutsch	Hancock
Beilenson	Diaz-Balart	Hansen
Bereuter	Dickey	Harman
Berman	Dicks	Hastings (FL)
Bevill	Dingell	Hastings (WA)
Bilbray	Dixon	Hayes
Bilirakis	Doggett	Hayworth
Bishop	Dooley	Hefley
Bliley	Doolittle	Hefner
Blumenauer	Dornan	Heineman
Blute	Doyle	Herger
Boehlert	Dreier	Hilliard
Boehner	Duncan	Hinchey
Bonilla	Dunn	Hobson
Bonior	Durbin	Hoekstra
Bono	Edwards	Holden
Borski	Ehlers	Horn
Boucher	Ehrlich	Hostettler
Brewster	Engel	Houghton
Browder	English	Hoyer
Brown (CA)	Ensign	Hutchinson
Brown (FL)	Eshoo	Hyde
Brown (OH)	Evans	Inglis
Brownback	Farr	Istook
Bryant (TX)	Fattah	Jackson (IL)
Bunn	Fawell	Jackson-Lee (TX)
Burr	Fazio	Jacobs
Burton	Fields (LA)	Jefferson
Calvert	Fields (TX)	Johnson (CT)
Camp	Filner	Johnson (SD)
Campbell	Flanagan	Johnson, E. B.
Canady	Foglietta	Johnson, Sam
Cardin	Foley	Johnston
Castle	Forbes	Jones
Chabot	Fowler	Kanjorski
Chambliss	Fox	Kaptur
Chenoweth	Frank (MA)	Kasich
Christensen	Franks (CT)	Kelly
Chrysler	Franks (NJ)	Kennedy (MA)
Clay	Frelinghuysen	Kennedy (RI)
Clayton	Frisa	Kennelly
Clement	Frost	Kildee
Clinger	Funderburk	Kim
Clyburn	Furse	King
Coble	Gallegly	Kingston
Coburn	Ganske	Kleczka
Coleman	Gejdenson	Klink
Condit	Gekas	Klug
Knollenberg	Oberstar	Slaughter
Kolbe	Obey	Smith (MI)
LaFalce	Olver	Smith (NJ)
Lantos	Ortiz	Smith (TX)
Largent	Orton	Smith (WA)
Latham	Owens	Solomon
LaTourette	Oxley	Spence
Laughlin	Packard	Spratt
Leach	Pallone	Stark
Levin	Parker	Stearns
Lewis (CA)	Pastor	Stenholm
Lewis (GA)	Paxon	Stockman
Linder	Payne (NJ)	Stokes
Lipinski	Payne (VA)	Studds
LoBiondo	Pelosi	Stump
Lofgren	Peterson (FL)	Stupak
Longley	Peterson (MN)	Talent
Lowey	Petri	Tanner
Lucas	Pickett	Tate
Luther	Pomeroy	Tauzin
Maloney	Porter	Taylor (MS)
Manton	Portman	Taylor (NC)
Manzullo	Poshard	Tejeda
Markey	Pryce	Thomas
Martinez	Quillen	Thompson
Martini	Quinn	Thornberry
Mascara	Radanovich	Thornton
Matsui	Rahall	Thurman
McCarthy	Ramstad	Tiahrt
McCollum	Rangel	Torkildsen
McCrery	Reed	Torres
McDermott	Regula	Torricelli
McHale	Rivers	Towns
McHugh	Roberts	Traficant
McInnis	Roemer	Upton
McIntosh	Rogers	Velazquez
McKinney	Rohrabacher	Vento
McNulty	Ros-Lehtinen	Visclosky
Meehan	Rose	Volkmer
Meek	Roukema	Vucanovich
Menendez	Roybal-Allard	Walker
Metcalf	Royce	Walsh
Meyers	Rush	Wamp
Mica	Sabo	Ward
Millender-McDonald	Salmon	Waters
Miller (CA)	Sanders	Watt (NC)
Miller (FL)	Sanford	Watts (OK)
Minge	Sawyer	Waxman
Mink	Saxton	Weldon (FL)
Moakley	Scarborough	Weldon (PA)
Mollohan	Schiff	White
Montgomery	Schroeder	Whitfield
Moorhead	Schumer	Wicker
Moran	Scott	Williams
Morella	Seastrand	Wilson
Myers	Sensenbrenner	Wise
Myrick	Serrano	Wolf
Nadler	Shaw	Woolsey
Neal	Shays	Wynn
Nethercutt	Shuster	Yates
Ney	Sisisky	Young (AK)
Nussle	Skaggs	Zeliff
	Skeen	
	Skelton	

NAYS—28

Allard	Geren	Neumann
Bentsen	Greene (UT)	Norwood
Bryant (TN)	Hastert	Pombo
Bunning	Hilleary	Schaefer
Buyer	Lazio	Shadegg
Collins (GA)	Lewis (KY)	Souder
Combest	Lightfoot	Weller
Deal	McKeon	Zimmer
Everett	Molinari	
Ewing	Murtha	

ANSWERED ''PRESENT''—2

Hoke	LaHood

NOT VOTING—17

Ackerman	Flake	McDade
Callahan	Ford	Richardson
Chapman	Gunderson	Riggs
Collins (IL)	Hunter	Roth
Collins (MI)	Lincoln	Young (FL)
DeLauro	Livingston	

□ 1122

Mr. BUYER, Ms. GREENE of Utah, and Mr. ALLARD changed their vote from ''yea'' to ''nay.''

Messrs. SPRATT, BALDACCI, PORTMAN, and FLANAGAN changed their vote from ''nay'' to ''yea.''

So the gentleman was permitted to use the exhibit in question.

The result of the vote was announced as above recorded.

Mr. WISE. Mr. Speaker, I move to reconsider the vote that was just taken.

MOTION TO TABLE OFFERED BY MR. CASTLE

Mr. CASTLE. Mr. Speaker, I move to lay the motion to reconsider the vote on the table.

The SPEAKER pro tempore (Mr. HEFLEY). The question is on the motion offered by the gentleman from Delaware [Mr. CASTLE] to lay on the table the motion to reconsider the vote offered by the gentleman from West Virginia [Mr. WISE].

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. CASTLE. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 232, noes 181, not voting 20, as follows:

[Roll No. 375]

AYES—232

Allard	Dunn	LaHood
Archer	Ehlers	Largent
Armey	Ehrlich	Latham
Bachus	English	LaTourette
Baker (CA)	Ensign	Laughlin
Baker (LA)	Everett	Lazio
Ballenger	Ewing	Leach
Barr	Fawell	Lewis (CA)
Barrett (NE)	Flanagan	Lewis (KY)
Bartlett	Foley	Lightfoot
Barton	Forbes	Linder
Bass	Fowler	Livingston
Bateman	Fox	LoBiondo
Bentsen	Franks (CT)	Longley
Bereuter	Franks (NJ)	Lucas
Bilbray	Frelinghuysen	Manzullo
Bilirakis	Frisa	Martini
Bliley	Funderburk	McCollum
Blute	Gallegly	McCrery
Boehlert	Ganske	McHugh
Boehner	Gekas	McIntosh
Bonilla	Gilchrest	McKeon
Bono	Gillmor	Metcalf
Brownback	Gilman	Meyers
Bryant (TN)	Goodlatte	Mica
Bunn	Goodling	Miller (FL)
Bunning	Goss	Molinari
Burr	Graham	Moorhead
Burton	Greene (UT)	Morella
Buyer	Greenwood	Myers
Callahan	Gutknecht	Myrick
Calvert	Hamilton	Nethercutt
Camp	Hancock	Neumann
Campbell	Hansen	Ney
Canady	Hastert	Norwood
Castle	Hastings (WA)	Nussle
Chabot	Hayes	Orton
Chambliss	Hayworth	Oxley
Chenoweth	Hefley	Packard
Christensen	Heineman	Parker
Chrysler	Herger	Paxon
Clinger	Hilleary	Petri
Coble	Hobson	Pombo
Coburn	Hoekstra	Porter
Collins (GA)	Hoke	Portman
Combest	Horn	Pryce
Cooley	Hostettler	Quillen
Cox	Houghton	Quinn
Crane	Hunter	Radanovich
Crapo	Hutchinson	Ramstad
Cremeans	Hyde	Regula
Cubin	Inglis	Roberts
Cunningham	Istook	Roemer
Davis	Johnson (CT)	Rogers
Deal	Johnson, Sam	Rohrabacher
DeLay	Kasich	Ros-Lehtinen
Diaz-Balart	Kelly	Roukema
Dickey	Kim	Royce
Doggett	King	Salmon
Doolittle	Kingston	Sanford
Dornan	Klug	Saxton
Dreier	Knollenberg	Scarborough
Duncan	Kolbe	Schaefer
Schiff	Stearns	Wamp
Seastrand	Stockman	Watts (OK)
Sensenbrenner	Stump	Weldon (FL)
Shadegg	Talent	Weldon (PA)
Shaw	Tate	Weller
Shays	Tauzin	White
Shuster	Taylor (MS)	Whitfield
Skeen	Taylor (NC)	Wicker
Smith (MI)	Thomas	Wilson
Smith (NJ)	Thornberry	Wolf
Smith (TX)	Tiahrt	Young (AK)
Smith (WA)	Torkildsen	Zeliff
Solomon	Upton	Zimmer
Souder	Walker	
Spence	Walsh	

NOES—181

Abercrombie	Green (TX)	Oberstar
Andrews	Gutierrez	Obey
Baesler	Hall (OH)	Olver
Baldacci	Hall (TX)	Ortiz
Barcia	Harman	Owens
Barrett (WI)	Hastings (FL)	Pallone
Becerra	Hefner	Pastor
Beilenson	Hilliard	Payne (NJ)
Berman	Hinchey	Payne (VA)
Bevill	Holden	Pelosi
Bishop	Hoyer	Peterson (FL)
Blumenauer	Jackson (IL)	Peterson (MN)
Bonior	Jackson-Lee (TX)	Pickett
Borski	Jacobs	Pomeroy
Boucher	Jefferson	Poshard
Brewster	Johnson (SD)	Rahall
Browder	Johnson, E.B.	Rangel
Brown (CA)	Johnston	Reed
Brown (FL)	Kanjorski	Rivers
Brown (OH)	Kaptur	Rose
Bryant (TX)	Kennedy (MA)	Roybal-Allard
Cardin	Kennedy (RI)	Rush
Clay	Kennelly	Sabo
Clayton	Kildee	Sanders
Clement	Kleczka	Sawyer
Clyburn	Klink	Schroeder
Coleman	LaFalce	Schumer
Condit	Lantos	Scott
Conyers	Levin	Serrano
Costello	Lewis (GA)	Sisisky
Coyne	Lipinski	Skaggs
Cramer	Lofgren	Skelton
Cummings	Lowey	Slaughter
Danner	Luther	Spratt
DeFazio	Maloney	Stark
DeLauro	Manton	Stenholm
Dellums	Markey	Stokes
Deutsch	Martinez	Studds
Dicks	Mascara	Stupak
Dingell	Matsui	Tanner
Dixon	McCarthy	Tejeda
Dooley	McDermott	Thompson
Doyle	McHale	Thornton
Durbin	McKinney	Thurman
Edwards	McNulty	Torres
Engel	Meehan	Torricelli
Evans	Meek	Towns
Fattah	Menendez	Traficant
Fazio	Millender-McDonald	Velazquez
Fields (LA)	Miller (CA)	Vento
Filner	Minge	Visclosky
Foglietta	Mink	Volkmer
Frank (MA)	Moakley	Ward
Frost	Mollohan	Waters
Furse	Montgomery	Watt (NC)
Gejdenson	Moran	Waxman
Gephardt	Murtha	Williams
Geren	Nadler	Wise
Gibbons	Neal	Woolsey
Gonzalez	Oberstar	Wynn
Gordon	Obey	Yates

NOT VOTING—20

Ackerman	Fields (TX)	McInnis
Chapman	Flake	Richardson
Collins (IL)	Ford	Riggs
Collins (MI)	Gunderson	Roth
de la Garza	Jones	Vucanovich
Eshoo	Lincoln	Young (FL)
Farr	McDade	

☐ 1140

Ms. SLAUGHTER changed her vote from ''aye'' to ''no''.

So the motion to table the motion to reconsider was agreed to.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. HEFLEY). The gentleman from Texas [Mr. DOGGETT] is recognized for 1 minute and is permitted to use the exhibit.

MOTION TO ADJOURN

Mr. VOLKMER. Mr. Speaker, I have a privileged motion at the desk.

The SPEAKER pro tempore. The Clerk will report the motion.

The clerk read as follows:

Mr. VOLKMER moves that the House do now adjourn.

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. VOLKMER. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 76, noes 344, not voting 13, as follows:

[Roll No. 376]

AYES—76

Abercrombie	Hilliard	Oberstar
Beilenson	Hinchey	Obey
Bishop	Hoyer	Olver
Blumenauer	Jefferson	Owens
Bonior	Johnson, E. B.	Pastor
Brown (CA)	Johnston	Payne (NJ)
Brown (FL)	Kennedy (MA)	Pomeroy
Brown (OH)	Kennedy (RI)	Rangel
Bryant (TX)	LaFalce	Reed
Clay	Lantos	Rush
Clyburn	Lewis (GA)	Sabo
Collins (MI)	Lowey	Schroeder
Conyers	Maloney	Serrano
Coyne	Manton	Slaughter
DeFazio	Markey	Spratt
Dellums	Martinez	Stark
Dicks	Matsui	Stokes
Dingell	McDermott	Thompson
Engel	McNulty	Torricelli
Fazio	Meek	Towns
Filner	Millender-McDonald	Volkmer
Foglietta	Miller (CA)	Waters
Frank (MA)	Mink	Watt (NC)
Frost	Moakley	Waxman
Gephardt	Neal	Wilson
Hastings (FL)		

NOES—344

Ackerman	Burr	Deal
Allard	Burton	DeLauro
Andrews	Buyer	DeLay
Archer	Callahan	Deutsch
Armey	Calvert	Diaz-Balart
Bachus	Camp	Dickey
Baesler	Campbell	Dixon
Baker (CA)	Canady	Doggett
Baker (LA)	Cardin	Dooley
Baldacci	Castle	Doolittle
Ballenger	Chabot	Dornan
Barcia	Chambliss	Doyle
Barr	Chenoweth	Dreier
Barrett (NE)	Christensen	Duncan
Barrett (WI)	Chrysler	Dunn
Bartlett	Clayton	Durbin
Barton	Clement	Edwards
Bass	Clinger	Ehlers
Bateman	Coble	Ehrlich
Becerra	Coburn	English
Bentsen	Coleman	Ensign
Bereuter	Collins (GA)	Eshoo
Bevill	Combest	Evans
Bilbray	Condit	Everett
Bilirakis	Cooley	Ewing
Blute	Costello	Fattah
Boehner	Cox	Fawell
Bonilla	Cramer	Fields (LA)
Bono	Crane	Fields (TX)
Borski	Crapo	Flanagan
Boucher	Cremeans	Foley
Brewster	Cubin	Forbes
Browder	Cummings	Fowler
Brownback	Cunningham	Fox
Bryant (TN)	Danner	Franks (CT)
Bunn	Davis	Franks (NJ)
Bunning	de la Garza	Frelinghuysen

Frisa
Funderburk
Furse
Gallegly
Ganske
Gejdenson
Gekas
Geren
Gibbons
Gilchrest
Gillmor
Gilman
Gonzalez
Goodlatte
Goodling
Gordon
Goss
Graham
Green (TX)
Greene (UT)
Greenwood
Gutierrez
Gutknecht
Hall (OH)
Hall (TX)
Hamilton
Hancock
Hansen
Harman
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hefner
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Holden
Horn
Hostettler
Houghton
Hunter
Hutchinson
Hyde
Inglis
Istook
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Johnson (CT)
Johnson (SD)
Johnson, Sam
Jones
Kanjorski
Kaptur
Kasich
Kelly
Kennelly
Kildee
Kim
King
Kingston
Kleczka
Klink
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Levin
Lewis (CA)
Lewis (KY)
Lightfoot
Lincoln
Linder
Lipinski
Livingston
LoBiondo
Lofgren
Longley
Lucas
Luther
Manzullo
Martini
Mascara
McCarthy
McCollum
McCrery
McHale
McHugh
McInnis
McIntosh
McKeon
McKinney
Meehan
Menendez
Metcalf
Meyers
Mica
Miller (FL)
Minge
Molinari
Mollohan
Montgomery
Moorhead
Moran
Morella
Murtha
Myers
Myrick
Nadler
Nethercutt
Neumann
Ney
Norwood
Nussle
Ortiz
Orton
Oxley
Packard
Pallone
Parker
Paxon
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pombo
Porter
Portman
Poshard
Pryce
Quillen
Quinn
Radanovich
Rahall
Ramstad
Regula
Riggs
Rivers
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Rose
Roth
Roukema
Roybal-Allard
Royce
Salmon
Sanders
Sanford
Sawyer
Saxton
Scarborough
Schaefer
Schiff
Schumer
Scott
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Sisisky
Skaggs
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Solomon
Souder
Spence
Stearns
Stenholm
Stockman
Studds
Stump
Stupak
Talent
Tanner
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Tejeda
Thomas
Thornberry
Thornton
Thurman
Tiahrt
Torkildsen
Torres
Traficant
Upton
Velazquez
Vento
Visclosky
Vucanovich
Walker
Walsh
Wamp
Ward
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
White
Whitfield
Wicker
Williams
Wise
Wolf
Woolsey
Wynn
Yates
Young (AK)
Zeliff
Zimmer

NOT VOTING—13

Berman
Bliley
Boehlert
Chapman
Collins (IL)
Farr
Flake
Ford
Gunderson
McDade
Richardson
Shuster
Young (FL)

□ 1159

Messrs. CUMMINGS, JACKSON of Illinois, GEJDENSON, DORNAN, MORAN, GUTIERREZ, BENTSEN, and WISE changed their vote from ''aye'' to ''no.''

So the motion was rejected.

The result of the vote was announced as above recorded.

FURTHER MESSAGE FROM THE SENATE

A further message from the Senate by Mr. Lundregan, one of its clerks, announced that the Senate had passed without amendment a concurrent resolution of the House of the following title:

H. Con. Res. 203. Concurrent resolution providing for an adjournment of the two Houses.

The SPEAKER pro tempore. The gentleman from Texas [Mr. DOGGETT] is recognized for 1 minute and he may use the chart.

TERRORIST LEGISLATION

Mr. DOGGETT. Mr. Speaker, America takes justifiable pride in the strength and determination of our Olympic athletes. America respects the strength and determination of the criminal investigators who are seeking to determine who and how these incidences were caused by. But now America has good cause to ask whether this Congress has the strength and determination to deal with terrorists.

Chemical markers called taggants could allow investigators of terrorist bombings to trace bomb materials and more quickly identify terrorists. But unfortunately, the same lobby group that stripped this provision from the antiterrorist legislation in the spring is now trying to block antiterrorist legislation again.

Their senseless slogan now appears to be, ''bombs don't kill people, people with bombs kill people,'' and those bombers have the right to remain anonymous.

Let us not side with these special interest lobbyists to protect the bombers. Enact antiterrorist legislation now.

MOTION TO ADJOURN

Mr. SKAGGS. Mr. Speaker, I offer a privileged motion.

The SPEAKER pro tempore (Mr. HEFLEY). The Clerk will report the motion.

The Clerk read as follows:

Mr. SKAGGS moves that the House do now adjourn.

The SPEAKER pro tempore. The question is on the motion to adjourn offered by the gentleman from Colorado [Mr. SKAGGS].

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. SKAGGS. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 57, noes 357, not voting 19, as follows:

[Roll No. 377]

AYES—57

Bonior
Brown (CA)
Brown (FL)
Brown (OH)
Clay
Clyburn
Coleman
Collins (MI)
Conyers
Coyne
DeFazio
Dellums
Dicks
Dingell
Engel
Fazio
Filner
Foglietta
Gephardt
Hastings (FL)
Hinchey
Hoyer
Jefferson
Johnson, E. B.
Kennedy (MA)
LaFalce
Lantos
Lewis (GA)
Markey
Matsui
McDermott
McNulty
Meek
Millender-McDonald
Mink
Moakley
Neal
Oberstar
Obey
Olver
Owens
Pastor
Payne (NJ)
Pomeroy
Schroeder
Skaggs
Slaughter
Stockman
Thompson
Torres
Torricelli
Towns
Volkmer
Waters
Watt (NC)
Waxman
Wilson

NOES—357

Abercrombie
Ackerman
Allard
Andrews
Archer
Armey
Baesler
Baker (CA)
Baker (LA)
Baldacci
Ballenger
Barcia
Barr
Barrett (NE)
Barrett (WI)
Bartlett
Barton
Bass
Bateman
Becerra
Beilenson
Bentsen
Bereuter
Berman
Bevill
Bilbray
Bilirakis
Bishop
Bliley
Blumenauer
Blute
Boehlert
Boehner
Bonilla
Bono
Borski
Boucher
Brewster
Browder
Brownback
Bryant (TN)
Bryant (TX)
Bunn
Bunning
Burr
Burton
Callahan
Calvert
Camp
Campbell
Canady
Cardin
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clayton
Clement
Clinger
Coble
Collins (GA)
Combest
Condit
Cooley
Costello
Cox
Cramer
Crane
Crapo
Cremeans
Cubin
Cummings
Cunningham
Danner
Davis
de la Garza
Deal
DeLauro
DeLay
Deutsch
Diaz-Balart
Dickey
Dixon
Doggett
Dooley
Doolittle
Dornan
Doyle
Dreier
Duncan
Dunn
Durbin
Edwards
Ehlers
Ehrlich
English
Ensign
Eshoo
Evans
Everett
Ewing
Fattah
Fawell
Fields (LA)
Fields (TX)
Flanagan
Foley
Forbes
Fowler
Fox
Frank (MA)
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Frost
Funderburk
Furse
Gallegly
Ganske
Gejdenson
Gekas
Geren
Gibbons
Gilchrest
Gillmor
Gilman
Gonzalez
Goodlatte
Goodling
Gordon
Goss
Graham
Green (TX)
Greene (UT)
Greenwood
Gutierrez
Gutknecht
Hall (OH)
Hall (TX)
Hamilton
Hancock
Hansen
Harman
Hastert
Hastings (WA)
Hayworth
Hefley
Hefner
Heineman
Herger
Hilleary
Hilliard
Hobson
Hoekstra
Hoke
Holden
Horn
Hostettler
Houghton
Hyde
Inglis
Istook
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Johnson (CT)
Johnson (SD)
Johnson, Sam
Johnston
Jones
Kanjorski
Kaptur
Kasich
Kelly
Kennedy (RI)
Kennelly
Kildee
Kim
King
Kingston
Kleczka
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
Laughlin
Lazio
Leach
Levin
Lewis (CA)
Lewis (KY)
Lightfoot
Lincoln
Linder
Lipinski
Livingston
LoBiondo
Lofgren
Longley
Lowey
Lucas
Luther
Maloney
Manton
Manzullo
Martinez
Martini
Mascara
McCarthy
McCollum
McCrery
McHale
McHugh
McInnis
McIntosh
McKeon
McKinney
Meehan
Menendez
Metcalf
Meyers
Mica
Miller (CA)
Miller (FL)
Minge
Molinari
Mollohan
Montgomery
Moorhead
Moran
Morella

Murtha
Myers
Myrick
Nadler
Nethercutt
Neumann
Ney
Norwood
Nussle
Ortiz
Orton
Oxley
Packard
Pallone
Parker
Paxon
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pombo
Porter
Portman
Poshard
Pryce
Quillen
Quinn
Radanovich
Rahall
Ramstad
Rangel
Reed
Regula
Riggs
Rivers
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Rose
Roth
Roukema
Roybal-Allard
Royce
Rush
Salmon
Sanders
Sanford
Sawyer
Saxton
Scarborough
Schaefer
Schiff
Schumer
Scott
Seastrand
Sensenbrenner
Serrano
Shadegg
Shaw
Shays
Shuster
Sisisky
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Solomon
Souder
Spence
Spratt
Stark
Stearns
Stenholm
Stokes
Studds
Stump
Stupak
Talent
Tanner
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Tejeda
Thomas
Thornberry
Thornton
Thurman
Tiahrt
Torkildsen
Traficant
Upton
Velazquez
Vento
Visclosky
Vucanovich
Walker
Walsh
Wamp
Ward
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
White
Whitfield
Wicker
Wise
Wolf
Woolsey
Wynn
Yates
Young (AK)
Zeliff
Zimmer

NOT VOTING—19

Bachus
Buyer
Chapman
Coburn
Collins (IL)
Farr
Flake
Ford
Gunderson
Hayes
Hunter
Hutchinson
Klink
LaTourette
McDade
Richardson
Sabo
Williams
Young (FL)

☐ 1221

Mr. DAVIS changed his vote from ''aye'' to ''no.''

So the motion was rejected.

The result of the vote was announced as above recorded.

WAIVING REQUIREMENT OF CLAUSE 4(B) OF RULE XI WITH RESPECT TO CONSIDERATION OF A CERTAIN RESOLUTION

Mr. MCINNIS. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 492 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 492

Resolved, That the requirement of clause 4(b) of rule XI for a two-thirds vote to consider a report from the Committee on Rules on the same day it is presented to the House is waived with respect to a resolution reported before August 1, 1996, providing for consideration or disposition of a conference report to accompany the bill (H.R. 3734) to provide for reconciliation pursuant to section 201(a)(1) of the concurrent resolution on the budget for fiscal year 1997.

MOTION TO ADJOURN

Mr. BONIOR. Mr. Speaker, I offer a preferential motion.

The SPEAKER pro tempore (Mr. HEFLEY). I offer a preferential motion.

The Clerk read as follows:

Mr. BONIOR moves that the House do now adjourn.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Michigan [Mr. BONIOR].

The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

Mr. BONIOR. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 50, nays 350, answered ''present'' 1, not voting 32, as follows:

[Roll No. 378]

YEAS—50

Abercrombie
Bonior
Brown (OH)
Clay
Clyburn
Collins (MI)
Conyers
Coyne
Dellums
Dicks
Dingell
Engel
Fazio
Filner
Foglietta
Frank (MA)
Gephardt
Hastings (FL)
Hinchey
Hoyer
Jefferson
Johnson, E. B.
Johnston
Kennedy (MA)
LaFalce
Lantos
Lewis (GA)
McDermott
McNulty
Millender-McDonald
Miller (CA)
Mink
Moakley
Neal
Oberstar
Olver
Pastor
Payne (NJ)
Rush
Schroeder
Slaughter
Stockman
Thompson
Towns
Velazquez
Volkmer
Waters
Watt (NC)
Waxman
Wilson

NAYS—350

Ackerman
Allard
Andrews
Archer
Armey
Bachus
Baesler
Baker (CA)
Baker (LA)
Baldacci
Ballenger
Barcia
Barr
Barrett (NE)
Barrett (WI)
Bartlett
Barton
Bass
Bateman
Becerra
Beilenson
Bentsen
Bereuter
Berman
Bevill
Bilbray
Bilirakis
Bishop
Bliley
Blumenauer
Blute
Boehlert
Boehner
Bonilla
Bono
Borski
Boucher
Brewster
Browder
Brown (FL)
Brownback
Bryant (TN)
Bryant (TX)
Bunn
Bunning
Burr
Burton
Callahan
Calvert
Camp
Campbell
Canady
Cardin
Castle
Chabot
Chambliss
Chenoweth
Christensen
Chrysler
Clayton
Clement
Clinger
Coble
Coburn
Coleman
Collins (GA)
Combest
Condit
Costello
Cramer
Crane
Crapo
Cremeans
Cubin
Cummings
Cunningham
Danner
Davis
de la Garza
Deal
DeLauro
Deutsch
Diaz-Balart
Dixon
Doggett
Dooley
Doolittle
Dornan
Doyle
Dreier
Duncan
Dunn
Durbin
Edwards
Ehlers
Ehrlich
English
Ensign
Eshoo
Evans
Everett
Ewing
Farr
Fattah
Fawell
Fields (LA)
Fields (TX)
Flanagan
Foley
Forbes
Fowler
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Frost
Funderburk
Furse
Gallegly
Ganske
Gejdenson
Geren
Gibbons
Gilchrest
Gillmor
Gilman
Gonzalez
Goodlatte
Gordon
Goss
Graham
Green (TX)
Greene (UT)
Greenwood
Gutierrez
Gutknecht
Hall (OH)
Hall (TX)
Hamilton
Hancock
Hansen
Harman
Hastert
Hastings (WA)
Hayworth
Hefley
Hefner
Heineman
Herger
Hilleary
Hilliard
Hobson
Hoekstra
Hoke
Holden
Horn
Hostettler
Houghton
Hunter
Hyde
Inglis
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Johnson (CT)
Johnson (SD)
Jones
Kanjorski
Kaptur
Kasich
Kelly
Kennedy (RI)
Kennelly
Kildee
Kim
King
Kingston
Kleczka
Klink
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
Laughlin
Lazio
Leach
Levin
Lewis (CA)
Lewis (KY)
Lightfoot
Lincoln
Linder
Lipinski
Livingston
LoBiondo
Lofgren
Longley
Lowey
Lucas
Luther
Maloney
Manton
Manzullo
Markey
Martinez
Martini
Mascara
Matsui
McCarthy
McCollum
McCrery
McHale
McHugh
McInnis
McKeon
McKinney
Meehan
Meek
Menendez
Metcalf
Meyers
Mica
Miller (FL)
Minge
Molinari
Mollohan
Moorhead
Morella
Murtha
Myers
Myrick
Nadler
Nethercutt
Ney
Norwood
Nussle
Obey
Ortiz
Orton
Oxley
Packard
Pallone
Parker
Paxon
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pombo
Pomeroy
Porter
Portman
Poshard
Pryce
Quillen
Quinn
Radanovich
Rahall
Ramstad
Rangel
Reed
Regula
Riggs
Rivers
Roberts
Roemer
Rohrabacher
Ros-Lehtinen
Rose
Roth
Roukema
Roybal-Allard
Royce
Sabo
Salmon
Sanders
Sanford
Sawyer
Saxton
Scarborough
Schaefer
Schiff
Schumer
Scott
Seastrand
Sensenbrenner
Serrano
Shadegg
Shaw
Shays
Shuster
Sisisky
Skaggs
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Solomon
Spence
Spratt
Stark
Stearns
Stenholm
Stokes
Studds
Stump
Stupak
Talent
Tanner
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Tejeda
Thomas
Thornberry
Thornton
Thurman
Tiahrt
Torres
Traficant
Upton
Vento
Visclosky
Vucanovich
Walker
Walsh
Wamp
Ward
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
White
Whitfield
Wicker
Wise
Wolf
Woolsey
Wynn
Yates
Young (AK)
Zeliff
Zimmer

ANSWERED ''PRESENT''—1

DeFazio

NOT VOTING—32

Brown (CA)
Buyer
Chapman
Collins (IL)
Cooley
Cox
DeLay
Dickey
Flake
Ford
Fox
Gekas
Goodling
Gunderson
Hayes
Hutchinson
Istook
Johnson, Sam
LaTourette
McDade
McIntosh
Montgomery
Moran
Neumann
Owens
Richardson
Rogers
Souder
Torkildsen
Torricelli
Williams
Young (FL)

☐ 1243

Mr. BUNN of Oregon changed his vote from ''yea'' to ''nay.''

So the motion to adjourn was rejected.

The result of the vote was announced as above recorded.

PERSONAL EXPLANATION

Mr. FOX of Pennsylvania. Mr. Speaker, on rollcall No. 378, I was in the Banking Committee hearing and I did not hear the pager. Had I been present, I would have voted ''Nay.''

The SPEAKER pro tempore (Mr. HEFLEY). The gentleman from Colorado [Mr. MCINNIS] is recognized for 1 hour.

Mr. MCINNIS. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Massachusetts [Mr. MOAKLEY], pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

(Mr. MCINNIS asked and was given permission to revise and extend his remarks and include extraneous material.)

Mr. MCINNIS. Mr. Speaker, House Resolution 492 is an extremely narrow resolution. The proposed rule merely waives the requirement of clause 4(b) of rule XI for a two-thirds vote to consider a report from the Committee on Rules on the same day it is presented to the House for a resolution reported from the committee before August 1, 1996, which provides for consideration or disposition of a conference report to accompany H.R. 3734, The Personal Responsibility and Work Opportunity Act.

This narrow, short-term, waiver will only apply to special rules providing for the consideration or disposition of a conference report to accompany the bill H.R. 3734, nothing else.

Mr. Speaker, House Resolution 492 was reported by the Committee on Rules by unanimous voice vote. The distinguished Member, Mr. MOAKLEY, stated in the Committee on Rules that he had no objections to this rule. The committee recognized the need for expedited procedures to bring the welfare reform conference report forward as soon as possible.

Mr. Speaker, I include the following extraneous material for the RECORD:

[From the U.S. News & World Report, June 3, 1996]

THE END OF WELFARE AS WE KNOW IT?

(By David Whitman)

Bertha Bridges is still waiting for the end of welfare as she knows it. Bridges and her three children have been on and off welfare since the early 1980s, and she has been unable to hold a job in recent years because school administrators often call several times a week to ask her to pick up her disruptive, severely depressed 13-year-old son for fighting and disobeying teachers.

Seventeen months after U.S. News first interviewed her for a cover story on welfare reform, matters have only worsened for the Detroit resident. Several weeks ago her son let three strangers into her house, and they promptly stole Bridges's money, jewelry, clothing, dishes and videocassette recorder. Her son is now back in a psychiatric hospital, his younger sister is starting to imitate him by refusing to complete school assignments and Bridges doesn't know where to turn for help. ''I'm living a nightmare,'' she says.

Last week, President Clinton and Bob Dole jousted to claim the title of welfare abolitionist—and to deny the other guy credit for overhauling a welfare system that still does little to encourage self-reliance. But while the candidates feud, many of the 4.6 million families on Aid to Families with Dependent Children are living out nightmares like that of Bridges.

Clinton claims that waivers granted by his administration to 38 states to conduct demonstration programs have led to a quiet revolution. ''The state-based reform we have encouraged,'' he said in his May 18 radio address, ''has brought work and responsibility back to the lives of 75 percent of the Americans on welfare.'' Yet according to federal statistics, only 13 percent of AFDC adults participated in any education, training or work program in a typical month in 1994, up a hair from 12 percent in 1992. At present, less than 1 in 100 AFDC parents toils each month in workfare programs in exchange for a relief check, a number that has remained constant since Clinton came to office.

Thanks largely to an improved economy, the number of Americans on AFDC—12.8 million—was 9 percent lower in January than three years earlier. Yet the rolls are still at historically high levels, and 1 in 5 American children still lives below the poverty line. In 1992, 13.5 percent of the nation's children received AFDC; in 1995, 13.4 percent of the country's children did so. One in seven kids in the United States is now on the dole.

According to the Department of Health and Human Services, 75 percent of AFDC recipients could be affected in an average month by at least one provision of the 61 waivers granted by the Clinton administration. That seems to be the basis for the president's claim that his waivers have reintroduced work and responsibility to the vast majority of AFDC recipients. But many of the waivers are for modest reforms. Such as allowing recipients to keep more earned income before their welfare checks are reduced.

The most far-reaching waivers permit states to impose time limits, usually two years. On how long a family can receive AFDC. According to a soon-to-be-released study by the Center for Law and Social Policy (CLASP), HHS has authorized 11 states to run statewide programs with full-family cash-aid cutoffs and two more states' applications are pending.

Awaiting results. It is too early to tell whether the new time limits will fundamentally alter welfare. Since it takes years for recipients to use up their cash aid, time limits so far have affected few families. With the exception of Chicago, none of the nation's 10 largest cities is in a full-family time-limit state—and the new CLASP report indicates that 91 percent of AFDC recipients in Illinois are exempt from the time limits because they apply there only to families whose youngest child is 13 or older.

Other states provide narrower exemptions and extensions than Illinois but still have protective loopholes. One of the biggest: HHS has insisted that no state can remove a family from the AFDC rolls if the mother has complied with program rules and failed to find a job despite her best efforts.

CLASP's Mark Greenberg worries that the new time limits could throw many needy women and children off welfare. ''If there are visible catastrophes,'' he says, ''other states may be reluctant to move forward. But if the catastrophes are largely invisible, the nation's safeguards for protecting children will start to unravel.'' In Washington, meanwhile, the politicians are still fiddling.

Mr. Speaker, I reserve the balance of my time.

Mr. MOAKLEY. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I did make the statement that I had no objection to the rule. That was based on the promise that we were going to have the bill at 8 p.m. last night. But we do not have the bill, so I do object to this rule.

Mr. Speaker, I yield 3 minutes to the gentleman from Kentucky [Mr. WARD].

Mr. WARD. Mr. Speaker, I have here a presentation.

Ms. DELAURO. Mr. Speaker, pursuant to rule XXX, I object to the gentleman's use of the exhibit.

The SPEAKER pro tempo. Does the gentleman plan to use this exhibit?

Mr. WARD. Yes, Mr. Speaker, I do.

The SPEAKER pro tempore. Pursuant to rule XXX, the question is: Shall the gentleman from Kentucky [Mr. WARD] be permitted to use the exhibit?

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Ms. DELAURO. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

PARLIAMENTARY INQUIRY

Mr. WELDON of Pennsylvania. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state it.

Mr. WELDON of Pennsylvania. Mr. Speaker, under paragraph 803 of Jefferson's Rules there is a provision, section 10, that states that no dilatory motion shall be entertained by the Speaker.

This particular section of the rules is very explicit. It goes through to proclaim that the clause was adopted in 1890 to make permanent a principle already enunciated in a ruling of the Speaker, who had declared that the ''object of a parliamentary body is action, not stoppage of action.''

Mr. Speaker, we have seen several motions to adjourn, one of which was offered by a colleague who then voted against that motion to adjourn.

We now have the second case, Mr. Speaker, of a chart being put up that is blank, that in fact has no substance.

The Speaker, has declined on a number of occasions in the history of this body or refused to allow procedures to continue that in effect stop the orderly process of business in this body.

I ask the Speaker, to rule on that section that, in fact, prohibits dilatory action. I ask the Speaker to rule on the parliamentary stature of an attempt to basically stop the action of the House through what in my opinion may be considered as a dilatory action under this particular rule of the operations of this body.

POINT OF ORDER

Mr. DOGGETT. Mr. Speaker, I have a point of order.

The SPEAKER pro tempore. The gentleman will state his point of order.

Mr. DOGGETT. Mr. Speaker, a vote is in order. This is not really even a legitimate parliamentary inquiry. I raise a point of order that with a vote already under way, this parliamentary inquiry is out of order and would ask that the Chair proceed with the vote previously ordered.

The SPEAKER pro tempore. The Chair is prepared to address the inquiry made by the gentleman from Pennsylvania [Mr. WELDON].

The rule XXX question is not a motion. The rule XXX question is in the nature of a point of order.

The gentlewoman from Connecticut [Ms. DELAURO] objects to the vote on the ground that a quorum is not present and makes the point of order that a quorum is not present.

Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 351, nays 53, answered ''present'' 2, not voting 27, as follows:

[Roll No. 379]

YEAS—351

Abercrombie
Ackerman
Andrews
Archer
Armey
Bachus
Baesler
Baker (CA)
Baker (LA)
Barcia
Barrett (NE)
Barrett (WI)
Bartlett
Bass
Bateman
Becerra
Beilenson
Bereuter
Bevill
Bilbray
Bishop
Bliley
Blumenauer
Blute
Boehlert
Boehner
Bonilla
Bonior
Bono
Borski
Boucher
Brewster
Browder
Brown (FL)
Brown (OH)
Brownback
Bryant (TX)
Bunn
Burton
Callahan
Calvert
Camp
Campbell
Canady
Cardin
Castle
Chabot
Chambliss
Christensen
Chrysler
Clay
Clayton
Clement
Clinger
Clyburn
Coble
Coburn
Coleman
Collins (MI)
Condit
Conyers
Cooley
Costello
Cox
Coyne
Cramer
Crane
Crapo
Cremeans
Cummings
Danner
Davis
de la Garza
DeFazio
DeLay
Dellums
Deutsch
Diaz-Balart
Dicks
Dingell
Dixon
Doggett
Dooley
Doolittle
Dornan
Doyle
Dreier
Duncan
Dunn
Durbin
Edwards
Ehlers
Ehrlich
Engel
English
Eshoo
Evans
Ewing
Farr
Fattah
Fawell
Fazio
Fields (LA)
Fields (TX)
Filner
Flanagan
Foglietta
Foley
Forbes
Fowler
Fox
Frank (MA)
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Frost
Funderburk
Furse
Gallegly
Ganske
Gejdenson
Gekas
Gephardt
Gilchrest
Gillmor
Gilman
Gonzalez
Goodlatte
Goodling
Gordon
Goss
Graham
Green (TX)
Gutierrez
Gutknecht
Hall (OH)
Hall (TX)
Hamilton
Hancock
Hansen
Harman
Hastings (FL)
Hastings (WA)
Hayworth
Hefley
Hefner
Heineman
Herger
Hilliard
Hinchey
Hobson
Hoekstra
Holden
Horn
Hostettler
Houghton
Hoyer
Hutchinson
Hyde
Inglis
Istook
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Jefferson
Johnson (SD)
Johnson, E.B.
Johnston
Jones
Kanjorski
Kaptur
Kasich
Kelly
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kim
King
Kingston
Kleczka
Klink
Klug
Knollenberg
Kolbe
LaFalce
Lantos
Largent
Latham
LaTourette
Laughlin
Leach
Lewis (CA)
Lewis (GA)
Lincoln
Lipinski
Livingston
LoBiondo
Lofgren
Lowey
Lucas
Luther
Maloney
Manton
Manzullo
Markey
Martini
Mascara
Matsui
McCarthy
McCollum
McCrery
McDermott
McHale
McHugh
McIntosh
McKinney
McNulty
Meehan
Meek
Menendez
Metcalf
Mica
Millender-McDonald
Miller (CA)
Miller (FL)
Minge
Mink
Moakley
Molinari
Mollohan
Montgomery
Moorhead
Morella
Murtha
Myers
Myrick
Nadler
Neal
Nethercutt
Neumann
Ney
Norwood
Nussle
Oberstar
Obey
Olver
Ortiz
Orton
Owens
Oxley
Pallone
Parker
Pastor
Paxon
Payne (NJ)
Payne (VA)
Pelosi
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pomeroy
Porter
Poshard
Pryce
Quillen
Quinn
Rahall
Reed
Regula
Riggs
Rivers
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Rose
Roybal-Allard
Royce
Rush
Sabo
Salmon
Sanford
Sawyer
Saxton
Schiff
Schroeder
Schumer
Scott
Seastrand
Sensenbrenner
Serrano
Shaw
Shays
Shuster
Sisisky
Skaggs
Skeen
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Solomon
Spence
Spratt
Stark
Stearns
Stenholm
Stokes
Studds
Stupak
Talent
Tanner
Tate
Taylor (MS)
Taylor (NC)
Tejeda
Thomas
Thompson
Thornton
Thurman
Torres
Upton
Velazquez
Visclosky
Volkmer
Vucanovich
Walker
Walsh
Wamp
Ward
Waters
Watt (NC)
Waxman
Weldon (PA)
White
Whitfield
Wicker
Williams
Wilson
Wise
Wolf
Woolsey
Wynn
Young (AK)
Zeliff

NAYS—53

Allard
Baldacci
Ballenger
Bentsen
Bilirakis
Bryant (TN)
Bunning
Buyer
Collins (GA)
Combest
Cubin
Cunningham
Deal
DeLauro
Ensign
Geren
Greene (UT)
Hastert
Hilleary
Hoke
Johnson (CT)
Johnson, Sam
Lazio
Levin
Lewis (KY)
Lightfoot
Linder
McInnis
McKeon
Packard
Pombo
Radanovich
Ramstad
Rangel
Sanders
Scarborough
Schaefer
Shadegg
Souder
Stockman
Stump
Tauzin
Thornberry
Tiahrt
Torkildsen
Towns
Traficant
Vento
Watts (OK)
Weldon (FL)
Weller
Yates
Zimmer

ANSWERED ''PRESENT''—2

Everett
LaHood

NOT VOTING—27

Barr
Barton
Berman
Brown (CA)
Burr
Chapman
Chenoweth
Collins (IL)
Dickey
Flake
Ford
Gibbons
Greenwood
Gunderson
Hayes
Hunter
Longley
Martinez
McDade
Meyers
Moran
Portman
Richardson
Roth
Roukema
Torricelli
Young (FL)

☐ 1309

Ms. DELAURO changed her vote from ''yea'' to ''nay.''

Ms. FURSE, Ms. RIVERS, Mr. HALL of Ohio, and Mr. SPENCE changed their vote from ''nay'' to ''yea.''

So the gentleman was permitted to use the exhibit in question.

The result of the vote was announced as above recorded.

Mr. MCDERMOTT. Mr. Speaker, I move that we reconsider the vote.

MOTION TO TABLE OFFERED BY MR. LARGENT

Mr. LARGENT. Mr. Speaker, I move to lay the motion to reconsider on the table.

The Speaker pro tempore (Mr. HEFLEY). The question is on the motion offered by the gentleman from Oklahoma [Mr. LARGENT] to lay on the table the motion to reconsider the vote offered by the gentleman from Washington [Mr. MCDERMOTT].

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. MCDERMOTT. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 239, noes 172, not voting 22, as follows:

[Roll No. 380]

AYES—239

Allard
Archer
Armey
Bachus
Baker (CA)
Baker (LA)
Ballenger
Barr
Bartlett
Barton
Bass
Bateman
Bereuter
Bilbray
Bilirakis
Bliley
Blute
Boehlert
Boehner
Bonilla
Bono
Brewster
Brownback
Bryant (TN)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Castle
Chabot
Chambliss
Christensen
Chrysler
Coble
Coburn
Collins (GA)
Combest
Condit
Cooley
Cox
Crane
Crapo
Cremeans
Cubin
Cunningham
Davis
de la Garza
Deal
DeLay
Diaz-Balart
Dickey
Doggett
Doolittle
Dornan
Dreier
Duncan
Dunn
Durbin
Ehlers
Ehrlich
English
Ensign
Everett
Ewing
Fawell
Fields (TX)
Flanagan
Foley
Forbes
Fowler
Fox
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Funderburk
Gallegly
Ganske
Gilchrest
Gillmor
Gilman
Goodlatte
Goodling
Gordon
Goss
Graham
Greene (UT)
Gutknecht
Hall (TX)
Hamilton
Hancock
Hansen
Hastert
Hastings (WA)
Hayworth
Hefley
Heineman
Herger
Hobson
Hoekstra
Horn
Hostettler
Houghton
Hutchinson
Hyde
Inglis
Istook
Jacobs
Johnson (CT)
Johnson, Sam
Jones
Kasich
Kelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Lewis (CA)
Lewis (KY)
Lightfoot
Lincoln
Linder
Livingston
LoBiondo
Longley
Lucas
Manzullo
Martini
McCollum
McCrery
McHugh
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Molinari
Moorhead
Morella
Myers
Myrick
Nethercutt
Neumann
Ney
Norwood
Nussle
Orton
Oxley
Packard
Parker
Paxon
Peterson (MN)
Petri
Pombo
Porter
Pryce
Quillen
Quinn
Radanovich
Rahall
Ramstad
Regula
Riggs
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Roukema
Royce
Salmon
Sanford
Saxton
Scarborough
Schaefer
Schiff
Scott
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Sisisky
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Solomon
Souder
Spence
Stearns
Stenholm
Stockman
Stump
Talent
Tate
Tauzin
Taylor (MS)
Thomas
Thornberry
Thornton
Tiahrt
Torkildsen
Traficant
Upton
Vucanovich
Walker
Walsh
Wamp
Weldon (FL)
Weldon (PA)
White
Whitfield
Wicker
Williams
Wilson
Wise
Wolf
Young (AK)
Zeliff
Zimmer

NOES—172

Abercrombie	Gejdenson	Moran
Ackerman	Gephardt	Murtha
Andrews	Geren	Nadler
Baesler	Gibbons	Neal
Baldacci	Gonzalez	Oberstar
Barcia	Green (TX)	Obey
Barrett (NE)	Gutierrez	Olver
Barrett (WI)	Hall (OH)	Ortiz
Becerra	Harman	Owens
Beilenson	Hastings (FL)	Pallone
Berman	Hefner	Pastor
Bevill	Hilliard	Payne (NJ)
Bishop	Hinchey	Payne (VA)
Blumenauer	Holden	Pelosi
Bonior	Hoyer	Peterson (FL)
Borski	Jackson (IL)	Pickett
Boucher	Jackson-Lee (TX)	Pomeroy
Browder	Jefferson	Poshard
Brown (CA)	Johnson (SD)	Rangel
Brown (FL)	Johnson, E. B.	Reed
Brown (OH)	Johnston	Rivers
Bryant (TX)	Kanjorski	Rose
Cardin	Kaptur	Roybal-Allard
Chapman	Kennedy (MA)	Rush
Clay	Kennedy (RI)	Sabo
Clayton	Kennelly	Sanders
Clement	Kildee	Sawyer
Clyburn	Kleczka	Schroeder
Coleman	LaFalce	Schumer
Collins (MI)	Levin	Serrano
Conyers	Lewis (GA)	Skaggs
Costello	Lipinski	Skelton
Coyne	Lofgren	Slaughter
Cramer	Lowey	Spratt
Cummings	Luther	Stark
Danner	Maloney	Stokes
DeFazio	Manton	Studds
DeLauro	Markey	Stupak
Dellums	Martinez	Tanner
Deutsch	Mascara	Tejeda
Dicks	Matsui	Thompson
Dingell	McCarthy	Thurman
Dixon	McDermott	Torres
Dooley	McHale	Torricelli
Doyle	McKinney	Towns
Edwards	McNulty	Velazquez
Engel	Meehan	Vento
Eshoo	Meek	Visclosky
Evans	Menendez	Volkmer
Farr	Millender-McDonald	Ward
Fattah	Miller (CA)	Waters
Fazio	Minge	Watt (NC)
Fields (LA)	Mink	Watts (OK)
Filner	Moakley	Waxman
Foglietta	Mollohan	Weller
Frank (MA)	Montgomery	Woolsey
Frost	Murtha	Wynn
Furse	Nadler	Yates

NOT VOTING—22

Bentsen	Gunderson	Meyers
Chenoweth	Hayes	Portman
Clinger	Hilleary	Richardson
Collins (IL)	Hoke	Seastrand
Flake	Hunter	Taylor (NC)
Ford	Klink	Young (FL)
Gekas	Lantos	
Greenwood	McDade	

□ 1330

Mr. POMBO changed his vote from ''no'' to ''aye.''

So the motion to table the motion to reconsider was agreed to.

The result of the vote was announced as above recorded.

PERSONAL EXPLANATION

Mr. PORTMAN. Mr. Speaker, due to a previous speaking commitment located off Capitol Hill earlier today, I missed votes on rollcall No. 379, to permit the use of an exhibit, and rollcall No. 380, to table the motion to reconsider. Had I been present, I would have voted ''yes'' on rollcoll No. 379 and ''yes'' on rollcall No. 380.

Mr. MOAKLEY. Mr. Speaker, reclaiming time I yielded to the gentleman from Kentucky [Mr. WARD], I yield myself such time as I may consume.

I thank my colleague and my friend, the gentleman from Colorado [Mr. MCINNIS], for yielding me the customary half hour.

Mr. Speaker, today, we are considering this rule waiving the two-thirds requirement for same day consideration because my Republican colleagues didn't finish the welfare bill until midnight last night.

And last evening, I agreed to this two-thirds rule because I was told this welfare bill would be available by 8 last night.

But, Mr. Speaker, we did not get the bill until quarter of one in the morning and that is completely unacceptable. Because, Mr. Speaker, this issue is very very important and 434 Members of Congress are going to be asked to vote on this enormous bill and the ink isn't even dry yet.

This bill is no small potatoes. It represents a major change in our welfare system which will affect millions and millions of Americans, most of those Americans, Mr. Speaker, are children.

For that reason I think no amount of time is too much. We have a very serious responsibility to the 9 million children who are supported by aid to families with dependent children and those children are depending on us to do it right.

I urge my colleagues to oppose this two-thirds rule. Congress hasn't had anywhere enough time to consider this bill and it will affect far too many children to be rushed through the Congress.

Mr. Speaker, I reserve the balance of my time.

Mr. MCINNIS. Mr. Speaker, I yield myself such time as I may consume.

First of all, I am pleased to announce that we now understand that the President is going to have a press conference here in about 8½ minutes where he will announce that he is in support of this bill. I am also pleased to announce they have located Leon Panetta, so we can now proceed to the substance of this issue that we have sitting right here in front of us.

The substance is very simple. That is, we have to change welfare in this country. The welfare bill originally went out of here with bipartisan support. It is going to go to the President of the United States with bipartisan support, and it is going to be signed by the President.

The gentleman from Massachusetts brings up a valid point. The problem is it is somewhat exaggerated. The gentleman shows a huge bill over there, as that is the bill that has been given to him in the last several hours or early this morning to read. That is correct. That particular bill was given to him. But about 99.9 percent of that bill is what has been previously contained.

The only changes really were twofold: First, on the family cap and, second, dealing with Medicaid. So that probably consumes maybe 20, 30 pages out of that entire bill. Yes, we have asked that Members here on the House floor take time this morning during their workday to read that 20 to 40 pages or whatever was necessary to be briefed by their staff.

We are trying to get this bill to the President. For the first time in a long time, we have general agreement on a major, major issue. We have got Democrat and Republican support on the House side. We have got Democrat and Republican support on the Senate side. We have got a Democratic President that is willing to sign it.

That means that we should expedite the movement of this bill. That means that this rule should pass. By the way, upstairs this bill was voted out of committee on a unanimous vote, no dissension upstairs. I think it is now an appropriate time for us to move on, pass this rule so that we can get to the meat of the conference committee report and send this bill to the President for signature.

Mr. Speaker, I reserve the balance of my time.

Mr. MOAKLEY. Mr. Speaker, I yield 5 minutes to the gentleman from Missouri [Mr. VOLKMER].

(Mr. VOLKMER asked and was given permission to revise and extend his remarks.)

Mr. VOLKMER. Mr. Speaker, I thank the gentleman for yielding the time to me.

Mr. Speaker, it is not any great pleasure that I come here today to be able to address the rule that is now before us. This is a rule that, when we as Democrats were in the majority, known as basically martial law, that we only used at the end of the session, usually the last 3 days, in order to facilitate the passage of conference reports in those last few days. Yet under this leadership and this majority, this year alone this martial law type of rule has been in effect longer than any time if you added up all of my previous 19 years here.

So in 1 year, this year, this session, we have used it more than I did in the previous 19 years. Now, that tells me a little bit about the running of the House and procedures in the House. This is not necessary. This rule is not necessary. If we follow the normal rules of the House, the rule to take up the welfare bill, it would be reported in a day, be taken up tomorrow in the normal course, be passed. The welfare bill will be taken up and passed. But for some reason or other, it has been dictated by on high, and that is what I did say, dictated by on high, the majority, the Speaker and the floor leader, the leadership of the Republicans have decided we are going to do it today.

They wanted to do it early this morning. They wanted to do this right away before any of us even had a chance to look at the bill.

The chairman, the ranking member of the committee has a copy of the bill there, and there is a copy right over here. I dare say on the gentleman's side and my side there is not 10 percent of the Members that have even read that bill. Now, they have a general idea of what is in it, but that is all.

A lot of them were willing to vote for it because I talked to Members on both sides. They are willing to vote for it, either for or against it this morning without knowing the details. Just the idea of what is in there.

That gives me a great deal of concern, that we have here representatives of the people in the U.S. House of Representatives that are willing to vote on a far-reaching piece of legislation that will impact on millions of people and yet doing it without knowing exactly what is in it. That gives me a great deal of concern about the Members of the U.S. House of Representatives, not as great a deal as the policy that is being followed of, again, dictating to the Members of the House. That is basically what we are seeing here, is a dictatorial policy, autocratic. The leadership knows better than anybody else. We are going to do it their way or no way, and that is what we are up against today.

It is that policy that I think has led us to a lack of bipartisanship in this House. It is the Republican leadership, in my opinion, Speaker GINGRICH, Floor Leader DICK ARMEY, that are responsible for the highly partisanship feeling that pervades this House today. It is not only just on this side. It is on the majority side, too. I hear it constantly, about the partisanship. Yet everybody stands up and says, We ought to be bipartisan; we need to be bipartisan.

How can we be bipartisan when the hand is never reached out to the other side to say, hey, what can we do together on this. That hand is never reached out. Instead, it is just like this legislation, this rule, it is dictated from above. It is toned down. Take it or leave it. That is the way it is. There is no bipartisanship. There is no attempt to be bipartisan in this House.

I hope that somewhere between now and the end of this session the majority leadership under the Speaker would see fit to not be so autocratic, not to be so dictatorial, but to reach out that hand to Members on this side and say, let us work together the rest of the year on legislation and let us be bipartisan. There is not much bipartisanship here today.

Mr. MCINNIS. Mr. Speaker, I yield myself such time as I may consume.

First of all, to the gentleman from Missouri, I wanted to caution him a little on the utilization of the word ''dictatorship.'' I do not think that adds to the comity on the floor. I think we should approach those kind of terms with some trepidation.

Let me address the other point. That is, I do not want the gentleman from Missouri, because I have great respect for the gentleman, to continue to use inaccurate facts. The gentleman stated to our body here that when they were in control we did not see these kind of rules until the end of the session. I do not know why this keeps coming up, but time after time after time, when we deal with a rule, Mr. Speaker, we have to repudiate that. I have got the facts right here. I would be happy, if the gentleman would like to come over here, we will show him the statistics.

Let me cover very briefly 1993. It was not near the end of the session when his side utilized this rule. In fact, it was in February, in March, in March, in March, in March, in March, and then, of course, we had some throughout the rest of the session, too. I just want to make sure that we are accurate on our facts.

The final thing I would caution the gentleman from Missouri, his statements about this is not bipartisan. In fact, I think this bill right here, No. 1, both Democrats and Republicans and unaffiliated and reform party people from across this country acknowledge that welfare needs to be changed. The system does not work. All of the incentive on this system is to stay on it, not to get off it. The system helps people that do not need help and does not help the people that really do need help.

Since I have been up here, I do not think I know such a major piece of legislation that has had more joint effort. Certainly the last 3 or 4 hours, I was somewhat amused when the gentleman said this morning, this morning escaped from us because, frankly, there was a lot of partisanship delay this morning. But we have gotten past that.

The bill itself, the substance of this bill is a bipartisan product, a Democrat and Republican product. Certainly. It has been brought up by the Republican leadership. It is a Republican part of our contract. It was one of our biggest efforts, but we have had lots of help and we have appreciated that.

□ 1345

It is bipartisan, and at 2 o'clock and 15 minutes, the President of this country is going to hold a press conference where we anticipate that he is going to agree to sign this bill.

Mr. Speaker, I yield 2 minutes to the gentleman from Pennsylvania [Mr. FOX].

Mr. FOX of Pennsylvania. Mr. Speaker, I thank the gentleman from Colorado [Mr. MCINNIS] for extending the time because today, Mr. Speaker, we have an opportunity to pass a stark welfare reform that requires work and personal responsibility and lifts families from lives of despair and hopelessness. I think we should especially look to the fact that for able-bodied individuals this Congress and this Government will make sure that we have job training and job placement for the able-bodied, and for those that truly are in need, just seeking it, we will be there.

The fact is that on child nutrition programs we are talking about block-granting the States, which is a great benefit because right now on child nutrition programs we are spending 15 percent to administer those programs, and the States, only 5 percent for administration. With the extra 10 percent they will receive from the Federal Government, they must feed more children more meals by our great standards. The States will follow the Federal standards.

On child support enforcement, we are going to make sure that all of those individuals and families that do not now have, for many deadbeat dads and other parents, the funds they need to make sure that the children are protected. They will have to adopt in each State programs like they have in Maine where they had 21,000 people who had not paid their child support; and when they said they could lose their driver's license, they in fact, 95 percent within 30 days, paid their child support payment.

So we see a program that is going to become more modern, more sensitive, and make sure that we take care of those in need, and we make sure that the welfare reform that we have crafted here is bipartisan and worthy of the votes of both sides of the aisle in both Chambers and, hopefully, as well, with our President.

Mr. MOAKLEY. Mr. Speaker, I yield back the balance of my time.

Mr. MCINNIS. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered. The resolution was agreed to.

A motion to reconsider was laid on the table.

CONFERENCE REPORT ON H.R. 3734, PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996

Mr. SOLOMON, from the Committee on Rules, submitted a privileged report (Rept. No. 104–729) on the resolution (H. Res. 495) waiving points of order against the conference report to accompany the bill (H.R. 3734) to provide for reconciliation pursuant to section 201(a)(1) of the concurrent resolution on the budget for fiscal year 1997, which was referred to the House Calendar and ordered to be printed.

Mr. SOLOMON. Mr. Speaker, I call up the resolution (H. Res. 495) waiving points of order against the conference report to accompany the bill (H.R. 3734) to provide for reconciliation pursuant to section 201(a)(1) of the concurrent resolution on the budget for fiscal year 1997 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 495

Resolved, That upon adoption of this resolution it shall be in order to consider the conference report to accompany the bill (H.R. 3734) to provide for reconciliation pursuant to section 201(a)(1) of the concurrent resolution on the budget for fiscal year 1997. All points of order against the conference report and against its consideration are waived. The conference report shall be considered as read. The yeas and nays shall be considered as ordered on the question of adoption of the conference report and on any subsequent conference report or motion to

dispose of an amendment between the houses on H.R. 3734. Clause 5(c) of rule XXI shall not apply to the bill, amendments thereto, or conference reports thereon.

The SPEAKER pro tempore (Mr. HEFLEY). The gentleman from New York [Mr. SOLOMON] is recognized for 1 hour.

Mr. SOLOMON. Mr. Speaker, for the purposes of debate only, I yield the customary 30 minutes to the gentleman from Massachusetts [Mr. MOAKLEY], pending which I yield myself such time as I might consume. During consideration of the resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, this rule waives all points of order against the conference report to accompany H.R. 3734, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, and against its consideration.

Additionally, the rule provides that the conference report shall be considered as read. The rule also orders the yeas and nays on the adoption of the conference report and on any subsequent conference report or motion to dispose of an amendment between the Houses.

Finally, the rule provides that the provisions of clause 5(c) of rule XXI requiring a three-fifths vote on any income tax rate increase shall not apply to the bill, amendments thereto, or to the conference report thereon.

Mr. Speaker, this rule is customary for conference reports. I urge support for the rule in order that we might send this legislation on to the President swiftly, since he now has decided he is going to sign this vital piece of legislation.

Mr. Speaker, in March 1995, I called up the rule that provided for consideration of the first welfare reform bill. Sixteen months, two bills, and two Presidential vetoes later we stand on the precipice of enacting real comprehensive, compassionate welfare reform legislation.

Throughout the passionate debate on this subject we have held firm on our principles to enact a reform to the Nation's welfare system which requires work, which imposes time limits on benefits for welfare recipients, and which allows for innovative State solutions to help the underprivileged in our communities. We have not departed from these principles throughout the confusing dialog with the President. These principles are embodied in the conference agreement before the House today.

Mr. Speaker, these principles are not implemented in a vacuum. The conference package addresses concerns associated with a radical overhaul of the Nation's welfare programs.

First and foremost, it should be made perfectly clear that this bill takes care of unfortunate people who are disabled, and able-bodied people are taken care of as well on a temporary basis, but the key word is temporary. After being taken care of on a limited basis, these people are going to have to go to work.

The legislation contains valuable reforms to the food stamp program, designed to curb fraud and abuse and requiring work for those food stamps.

The agreement authorizes $22 billion in child care funding over the next 6 years, which is more than $3 billion over current law.

Finally, the legislation contains tough measures to crack down on deadbeat dads who abrogate their moral responsibility to their children; and, Mr. Speaker, in contrast to the bold and honest proposals that Congress has put forward to reform welfare, the President has acted with characteristic temerity.

The alleged welfare reform that the Clinton administration says it has achieved is in actuality a fraud. It just is not there, and the savings show it. The President asserts that he has achieved a degree of welfare reform by granting waivers from his bureaucrats for States to experiment in this area.

The reality is that we have heard testimony on this floor from State after State that the waiver process is that thoughtful and experimental governors must troop to Washington DC, hat in hand, and request permission to reform low-income programs at home. The waiver request is then subject to endless debate by bureaucrats and subject to negotiation and even change by the Federal departments involved.

Mr. Speaker, my State of New York has several waiver requests pending for low-income programs, and New York certainly needs flexibility for budgetary purposes, and we are being stonewalled by this administration because none of those waivers have been granted in a State that is overburdened with welfare problems today. Thankfully, this Byzantine procedure will be relegated to the dust bin of history upon enactment of this legislation. The citizens of the States, in whom I have the utmost confidence, will be finally free to use local solutions to help low-income families in their neighborhoods.

Mr. Speaker, I was raised to treat the less fortunate in our society with compassion, as most Americans are. The way to effect change for those who suffer in poverty is certainly not additional handouts and entrapment in the current cycle of dependency that has bred second- and third- and now fourth-generation welfare recipients. Rather, we should emphasize welfare as a temporary boost from despair to the sense of self-worth inherent in work.

Mr. Speaker, that is what we ought to be doing, that is what we can do here today. This legislation gives the single moms and kids, who are the vast majority of welfare recipients, an opportunity to escape a life of relying on government benefits. A vote against this package is a vote to deny kids on welfare hope to escape a life of welfare dependency.

Mr. Speaker, this House will today once again pass comprehensive welfare reform by a wide bipartisan margin. The Senate is likely to do the same before we recess this Friday. I sincerely hope the President lives up to his announcement a few minutes ago and agrees with the bipartisan majorities in both houses of Congress and overwhelming public sentiment and he signs the legislation into law. If he does, the status quo goes out the window, and finally, we are going to do something about this ever, ever-increasing welfare load in our country.

I strongly urge passage of the bill.

Mr. Speaker, I reserve the balance of my time.

Mr. MOAKLEY. Mr. Speaker, I yield 4 minutes to the gentleman from Washington [Mr. MCDERMOTT].

(Mr. MCDERMOTT asked and was given permission to revise and extend his remarks.)

Mr. MCDERMOTT. Mr. Speaker, we started this Congress with the majority indicating that they were going to follow new procedures, and they made a big show of all the rules changes we were going to have, but here we are ramming through the biggest change of policy toward children in this country with a bill that has been in our hands for a little more than 12 hours.

This 1,200- or 1,500-page bill was delivered to the Members of Congress last night at 1 o'clock in the morning. All that is being characterized as partisan fighting out here is basically a resistance to having something like this rammed through the Congress with a lot of good rhetoric wrapped around it, but the facts belie what is being said.

Now, the gentleman from New York [Mr. SOLOMON] has started to debate the bill and said this is a bill about work, but if my colleagues take this bill, and they go to page 80 under section 415, it is the section called waivers, and if my colleagues can wade through this language, and I will read it for them:

> Except as provided in subparagraph (B), if any waiver granted to a State under section 1115 of this Act or otherwise which relates to the provision of assistance under a State plan under this part (as in effect on September 30, 1996) is in effect as of the date of the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the amendments made by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (other than by section 103(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) shall not apply with respect to the State before the expiration.

Let me tell my colleagues what that means. That means that in 43 States there is no requirement for work. Every bit of work requirement in this bill is a fraud because with that waiver on page 80, section 415, we allow any State who has a waiver now in effect, and there are 43 of them in, if they are in effect, they can waive the work requirements.

□ 1400.

There are only seven places in the United States making up 5 percent of the welfare load; that is Alaska, Idaho.

Rhode Island, Kansas, Kentucky, New Mexico, and Nevada that do not have waivers. If we read that section further, all they have to do is get a waiver from the Federal Government and those seven States can be out. There is no requirement for work in this bill, because they write all the perfect language, spend 50 pages saying work, work, work, and then at the bottom, they give a waiver. If there is a waiver, Mr. Speaker, in their State, their State does not have to provide a job.

Let me tell the Members what it is like in Washington State, because I know the situation there. We have 100,000 people on public assistance. We have 125,000 people who have been drawing unemployment benefits. That is 225,000 people in the State of Washington who do not have work.

If tomorrow, with this bill passed, every one of them showed up and said, ''I want a job,'' the State of Washington could say, ''We do not have any responsibility for you. We have a waiver. The State of Washington has a waiver.'' Even if they were going to be responsible, even if the State of Washington said, ''We really care about these 225,000 people and their families,'' last year, and the State of Washington, Members have to remember, is the fifth most rapidly growing State economically. We are at the top in this country. In our State last year we provided 44,000 new jobs.

Mr. Speaker I urge people to vote against this bill. It is bad. It is a fraud.

Mr. SOLOMON. I yield myself such time as I may consume.

I am a little concerned, Mr. Speaker, I want to take just a minute to tell the gentleman, I think he is on the Committee on Ways and Means. As a matter of fact, at 12 o'clock last night this report was filed. There were those of us who were here and saw to it that the report was delivered to the minority at that hour. However, earlier in the day, in the morning yesterday, this report was complete and given to the minority. I do not know why the gentleman from Washington did not see it. His own staff on the Committee on Ways and Means had possession of this report, so the gentleman should have done his due diligence and he would have had that information.

Mr. Speaker, let me just say one thing about the work requirements. I am a little concerned with the bill, because it has been watered down so much. As a matter of fact, when the bill left this House we had a family cap, which meant young girls that continue to have baby after baby after baby could not just continue to have more and more and more welfare benefits given to them. Unfortunately, that was dropped. A phrase was put in that would allow States to opt in, or rather, would allow States to opt out, as opposed to opting in.

Let me tell the Members what happens in a State like New York State, where we have had for years now the Cadillac of welfare programs and the Cadillac of Medicaid programs, whereby New York State has exercised their option to opt in for all of these various programs above and beyond the base coverages for welfare and Medicaid.

In our State, we do not stand any chance of being able to change that law, so if we had arranged to have them be able to opt in, as opposed to opt out, then we could have expected some real change. So I am concerned about that, but we will live to fight that battle another day.

Mr. Speaker, as the gentleman's President is saying, this is a work-for-welfare program. I am surprised to hear the gentleman from Washington try to refute that.

Mr. CAMP. Mr. Speaker, will the gentleman yield?

Mr. SOLOMON. I yield to the gentleman from Michigan.

Mr. CAMP. Mr. Speaker, I thank the chairman of the committee for yielding to me.

Mr. Speaker, I know there has been some issue raised regarding the waivers for the work requirement. The waivers are all drawn more strictly than current law. I think that is an important point to make. The waivers that have been given by the administration are more strict than current law. The current waivers do not apply to the percentage work requirement in the legislation. I think that is another important point to make. I thank the gentleman for yielding to me.

Mr. SOLOMON. Mr. Speaker, I reserve the balance of my time.

Mr. MOAKLEY. Mr. Speaker, I yield 2 minutes to the gentleman from Texas [Mr. COLEMAN].

(Mr. COLEMAN asked and was given permission to revise and extend his remarks.)

Mr. COLEMAN. Mr. Speaker, I thank the gentleman from Massachusetts for yielding me this time.

Mr. Speaker, I think it is important to point out, regardless of the politics of welfare reform, the issue ought to be what does the bill do. Regardless of whether or not a past President or a sitting President would sign or veto a bill, it should have nothing to do with the legislative branch priority and prerogative to pass good legislation.

Mr. Speaker, I know many have worked long and hard on this bill and others like it over the past year and a half and longer. In fact, the discussion of welfare reform has been debated since I came here 14 years ago. I need to say, however, to my colleagues that it is not enough to play the politics with welfare reform that we are attempting to do today.

I certainly do not intend to support welfare reform and then go home and applaud myself and tell people, are you not proud we have welfare reform? We have to look at what we are doing to children. More than 1 million children will be thrown off the welfare rolls.

What kind of Nation is it that says, ''We care about what is in front of your name: Documented child, undocumented child, poor child, rich child''? What difference does that make to a great Nation? I submit to the Members, it should make none. All of us here in this country understand that we ought to care for children regardless of their station in life, regardless of the country from which they came. To suggest that we should do this in this legislation is plain wrong.

I know all of the 50 States are greatly benevolent. By the way, that reminds me, why did we take over this program in the 1960's in the first place up here at the Federal level? As I recall, we had a patchwork, quiltwork of 50 different programs, some good to the poor, some bad to the poor, some harsh, causing people, of course, to migrate from State to State, based upon the benefits that they or their children could receive during tough economic times.

This legislation also does not deal with tough economic issues the way it should.

Mr. MOAKLEY. Mr. Speaker, it gives me great pleasure to yield 5 minutes to the distinguished gentleman from New York [Mr. RANGEL].

(Mr. RANGEL asked and was given permission to revise and extend his remarks.)

Mr. RANGEL. Mr. Speaker, let me thank the gentleman from Massachusetts [Mr. MOAKLEY] for giving me an opportunity to speak out on this. I am going to say what is on everybody's mind. It is just so close to the election, I suppose, on both sides of the aisle we get blinded about substance in our concern as to what is it that the pollsters really want.

A lot of concern has been in the White House and on the Hill as to whether or not the President would breach his promise to change welfare as we know it. I would think that the chairman of the Committee on Rules, notwithstanding how diligently the Committee on Rules has worked on this legislation, would have to agree that there is no urgency in terms of Members understanding the work that was done in conference. This is not an unusual thing, unless it has something to do with the fact that we are going into recess, and that this will be a political issue back home.

Other than that, it seems to me if we are talking about millions of children, children who would be Democrat, Republican, Christians, Jews, black, white, Americans, and certainly the lesser among us, that all of us would want to make certain that we are doing the right thing; and really, not even push the President into making a hasty decision, when at least the last position he took was that he appreciated the direction in which the legislation was going and he saw some imperfections which could be worked out.

But it was he who said that he wanted to change welfare as we know it. What is welfare? What is this obsession about putting people to work? Everyone agrees if you are able to work, you

should be working. Every taxpayer should be angry and annoyed to find people slipping back on their responsibilities and not working.

Are we talking about just women, or are we talking about women that have children? I pause, because it is not a rhetorical question. The bills that I know of say aid for dependent children. I think what we are saying, I would say to the gentleman from New York [Mr. SOLOMON], is that that child will be held responsible for any conduct that we politically do not like about the mother.

We are going even further, not as far as the gentleman would like, but I think even the President agrees with the gentleman's posture, that if after 5 years or 4 or 3 or 2 or whatever the Governors decide, I think the minimum is 2 years, that if for any reason at all, there are no jobs available, and if the mother played by the rules, signed up, went into training, did all of the American things in order to show that she wanted to maintain her dignity, she wanted her family not to stay on welfare, she wanted to go into the private sector and contribute, if all of those things are established, it is my understanding it really does not make any difference. Playing by the rules does not make a difference, in election years, because we said it does not make any difference what the heck you have tried to do; the question is, are you working.

Quite frankly, I believe that the mother could vote with her feet if she does not like the situation employment-wise. I am mean enough to be with you. I am a politician, too. My problem is the child. What did the child have to do with the fact that the mother wanted to work, did not want to work, jobs were there, jobs were not there? Do Members know what the political question is? The Republicans will throw 2 million people, children, into poverty, and my President will only throw 1 million into poverty.

Mr. Speaker, I do not want to get involved in religion around here, but there is not a denomination of people that do not believe that the helpless of this country—just being an American means you are supposed to help them. You do not send a 2-year-old child or a 2-month-old child out to get a job. Someone has to be responsible. Someone has to be responsible for that child. Do not ask the child for its identification, and ask whether or not it is a citizen. Do not ask the child whether, by choice, the mother is a bum. Do not ask the child what the unemployment statistics are. As Americans we believe in taking care of our children.

This is a political bill. It should not be passed into law. It should not be passed here. The President should not sign it if you do shove it down his throat.

Mr. SOLOMON. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from Jacksonville, FL, Mrs. TILLIE FOWLER, who has been a real leader in this effort.

(Mrs. FOWLER asked and was given permission to revise and extend her remarks.)

Mrs. FOWLER. Mr. Speaker, the American welfare system was intended to be a safety net for those who fall on hard times. Unfortunately, it has become an overgrown bureaucracy which perpetuates dependency and denies people the chance to live the American dream.

I am pleased the President has just announced that he would sign the Republican welfare bill. We knew when it got this close to the election this President would choose the path of political expediency, as he always does. But this legislation is not about saving money, it is about saving hope and saving lives while reforming a broken system and while preserving the safety net.

This bill encourages work and independence and discourages illegitimacy. I urge my colleagues to vote for fairness, compassion, and responsibility, and pass a conference agreement on H.R. 3437.

Mr. MOAKLEY. Mr. Speaker, I yield 3 minutes to the gentleman from California, the Honorable GEORGE MILLER, the ranking member on the Committee on Resources.

(Mr. MILLER of California asked and was given permission to revise and extend his remarks.)

Mr. MILLER of California. Mr. Speaker, today is a serious and sad day. Not only are we presented with a welfare bill by the Republicans that for the first time in history does a great deal of harm to children in this country, but we have learned in the last few minutes that the President of the United States, Mr. Clinton, now says that he will sign that bill.

This is a President who, along with the First Lady, have spent much of their public life trying to help children. Now he says he will sign a bill that, for the first time, knowingly, he knowingly, he has been presented the evidence by his own Cabinet, he has been presented the evidence by the Urban Institute and others, that will knowingly put somewhere around 1 million children who are currently not into poverty, into poverty.

Almost half of those children are in families that are working, where people get up and they go to work every day. But at the end of the year, they are poor. This bill puts those children into poverty. That cannot be a proper purpose of the U.S. Congress, and that cannot be a proper endorsement for the President of the United States.

□ 1415

It is against the interest of our children. Yes, this program was started many years ago to try and save the children. For many, many years we have lifted those children out of poverty, not as well as we have done for the seniors, but it was a national goal.

This bill now for the first time, again knowingly, the evidence is in front of us, and yet we are being asked to make a decision to reverse that trend and to once again put children into poverty. They can lose their benefits under this with nobody having offered their parents a chance to work or requiring them to do so, because in the 11th hour those same Governors who boasted about their desire to put people to work came in and got loopholes put into this bill so they do not have to meet the very standards that they said they were prepared to change this program from welfare to work.

So how did they achieve the budget savings, then? They achieved the budget savings by going after children, by going after women. I grew up, and I think most people in this country believe that when you said women and children first, what you were saying is you wanted to care for those individuals. This legislation suggests that they will be the first to be harmed and that is what this legislation allows.

I appreciate all of the theory in the legislation, but the fact of the matter is every time that the pedal meets the road here, what we see is that in fact they are sacrificed. These children now pay to provide the $60 billion in savings that the majority says that they want. We cannot allow that to happen. this President should be demanding that this bill simply do no harm to those children. You can get all of the welfare reform you want and still do no harm to the children. But unfortunately this President has joined the Republicans now in making the children the very victims of the system he said he wanted to reform.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HEFLEY). The Chair will make a brief statement in clarification of his response to the parliamentary inquiry propounded by the gentleman from Pennsylvania [Mr. WELDON] during the consideration of House Resolution 492.

In that response, the Chair merely intended to indicate that, in the discretion of the Chair, the objection by the gentlewoman from Connecticut under rule XXX was not then a dilatory motion.

Mr. SOLOMON. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, in response to the previous speaker for whom I have a great deal of respect, he came to this body about 20 years ago and I do not know what experience he had in previous government, but when he is critical of the Governors of these States, I look at my own Governor, Gov. George Pataki. He is probably one of the most knowledgeable people in America today about what it means about jamming things down the throats that we do here in Washington, sending it back to the States and local government.

George Pataki was a town mayor before he became a State assemblyman in the lower house and then before he became a State senator and now Governor. Believe me, he knows what unfunded mandates mean to a State like

ours where we have seen job after job after job chased out of our State because we just could not afford to do the things for business and industry that were necessary because of the terrible welfare burden. That is all changing now and it will change with the adoption of this legislation. We are once and for all going to be able to let those people who have the experience, those people down at the local levels of government who have to deal with the welfare recipients day in and day out, let them come up with the solutions. That is what this debate is all about.

Mr. Speaker, I yield 2 minutes to the gentlewoman from Columbus, OH [Ms. PRYCE], a member of the Committee on Rules.

Ms. PRYCE. Mr. Speaker, I thank the distinguished chairman of the Rules Committee for yielding me this time. I rise in strong support of this fair rule to bring about real welfare reform.

Mr. Speaker, a generation ago, Americans began a much-celebrated war on poverty in the hope of creating a Great Society. But nearly 30 years and more than $5 trillion later, what we are left with is a failed welfare system that has deprived hope, diminished opportunity, and literally destroyed precious lives. Our country, and the future generations of Americans who will lead her, deserve a better system.

Today we will consider a conference report that replaces a welfare system debilitated by strict Federal control with a system based on innovation and flexibility at the State and local level. Instead of promoting dependency and illegitimacy, this conference agreement is built on the dignity of work and the enduring strength of families. By taking the Federal bureaucracy out of welfare, this legislation promotes creative solutions closer to home and offers a real sense of hope to the truly needy and the less fortunate.

Mr. Speaker, despite the comments we will hear today, this is a compassionate bill. Helping those who by no fault of their own have fallen on hard times is the right thing to do. This bill responds to that in the finest American tradition. But when we help people that are able-bodied, when we just hand them a check, those people who make little or no effort to help themselves, we risk destroying the American spirit and undermining our society at large.

This conference agreement represents a true bipartisan attempt to change welfare as we know it. I hope the President will not shy away again from this historic opportunity for change.

In closing, Mr. Speaker, I urge my colleagues to have the courage to set aside the status quo, to think of the children and families of this Nation and to embrace real reform. I urge a ''yes'' vote on both sides of the aisle for this rule and the conference report.

Mr. MOAKLEY. Mr. Speaker, I yield 2½ minutes to the gentlewoman from Florida [Mrs. MEEK].

(Mrs. MEEK of Florida asked and was given permission to revise and extend her remarks.)

Mrs. MEEK of Florida. Mr. Speaker, both times I have risen, I have risen in strong opposition to the rule and I will be doing so, I feel, to the conference report.

Mr. Speaker, I do not think many people in this Congress really understand the effects of welfare. I think that the system should be reformed. I am sure that there are many people who still abuse this system. We have not yet changed to any great extent the enforcement, to be sure, that people who do not deserve welfare are on it and those who are abusing it get punished for being so.

Mr. Speaker, I contend that this conference report does not meet the needs of the people they are hoping that it will meet. We are still going to have hungry children, children who are not taken care of by their States. I served as a State legislator. We still did not give matching funds for the funds that the Federal Government gave us. Now that we are cutting the funds, are they going to do any better? My answer is no.

The real world will teach everyone in this Congress that you are hurting children. It seems to me that you are doing it deliberately because many of us have said to you and shown you evidence that it is going to do it. OMB has done it. Several agencies with whom you have great credibility have shown the same. It permits the States to experiment with our children in order to save $40 to $60 billion in Federal funds. Why save it when you are losing your main human resources, your children?

Almost one-third of these cuts come from mistreating the children of immigrants. Do you feel that the legal immigrant children in this country should be treated any less? Would you want your children to be treated any less than when they go down to get health care and they tell them they cannot be treated because their parents have been here 16 years or more paying taxes into the American Government, their sons and daughters have gone to war for this country? Are you going to say to those children, No, you can't get any more treatment. Go to the State. Go to the county. When they get to the counties and they get to the States, there is no money. I have been there and I know there is none.

The Republican majority is going to ban food stamps and SSI for some children, particularly those that are disabled and those that are poor. It bars Medicaid for legal immigrants. Is that going to make them any less ill because we are barring it in this bill which we are using here in a vacuum?

We have done perhaps no impact study. We do not know how this is going to impact on States like Florida and California. I say, Mr. Speaker, that this is wrong and that the Republican majority should realize what they are doing. Otherwise in the end the people will speak, and I hope they do.

Mr. Speaker, I rise in strong opposition to the rule and the conference report itself. This rule is designed to prevent both the Members and the public from learning the details of this fatally flawed bill.

This bill permits the States to experiment with our children in order to save $60 billion in Federal funds. Almost one-third of these cuts—$18 billion—come from treating the children of immigrants more harshly than other children.

The Republican majority bans food stamps and supplemental security income payments for virtually all legal immigrants. The bill bars Medicaid for legal immigrants who are elderly or disabled.

These immigrants the Republican majority wants to penalize are legally here. They played by the rules. They meet every requirement of the law. They live and work hard; they pay taxes; they serve in the military. They will not vanish simply because the majority passes this bill.

What will happen is that these costs now paid by the Federal Government will be unfairly shifted to States like Florida, and counties like Dade, that have a high number of legal immigrants.

Let me give the House a concrete idea of how unfair this bill really is. My own State of Florida estimates that it will lose more than $300 million a year in Federal funds because of this bill.

Who ends up paying? My constituents in Dade County and the State of Florida.

The bill instructs States to deny school lunches to undocumented immigrants. The chairman of the Dade County School Board says that one-quarter of the children in the Dade schools were born in a foreign country. The Dade County schools would have to collect information from every single child in order to determine which ones can get subsidized lunches. The Republican majority is trying to balance the budget and cut taxes for the wealthy by creating local paperwork and higher local taxes.

It is wrong and it is unfair for the Republican majority to force State and local governments—meaning our taxpayers back home—to pay for legal immigrant residents who are in this country because they complied with the immigration laws that previous Congresses have enacted.

I urge my colleagues to vote against this rule and against the conference report.

Mr. SOLOMON. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, one of my colleagues just approached me, and they said they hope the American people that might be watching on C–SPAN would ask the question of all of us: Are you satisfied with the status quo?

That seems to be what I hear from the other side of the aisle, even though the President is going to sign this bill, that they are satisfied with the status quo. The people I represent are not satisfied with that status quo.

Mr. Speaker, I yield 1 minute to the gentleman from Erie, PA [Mr. ENGLISH], one of the outstanding freshman Members of this body.

Mr. ENGLISH of Pennsylvania. Mr. Speaker, I rise in strong support of this rule and in strong support of this conference report, the most sweeping welfare reform legislation this country has seen since the Great Society.

As Franklin Delano Roosevelt warned in the late 1930's, giving permanent aid to anyone destroys them. By creating an underclass culture of poverty, dependency, and violence, we have been destroying the very people we have been claiming to help. How many more families will be trapped in the current welfare system while we waste time in Washington?

I am delighted to see that the President has indicated he may support this conference report, which will require for the first time ever able-bodied welfare recipients to work for their benefits. Every family receiving welfare must work within 2 years or lose benefits, and lifetime benefits are limited to 5 years.

This is a balanced, mainstream approach that links welfare rights to personal responsible behavior. I urge the House to adopt this rule and lay the groundwork for passage of this conference report.

Mr. SOLOMON. Mr. Speaker, I yield such time as he may consume to the gentleman from Sanibel, FL [Mr. GOSS].

(Mr. GOSS asked and was given permission to revise and extend his remarks.)

Mr. GOSS. Mr. Speaker, I rise in strong support of this rule and this bill because we all know that the era of big government is indeed over.

Mr. Speaker, I thank my friend, the distinguished chairman of the Rules Committee, for yielding me this time. The wisdom of SOLOMON has been in great demand these last few days, and once again he has delivered a fair and workable rule to this body. Our Rules Committee labored diligently yesterday evening and this morning to accommodate both the strong desire of the majority of Americans that we end welfare as we know it—and the legitimate efforts that have been underway among Members of Congress and the administration to negotiate a final product. For that reason, we brought two rules, in order to give the conferees as much time as possible to complete their work while getting welfare reform to the President this week. This rule allows the House to consider a milestone bill—one that lays to rest 30 years of big-government policies that have cost $5.5 trillion but failed to win the war on poverty. I must say I am disturbed by the hand-wringing and demagoguery that is emanating from some members of the minority. Their assurances that they do want to reform welfare, but they just don't want to do it in this way, ring quite hollow. Remember that they had the opportunity when they controlled both Houses of Congress and the White House for 2 years—an opportunity they refused to capitalize on. So now, with a President who has pledged to end welfare as we know it, and a congressional majority committed to dismantling the Big Brother, Washington-knows-best bureaucracy that has made welfare a dependency trap—we are finally going to make welfare reform happen. I am sorry that the ultraliberal wing of the Democrat Party in this House is having trouble with that result—but it's one the American people are demanding. If those in the minority succeed in their carefully orchestrated attempt to delay enactment of this bill, I suspect they will have to answer to their constituents for denying poor Americans a fighting chance to break out of poverty and become productive members of this society. Mr. Speaker, this legislation unleashes the creativity of our States to solve problems or poverty at home. It unshackles them from the burdens of costly and micromanaging Federal regulation—while providing significant resources for children and job programs. It allows those precious Federal dollars that are so desperately needed by our Nation's poor to bypass the grossly inefficient Federal bureaucracy. And it emphasizes work for those who can, along with compassion for those who can't. This is a balanced bill—and it's time for the defenders of the status quo to get with the program and heed the words of the President. Support this rule and the bill.

Mr. MOAKLEY. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, the chairman of the Rules Committee just said if people are opposed to this rule and this bill that they are for status quo. That is absolutely incorrect.

The people who are opposed to this bill are opposed to it because it puts another 1 million children into poverty and does not go far enough.

Mr. Speaker, I yield 3 minutes to the gentleman from Indiana [Mr. ROEMER].

(Mr. ROEMER asked and was given permission to revise and extend his remarks.)

Mr. ROEMER. Mr. Speaker, this bill, this conference report that we will soon vote on, represents the biggest change to our social policy in the last 60 years. We have moved from the New Deal to the New Frontier to the Great Society, and now hopefully to the fair deal.

Where have we gone in this debate over the last year? We started with H.R. 4, a bill that I think was terrible for this Nation and for our children, that was mean to our children, that was unfair to the people that we wanted to give skills to go to work, that was not fair to our parents who had children home from child care. That bill has been vastly changed. Just recently we voted for a bill to come out of the House, and 30 of us Democrats voted to move the process along and improve the bill in the Senate and House conference, where it has been improved, and I will vote to support this conference.

President Clinton deserves credit for his willingness to sign this bill, and he deserves praise for his determination to change previous bills that were mean to children and that did not give the resources to our workers to stay off welfare.

Let us move forward in a bipartisan way to continue to modify what can be a better and better bill, through Executive order, through legislative change, and through bipartisan work. Let us march forward together, Democrats and Republicans, to change the status quo and move to the fair deal for our taxpayers, and for those recipients of welfare and those children that are being raised from generation to generation in welfare. We can work together. We can and must work together for the recipients of welfare and for the taxpayers of this country.

Again, President Clinton will sign this bill, according to all the reports, and he has indicated a willingness to work in a bipartisan way. I am glad that the President changed the first bill, H.R. 4. I am glad that the President vetoed those initial bills that were mean to children and were not fair to get people permanently off welfare.

I hope to continue to work across this middle aisle, Democrats and Republicans, reaching out to join hands and to claim back a system for the taxpayer and the American people and our children, so that we do have the biggest change in social policy in the last 60 years, moving from the New Deal to the fair deal for our taxpayers.

□ 1430

Mr. SOLOMON. Mr. Speaker, I yield myself such time as I may consume to say that my good friend from Boston, MA, Mr. MOAKLEY, made the statement that he is not for the status quo but he is opposed to this bill. We hear that so many times, but, but, but, but, but, but. Nobody is ever ready to put themselves on the line for welfare reform. Today we have it.

Mr. Speaker, I yield 2 minutes to the gentleman from Claremont, CA, Mr. DAVID DREIER, my good friend and member of the Committee on Rules.

(Mr. DREIER asked and was given permission to revise and extend his remarks.)

Mr. DREIER. Mr. Speaker, I rise in strong support of this rule and the conference report. The gentleman from New York [Mr. SOLOMON] is absolutely right when he says that it is very easy to find things in this measure which we do not all support.

I admit I have some concerns about some provisions as they impact my State of California. But the fact of the matter is, ending welfare as we know it is what the President said that he wanted to do when he was a candidate back in 1992. My friend, the gentleman from Illinois [Mr. MANZULLO], just reminded me that it has gotten to the point where a Republican Congress has been able to do what a Democratic Congress did not do in the first 2 years of the President's term, and that is end welfare as we know it.

So we have finally gotten to the point where we are looking at the fact that over the last 3 decades we have expended $5.3 trillion on welfare payments of all kinds and we have seen the poverty rate move from 14.7 percent to 15.1 percent. So everyone, Democrats and Republicans alike, as the gentleman from New York [Mr. SOLOMON] just said, and the gentleman from Massachusetts [Mr. MOAKLEY], our friend from south Boston, acknowledges he does not want to support the status quo and we must change the welfare system.

Now, earlier today, when the chairman of the Subcommittee on Human

Resources, the gentleman from Florida [Mr. SHAW], was before the Committee on Rules, he talked about the fact that we will most likely, in the 105th Congress, need to make some sort of modification to this measure, but if we defeat this conference report there will be no welfare reform.

We have gotten a measure, and the President has finally gotten to the point where he has agreed to sign it. That is why, as my friend, the gentleman from Indiana [Mr. ROEMER], said, we need to move ahead with bipartisan support so we can try our darnedest to address a system which is broke.

There are many more things that need to be done. Entitlement reform is something that is important, so that we are not simply, as many are labeling this thing, attacking those who are less fortunate. We need to realize that this measure is designed not just to help those taxpayers who are shouldering the responsibility but also to do everything we can to help people get out of that generational cycle of dependence.

Support the rule and support the conference report.

Mr. MOAKLEY. Mr. Speaker, I yield myself such time as I may consume.

It has been referred to some people on my side as being for the status quo. Two weeks ago we voted for the Tanner-Castle bill, which was a reform bill. It had much more reform than this. So it is not that we are for the status quo. We want a real reform bill. This is not it.

Mr. Speaker, I yield 2 minutes to the gentlewoman from North Carolina [Mrs. CLAYTON].

Mrs. CLAYTON. Mr. Speaker, I think that the conference report will pass and, therefore, there will be reform because the majority of our Members truly think they are reforming the welfare system. But reforming the welfare system means that we would have provisions in there that would ensure we were decreasing dependency, we would encourage work and we would be supportive to families. Those kind of structures are not present.

I know everyone has good intentions, and certainly reform is because we are trying to reduce a big deficit, because we know already the amount of money we spend on welfare is really insignificant to the total amount that we spend. If we wanted to reduce the budget, we would be reforming other things. Like the gentleman has just said, entitlements would be that issue.

Hopefully, we can understand that those of us who will vote against this are really making a statement. We care about children too much to rob Paul to pay Peter. We are not willing to rob children of their opportunity and their future in order to provide other people an opportunity to live.

Also we say we are about teenage pregnancy prevention, and yet this House last month had the opportunity just to appropriate $30 million to prevent teenage pregnancy. We know over a half million young people become pregnant every year. We spend annually $6.5 billion, yet we will not put a small amount of money to encourage young people to do the positive behavior activity so they will not lead a life of dependency.

We say we want to decrease dependency. We want to give kids stepping stones, but we put these stumbling blocks in their way. Mr. Speaker, this is not supportive of children, and I give no bad intents to anyone, but this conference bill, and I hope I am wrong, I hope I am wrong. I hope, indeed, millions of children do not suffer, but I could not vote in good conscience for a bill that I am not assured of that.

Reform means encouraging young people for support, decreasing dependency and making provisions for work. Vote against this conference bill.

Mr. SOLOMON. Mr. Speaker, I yield 1 minute to the gentleman from Egan, IL, Mr. DON MANZULLO, an outstanding Member.

(Mr. MANZULLO asked and was given permission to revise and extend his remarks.)

Mr. MANZULLO. Mr. Speaker, in the last 31 years this country has spent over $5.4 trillion on the welfare system, and what do we have to show for it? We have generation after generation locked in a seemingly endless cycle of destitution and poverty. They are the lost forgotten statistics, dependent on the Federal entitlement trap that strips them of their dignity, destroys families, damages our work ethic, and destroys the self-esteem of those trapped in the system.

Cruelty is allowing this destructive system to continue. By passing this welfare reform bill we will restore hope and opportunity by making work, and not welfare, a way of life.

Our current welfare system has not only failed those in the system, but it has also failed those who have been supporting it, the hard working taxpayer. It has failed the forgotten American, the one who gets up in the morning, packs a lunch, sends the kids off to school. That person is working harder than ever to make ends meet, and the typical American family is paying over $3,400 a year in taxes for welfare payments to perpetuate a failed system.

Mr. Speaker, we should pass this bill and pass it swiftly.

Mr. SOLOMON. Mr. Speaker, I yield 2½ minutes to the gentlewoman from Kansas [Mrs. MEYERS], one of the truly outstanding Members of this body, who is retiring at the end of this year. She has been such a great Member, and we are going to miss her.

(Mrs. MEYERS of Kansas asked and was given permission to revise and extend her remarks.)

Mrs. MEYERS of Kansas. Mr. Speaker, I thank the gentleman for those comments.

Mr. Speaker, I support this rule and urge my colleagues to support it. The Personal Responsibility Act is a good start toward reforming our welfare system. Because of the block grant, the entitlement nature of the program is ended.

We ask able-bodied people between 18 and 50 who receive food stamps to do some work for their benefits. We reform the SSI program to help stop monthly checks from going to prisoners and checks that were going to healthy children. And we finally tell recent immigrants that the promise of America does not automatically include a welfare check.

But many issues remain unaddressed, and I believe the most serious is the ever-increasing illegitimacy rate. In 1994, one-third of our children were born into homes where no father ever lived. And by the year 2000, 80 percent of minority children and 40 percent of all children in this country will be born out of wedlock.

Unfortunately, the conference report does nothing to require that fathers be identified. States who currently do nothing to identify fathers can continue to do nothing, and those States who continue to reward teenage pregnancy can continue to do so.

Finally, there is no effort to enforce a family cap, even though we know that the family cap has reduced a drop in additional children in New Jersey, where it is now statewide policy.

To repeat, this bill is a good start, but I believe we cannot reform our welfare system until we address the growth in illegitimacy. The link between our ever-increasing illegitimacy rates and the growth in AFDC rolls are not casual. They are cause and effect. Why is it too much to ask that children have two responsible adults as parents? Sadly, we continue to encourage the opposite.

A previous speaker said that the cost of welfare was very modest in this country. The cost of AFDC alone, I am not talking about SSI or illegal aliens or legal aliens or anything else, just AFDC, is $70 billion a year because it is $16 billion a year AFDC, it is one-fourth of Medicaid, half of food stamps, about a third of housing plus all of the training and day care programs. It is between $70 and $80 billion a year.

Mr. MOAKLEY. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania [Mr. FATTAH].

Mr. FATTAH. Mr. Speaker, I rise in opposition to the rule. This rule and this bill, this conference committee, is built on the biggest lie that has ever been told to the American people, and that is that we are spending too much as a country to help poor people.

There is no calculation that any legitimate analysis of a Federal budget would tell us that we spent $5 trillion on the war on poverty. It is all made up out of whole cloth. It includes items like the Pell grants and all kinds of other programs, and education. The AFDC payments are about a little more than one penny out of every dollar that this Government spends to help poor children.

We have gotten everybody convinced that we are spending just too much money on poor people, and now we have convinced them that Speaker GINGRICH and the Republican majority are coming to help these poor children, that this is just a major effort to really help poor children, and cutting $60 billion is just the best way to help them find their way to the American dream.

This rule, this conference committee, the Washington Post in its editorial today said it was a bad idea. They said it was a defining moment of where this country was headed. And there will be Members who will come to the floor today, because they want to be reelected and will vote for it, but out into the future there will be days that they will truly regret that they did not have the courage to stand up and oppose this hideous proposal.

Mr. SOLOMON. Mr. Speaker, I yield 1 minute to the former governor of Delaware, MIKE CASTLE, one of the people that probably knows best about the real problems or how this ought to be dealt with, and who knows that one of the reasons the welfare system in this country has failed miserably is because we inside the beltway have tried to dictate back to the States and local governments.

Mr. CASTLE. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, I support the rule and the bill. We stand today at a historic divide, a defining moment that separates the past from the future, one which pits personal responsibility, work, and State flexibility against the largely failed welfare policies and practices of the past. Today marks a turning point for all of us, the Congress, our constituents, and perhaps most importantly, those welfare recipients.

I am pleased that the bipartisan Castle-Tanner reform proposal has provided some very positive changes and provisions that will help shame welfare reform for the better. Perhaps the most important provision we helped retain was current law on guaranteeing Medicaid eligibility to all welfare recipients and those who may be eligible in the future. Also, the food stamp optional block grants and the child welfare block grants were dropped, thus retaining minimum Federal standards and preserving these national safety nets.

On balance, we have achieved what we can all support. With this legislation we have finally begun the process by which America's underclass problem can be solved, and break a generational cycle and culture of dependency and poverty.

Congress is now the shepherd of welfare reform, not the President, and it is up to us to review and improve upon this proposal. I, for one, stand ready and committed to revisit it, if need be, to make sure welfare reform is going to work.

Mr. Speaker, we stand today at a historic divide, a defining moment that separates the past from the future; one which pits personal responsibility, work, and State flexibility against the largely failed welfare policies and practices of the past. Today marks a turning point for all of us—the Congress, our constituents, and perhaps most importantly, those welfare recipients.

Just as our Nation was formed, we stand ready to forward a bold experiment in reforming our Nation's welfare system. But like most experiments, we will most certainly have to revisit our decisions. Though we have tried, there may not be enough resources for children's care, or to adequately fund the work program that is the centerpiece of this legislation. There most likely will be economic downturns that force Governors and the Congress to reevaluate. States may require more flexibility in meeting the stringent work requirements. There are innumerable potential pitfalls.

As a coauthor of the bipartisan Castle-Tanner welfare reform proposal, JOHN TANNER and I have helped forward some very positive changes and provisions that will help shape reform welfare for the better.

Perhaps the most important provision I helped retain was current law on guaranteeing Medicaid eligibility to all welfare recipients, and those who may be eligible in the future. The food stamp optional block grant and the child welfare block grant were dropped, thus retaining minimum Federal standards and preserving these national safety nets.

Protecting children in families that lose cash assistance is a high priority. Although I would have preferred mandatory in-kind assistance after a 5-year time limit on cash assistance, I am mostly satisfied that a provision could be added that would ensure that States can utilize Federal funds from the social services block grant for the care of the child. Furthermore, we were successful in ensuring that a higher State maintenance of effort on State spending could be included in the conference report. We also were successful in including language that would require that Congress review in 3 years the work program to ensure its success. Last, Castle-Tanner has had a moderating impact on the burdens that the noncitizen provisions will put on our Nation's future citizens, primarily in the health care area. While Castle-Tanner included stronger protections for children and families under the cash block grant, increased funding for the welfare-to-work programs, significantly smaller food stamp cuts, and less severe immigrant cuts, its fingerprints can be readily identifiable on this conference report.

Nevertheless, on balance, we have achieved what we all can support: with this legislation, we have finally begun the process by which America's underclass problem can be solved, and break a generational cycle and culture of dependency and poverty.

This is not a perfect experiment, but then experiments usually aren't. Congress is now the shepard of welfare reform—not the President—and it is up to us to review and improve upon this proposal. I, for one, stand ready and committed to revisit this as it is implemented, and as we gain empirical evidence that our effort can be successful in making work pay more than welfare. And only then will we be truly able to say that we have ''ended welfare as we know it.'' It's worth taking some risks to end it.

Mr. MOAKLEY. Mr. Speaker, I yield 1 minute to the gentleman from South Carolina [Mr. CLYBURN].

Mr. CLYBURN. Mr. Speaker, I rise today in opposition to the conference agreement. Being a slightly better option than the House passed version of the bill does not mean this is a good piece of legislation.

Welfare should be a temporary transition from welfare to work. Unfortunately this is 1996, an election year, and we have entered the ''silly season.'' Rather than being a constructive debate, the welfare reform debate has become, for the most part silly talk of budgetary savings and time limits—not helping those in need of assistance learn how to help themselves.

I think the designers of this legislation have forgotten a valuable lesson: If you give a man a fish, you feed him for a day but if you teach that man how to fish, he can feed himself for a lifetime.

This conference report would consist of a check for 2 years and then a requirement for work programs for only 50 percent of families receiving welfare payments—6 years from now.

The Republicans have forgotten the parable about feeding a family for a lifetime but instead have decided that it is much cheaper to write a check to a welfare family than provide the necessary training to ensure that another check never has to be written to that family.

And under the guise of welfare reform even these checks are becoming smaller. Under the House passed version of this conference agreement the average annual cut per food stamp household in South Carolina would be $265, and this cut would grow to $394 by 2002. Under the Senate version of the bill, food stamp households in South Carolina stand to lose even more. While it is not clear what the actual cut would be for South Carolina families under the conference agreement, it is clear that my State's most vulnerable households would be between the proverbial rock and a hard place with little or no hope of any training to help them lift themselves permanently out of poverty.

With the talk of personal responsibility being tossed around, I find it ironic that at the same time our Nation's most vulnerable families are being required to do more for themselves, our States are being asked to do even less.

In this conference agreement, unlike the Tanner-Castle substitute bill I supported earlier this month, States are required to spend only 75 percent of what they spent in 1994 in return for a block grant check from the Federal Government. At the same time, it is projected that as a result of this legislation 8,170 children in my state of South Carolina will be pushed into pvoerty.

I urge my colleagues not to support this agreement. Although it may be the lesser of two evils, it is not the best we can do nor is it the best we can afford to do.

□ 1445

Mr. HALL of Ohio. Mr. Speaker, I yield 1 minute to the gentlewoman from Texas [Ms. JACKSON-LEE].

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, the politic thing to do today is to get in the well of the House and hit your gavel down and say I am against the deadbeat on welfare, and I am right with you for welfare reform. As America watches those of us who have a difference of opinion, we will get castigated and accused as supporting those who would not work. But I come today to oppose this rule.

I hope that those who have goodwill and understand what America is all about will realize that I believe in welfare reform but I do not believe in putting 1 million children in the streets. I do not believe in a weak work program where States will not have the work to give to those who are on welfare. I do not believe in a shortened contingency fund so that, when the 5 years comes, those who have not been able to bridge themselves out of welfare will not have the support that they need.

I do not believe in sending legal immigrants into war, but yet when they need a helping hand this Nation will say you can fight for us but we do not have any support for you and your children. I do not believe in dispossessing the disabled. I do not believe in denying SSI benefits to 300,000 children.

Oh, we could be politic today and many will do that. But it does not matter to me because there are people in this country who need our help. This is a bad welfare reform. Vote against it.

Mr. SOLOMON. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, if my colleagues want to take child abuse out of the welfare families, the best thing to do is to bring these people up out of the poverty system and given them meaningful jobs. That is what this legislation is meant to do.

Mr. Speaker, I yield 2 minutes to the gentleman from Florida [Mr. WELDON], someone I am very proud of because he gave up a very lucrative medical practice to come here and try to do something for America.

Mr. WELDON of Florida. Mr. Speaker, I thank the distinguished gentleman for yielding, and it has been a pleasure for me to be here and advocate for the people in my district, who have been calling out for welfare reform for many years.

Mr. Chairman, they know that the current welfare system is broken. The people in my district know that the rate of poverty has not decreased since welfare has been enacted. The average stay on welfare is 13 years, and today illegitimacy rates among many welfare families approach 50 percent.

Mr. Speaker, I rise in strong support of the bill, and strong support of this rule. H.R. 734 will truly finally end welfare as we know it.

It did not take a Republican Congress to end welfare as we know it. This bill makes welfare a helping hand, not a lifetime handout. It places 5-year limits on collecting AFDC benefits. For hardship cases States can exempt 20 percent of their case load from the 5-year limit, and able-bodied people must work after 2 years or lose their benefits.

It cuts taxpayer financed welfare for noncitizens and felons. It returns power and flexibility to the States. It ends numerous redundancies within the welfare system by giving block grants to the States and rewards States for moving families from welfare to work.

It seeks to halt the rising illegitimacy rates. Moms are encouraged for the first time to identify the father or risk losing benefits by as much as 25 percent. It increases efforts to make deadbeat dads pay child support. And these, of course, are men who father children but then have shirked their financial responsibility for caring for them.

It gives cash rewards to the top five States who make the most successful improvement in reducing illegitimacy. As we know, fatherlessness is linked to high juvenile crime rates, high drug abuse rates, and declining educational performance. Support the rule and support the bill.

Mr. Speaker, I rise in strong support of H.R. 3734 the Personal Responsibility and Work Opportunity Act. This historic welfare reform bill will end welfare as we know it. During the past 30 years, taxpayers have spent $5 trillion on failed welfare programs. What kind of return have the taxpayers received on their investment? The rate of poverty has not decreased at all. Furthermore, the average length of stay on welfare is 13 years. Today's illegitimacy rate among welfare families is almost 50 percent and crime continues to run rampant. Current programs have encouraged dependency, trapped people in unsafe housing, and saddled the poor with rules that are antiwork and antifamily. Clearly, those trapped in poverty and the taxpayers deserve better.

This bill overhauls our broken welfare system. This plan makes sure welfare is not a way of life; stresses work not welfare; stops welfare to felons and most noncitizens; restores power and flexibility to the States; and offers States incentives to halt the rise in illegitimacy.

By imposing a 5-year lifetime limit for collecting AFDC, this bill guarantees that welfare is a helping hand, not a lifetime handout. Recognizing the need for helping true hardship cases, States would be allowed to exempt up to 20 percent of their caseload from the 5-year limit. In addition, H.R. 3734 for the first time ever requires able bodied welfare recipients to work for their benefits. Those who can work must do so within 2 years or lose benefits. States will be required to have at least 50 percent of their welfare recipients working by 2002. To help families make the transition from welfare to work, the legislation provides $4.5 billion more than current law for child care.

Under this bill future entrants into this country will no longer be eligible for most welfare programs during their first 5 years in the United States. Felons will not be eligible for welfare benefits, and State and local jails will be given incentives to report felons who are skirting the rules and receiving welfare benefits.

Our current system has proven that the one-size-fits-all welfare system does not work. H.R. 3734 will give more power and flexibility to the States by ending the entitlement status of numerous welfare programs by block granting the money to the States. No longer will States spend countless hours filling out the required bureaucratic forms hoping to receive a waiver from Washington to implement their welfare program. States will also be rewarded for moving families from welfare to work.

Finally, this bill addresses the problem of illegitimacy in several ways. H.R. 3734 authorizes a cash reward for the five States most successful in reducing illegitimacy. It also strengthens child support enforcement provisions and requires States to reduce assistance by 25 percent to individuals who do not cooperate in establishing paternity. Lastly, this bill mandates an appropriation grant of $50 million annually to fund abstinence education programs combating teenage pregnancy and illegitimacy.

The sad state of our current welfare system and the cycles of poverty and hopelessness it perpetuates are of great concern to me. I believe this bill goes to the heart of reforming the welfare system by encouraging and helping individuals in need become responsible for themselves and their family. I wholeheartedly support this bill because it makes welfare a helping hand in times of trouble, not a hand out that becomes a way of life. I truly believe that this reform will give taxpayers a better return on their investment in helping those in need.

Mr. SOLOMON. Mr. Speaker, I yield 2 minutes to the gentleman from Maine [Mr. LONGLEY], another outstanding new Member of this body. I particularly like him because he is a former Marine.

(Mr. LONGLEY asked and was given permission to revise and extend his remarks.)

Mr. LONGLEY. Mr. Speaker, I want to compliment the gentleman from New York [Mr. SOLOMON], chair of the Committee on Rules, and also members of the committee for bringing this important legislation to the floor, bringing this rule to the floor. This has been delayed far too long.

This is a bill that is about child abuse. It is drug abuse. It is crime and violence and the fact that, for too many Americans who are trapped in this system, the American dream has become the American nightmare.

I do not argue with the fact that the welfare system is a hand in need to those who need it. But for too many it has become a prison. This is about women and children who are suffering under this system as well as the social workers and the law enforcement officers who are forced to deal with the ramifications of the aspects of the system that do not work.

Mr. Speaker, for too long we have been delaying this. We have delayed this vote for most of the day. The fact of the matter is that welfare reform is at the door. It has been knocking for

almost 30 years, and it is finally here today. This afternoon, hopefully, it will be voted on and we will send it to a President who will endorse it. I think that is a tremendous accomplishment for the people of this country.

I would also say it is a first step. The system has become so complex between the different aspects of service and how they are available to help people, that even the people running the system have difficulty understanding it, let alone those who have need for assistance. So, it is a first step in the direction of reform, in the direction of providing an American dream for more Americans and getting rid of the American nightmare.

Mr. SOLOMON. Mr. Speaker, I yield 1 minute to the gentleman from Texas [Mr. SMITH], an outstanding Member who has dealt with the immigration problem in this country.

Mr. SMITH of Texas. Mr. Speaker, I rise in strong support of the rule and the Personal Responsibility Act. Welfare has harmed our children, families, and taxpayers. It has created a culture of dependency that saps people's desire to better their lives. And welfare has undermined America's longstanding immigration policy.

America has always welcomed new citizens with the energy and commitment to come to our shores to build a better future. We've always ensured that immigrants are self-reliant—not dependent on American taxpayers for support. Since 1917, noncitizens who have become public charges after they enter the United States have been subject to deportation.

Welfare undermines this policy and harms immigrants. Rather than promoting hard work, welfare tempts immigrants to come to America to live off the American taxpayer. Noncitizen SSI recipients have increased 580 percent over the past 12 years, and will cost American taxpayers $5 billion this year alone.

H.R. 3734 restores America's historic immigrants policy and ends the cruel welfare trap. It ensures that sponsors, not taxpayers, will support new immigrants who fall on hard times. Just as deadbeat dads should support the children they bring into this world, deadbeat sponsors should support the immigrants they bring into our country.

I urge my colleagues to support this rule and vote for this bill.

Mr. SOLOMON. Mr. Speaker, I yield 2 minutes to the gentleman from Savannah, GA [Mr. KINGSTON].

Mr. KINGSTON. Mr. Speaker, I thank the gentleman from New York for yielding.

It is interesting we have heard from the Democrats a number reasons why they are not going to support this bill today. One of their reasons was they have not had time to look at it. I am a relatively new Member of Congress. I have been here 4 years. We have been debating welfare for 4 years. I know that for a fact. I have been here. If they have not read the bill by now and have not been following the debate, that is not the fault of the Republican Congress.

The second reason they say that is that welfare does not cost that much. If you add in all the Federal Government welfare programs, the cost is $345 billion, which is ore than we spend on defense. I am not sure what they consider money if $345 billion is not. We spent $5 trillion since LBJ's Great Society programs, and that is enough money. That is more than we spent on World War II.

The final reason they are saying is that it is cruel to children. Nothing is more cruel than having a welfare system that traps children in poverty, that makes children and families break up, that makes them live in housing projects where the dad cannot be at home, where there is high drug use, where there are teenage dropout rates and teenage drug abuse. I do not see why they think that is compassion.

Our program sends $4 billion more on child care than the Democrat proposal. And that is using their frame of thinking that is more compassion than what they have. Welfare reform is family friendly. Welfare should not be a life style. It should be something that society gives people a temporary helping hand, not a permanent handout, not a hammock forever to swing in but a temporary safety net so that people can get back into the socioeconomic mainstream and enjoy the American dream just like the rest of us.

Mr. MOAKLEY. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I want to begin by reminding my colleagues of one very important fact. Today 9 million children depend upon Aid to Families With Dependent Children for their survival. When we are talking about reforming welfare, we are talking about these 9 million American children, and we need to be very, very careful on what changes we make.

Mr. Speaker, this is not to say that I am opposed to welfare reform. In fact, I am very much in favor of welfare reform. I have seen too many children growing up surrounded by violence. I have seen too many fathers completely abandon their responsibilities. And I have seen too many single mothers too dejected and overwhelmed to look for jobs.

These days being poor is not what it used to be. It used to be that families stuck together. It used to be if you worked hard enough you could support your family. But, Mr. Speaker, unfortunately times have changed.

I agree with the editorial in the August 12 issue of the New Republic which says that, although our current welfare system may not have created the current underclass, it certainly sustains it. I agree that welfare reform is one of the most important issues that we can take up in this Congress. Today's Boston Globe says that under this bill, poverty will grow with welfare done on the cheap. We need to be very careful, Mr. Speaker, how we change AFDC and not do it on the cheap.

This bill, Mr. Speaker, is not the way to do it. I hoped that after this bill came out of conference, I would be able to support it. But after looking at it, I cannot because, Mr. Speaker, I cannot vote for a bill that will push 1 million additional children below the poverty level. I cannot vote for a bill that may not guarantee health care to poor children and a conference committee that cuts food stamps. I cannot vote for a bill that will provide no protection for bad times. If there is a recession, millions of people will be completely destitute. And, Mr. Speaker, I cannot vote for a bill that allows States to take at least one-half of their Federal money and spend it on something other than children.

This Gingrich welfare bill, Mr. Speaker, is too tough on children. It is weak on work, and it is soft on deadbeat parents. Mr. Speaker, as I said, two out of every three people on welfare is a child, and we have a responsibility to those children. We have a responsibility to make sure that under no circumstances whatsoever will they be hurt. We have a responsibility, Mr. Speaker, to make sure that their health and their safety is placed far above any jockeying for political advantage.

So I urge my colleagues to oppose this rule and oppose the conference committee bill and I yield back the balance of my time.

□ 1500

Mr. SOLOMON. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, did I hear the gentleman right when he said, the Gingrich welfare bill? Is that not strange? I thought it was the Gingrich-Clinton welfare bill, because the President has just announced he is going to sign the bill. Mr. Speaker, colleagues, I would just say to you, what is compassionate about locking poor people into a lifetime of welfare dependency? That is what this debate is all about. If you are really sincere, if you really care about poor people in America, do something for them. Change the status quo which has failed miserably.

I see my good friend, the gentleman from Texas [Mr. STENHOLM], sitting over here, came here with me 18 years ago. He came before the Committee on Rules about an hour or so ago and he said, JERRY, this a bipartisan bill. He said, we Democrats have had input to it. It is a compromise. It is a step in the right direction.

Mr. Speaker, what I was hearing is, no more ifs, ands and buts. This is the compromise. This is the step in the right direction we need to move in.

Let us vote for this bill now. Vote for the rule and the bill and let us get on with trying to change the welfare system in America for the good of the poor.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore (Mr. RIGGS). The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. MOAKLEY. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

Pursuant to clause 5 of rule XV, the Chair will reduce to 5 minutes the minimum period of time within which a vote by electronic device, if ordered, will be taken on the question of agreeing to the resolution.

The vote was taken by electronic device, and there were—yeas 259, nays 164, not voting 10, as follows:

[Roll No. 381]

YEAS—259

Allard	Dooley	Kasich
Archer	Doolittle	Kelly
Armey	Dornan	Kim
Bachus	Doyle	King
Baesler	Dreier	Kingston
Baker (CA)	Duncan	Kleczka
Baker (LA)	Dunn	Klug
Ballenger	Ehlers	Knollenberg
Barr	Ehrlich	Kolbe
Barrett (NE)	English	LaHood
Bartlett	Ensign	Largent
Barton	Everett	Latham
Bass	Ewing	LaTourette
Bateman	Fawell	Laughlin
Bereuter	Fields (TX)	Lazio
Bilbray	Flanagan	Leach
Bilirakis	Foley	Lewis (CA)
Bishop	Forbes	Lewis (KY)
Bliley	Fowler	Lightfoot
Blute	Fox	Lincoln
Boehlert	Franks (CT)	Linder
Boehner	Franks (NJ)	Lipinski
Bonilla	Frelinghuysen	Livingston
Bono	Frisa	LoBiondo
Brewster	Funderburk	Longley
Browder	Gallegly	Lucas
Brownback	Ganske	Manzullo
Bryant (TN)	Gekas	Martini
Bunn	Geren	McCollum
Bunning	Gilchrest	McCrery
Burr	Gillmor	McDermott
Burton	Gilman	McHugh
Buyer	Goodlatte	McInnis
Callahan	Goodling	McIntosh
Calvert	Goss	McKeon
Camp	Graham	Metcalf
Campbell	Greene (UT)	Meyers
Canady	Greenwood	Mica
Castle	Gutknecht	Miller (FL)
Chabot	Hall (TX)	Molinari
Chambliss	Hamilton	Montgomery
Chapman	Hancock	Moorhead
Chenoweth	Hansen	Morella
Christensen	Hastert	Myers
Chrysler	Hastings (WA)	Myrick
Clinger	Hayes	Nethercutt
Coble	Hayworth	Neumann
Coburn	Hefley	Ney
Collins (GA)	Heineman	Norwood
Combest	Herger	Nussle
Condit	Hilleary	Orton
Cooley	Hobson	Oxley
Cox	Hoekstra	Packard
Cramer	Hoke	Parker
Crane	Holden	Paxon
Crapo	Horn	Payne (VA)
Cremeans	Hostettler	Peterson (FL)
Cubin	Hunter	Peterson (MN)
Cunningham	Hutchinson	Petri
Davis	Hyde	Pickett
Deal	Inglis	Pombo
DeLay	Istook	Porter
Diaz-Balart	Johnson (CT)	Portman
Dickey	Johnson, Sam	Poshard
Dicks	Jones	Pryce
Quillen	Shadegg	Thornberry
Quinn	Shays	Tiahrt
Radanovich	Shuster	Torkildsen
Ramstad	Skeen	Traficant
Regula	Smith (MI)	Upton
Riggs	Smith (NJ)	Vucanovich
Roberts	Smith (TX)	Walker
Roemer	Smith (WA)	Walsh
Rogers	Solomon	Wamp
Rohrabacher	Souder	Watts (OK)
Ros-Lehtinen	Spence	Weldon (FL)
Rose	Stearns	Weldon (PA)
Roukema	Stenholm	Weller
Royce	Stockman	White
Salmon	Stump	Whitfield
Sanford	Talent	Wicker
Saxton	Tanner	Wolf
Scarborough	Tate	Young (AK)
Schaefer	Tauzin	Zeliff
Schiff	Taylor (MS)	Zimmer
Seastrand	Taylor (NC)	
Sensenbrenner	Thomas	

NAYS—164

Abercrombie	Gibbons	Neal
Ackerman	Gonzalez	Oberstar
Andrews	Gordon	Obey
Baldacci	Green (TX)	Olver
Barcia	Gutierrez	Ortiz
Barrett (WI)	Hall (OH)	Owens
Becerra	Harman	Pallone
Beilenson	Hastings (FL)	Pastor
Bentsen	Hefner	Payne (NJ)
Berman	Hilliard	Pelosi
Bevill	Hinchey	Pomeroy
Blumenauer	Hoyer	Rahall
Bonior	Jackson (IL)	Rangel
Borski	Jackson-Lee (TX)	Reed
Boucher	Jacobs	Rivers
Brown (CA)	Johnson (SD)	Roybal-Allard
Brown (FL)	Johnson, E. B.	Rush
Brown (OH)	Johnston	Sabo
Bryant (TX)	Kanjorski	Sanders
Cardin	Kaptur	Sawyer
Clay	Kennedy (MA)	Schroeder
Clayton	Kennedy (RI)	Schumer
Clement	Kennelly	Scott
Clyburn	Kildee	Serrano
Coleman	Klink	Sisisky
Collins (IL)	LaFalce	Skaggs
Collins (MI)	Lantos	Skelton
Conyers	Levin	Slaughter
Costello	Lewis (GA)	Spratt
Coyne	Lofgren	Stark
Cummings	Lowey	Stokes
Danner	Luther	Studds
de la Garza	Maloney	Stupak
DeFazio	Manton	Tejeda
DeLauro	Markey	Thompson
Dellums	Martinez	Thornton
Deutsch	Mascara	Thurman
Dingell	Matsui	Torres
Dixon	McCarthy	Torricelli
Doggett	McHale	Towns
Durbin	McKinney	Velazquez
Edwards	McNulty	Vento
Engel	Meehan	Visclosky
Eshoo	Meek	Volkmer
Evans	Menendez	Ward
Farr	Millender-McDonald	Waters
Fattah	Miller (CA)	Watt (NC)
Fazio	Minge	Waxman
Fields (LA)	Mink	Williams
Filner	Moakley	Wilson
Foglietta	Mollohan	Wise
Frank (MA)	Moran	Woolsey
Frost	Murtha	Wynn
Furse	Nadler	Yates
Gejdenson		
Gephardt		

NOT VOTING—10

Flake	Jefferson	Shaw
Ford	McDade	Young (FL)
Gunderson	Richardson	
Houghton	Roth	

□ 1521

Mrs. KENNELLY and Mr. JOHNSON of South Dakota changed their vote from ''yea'' to ''nay.''

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. RIGGS). The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. MOAKLEY. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 281, nays 137, not voting 15, as follows:

[Roll No. 382]

YEAS—281

Allard	Everett	Lucas
Archer	Ewing	Luther
Armey	Fawell	Manzullo
Bachus	Fields (TX)	Martini
Baesler	Flanagan	Mascara
Baker (CA)	Foley	McCarthy
Baker (LA)	Forbes	McCollum
Ballenger	Fowler	McCrery
Barcia	Fox	McHugh
Barr	Franks (CT)	McInnis
Barrett (NE)	Franks (NJ)	McIntosh
Bartlett	Frelinghuysen	McKeon
Barton	Frisa	Metcalf
Bass	Frost	Meyers
Bateman	Funderburk	Mica
Bentsen	Gallegly	Miller (FL)
Bereuter	Ganske	Minge
Bilbray	Gekas	Molinari
Bilirakis	Geren	Montgomery
Bishop	Gilchrest	Moorhead
Bliley	Gillmor	Morella
Blute	Gilman	Myers
Boehlert	Goodlatte	Nethercutt
Boehner	Goodling	Neumann
Bonilla	Gordon	Ney
Bono	Goss	Norwood
Boucher	Graham	Nussle
Brewster	Greene (UT)	Orton
Browder	Greenwood	Oxley
Brownback	Gutknecht	Packard
Bryant (TN)	Hall (OH)	Parker
Bunn	Hall (TX)	Paxon
Bunning	Hamilton	Payne (VA)
Burr	Hancock	Peterson (FL)
Burton	Hansen	Peterson (MN)
Buyer	Harman	Petri
Callahan	Hastert	Pickett
Calvert	Hastings (WA)	Pombo
Camp	Hayworth	Porter
Campbell	Hefley	Portman
Canady	Hefner	Poshard
Castle	Heineman	Pryce
Chabot	Herger	Quillen
Chambliss	Hilleary	Quinn
Chapman	Hobson	Radanovich
Chenoweth	Hoekstra	Ramstad
Christensen	Hoke	Regula
Chrysler	Holden	Riggs
Clement	Horn	Rivers
Clinger	Hostettler	Roberts
Coble	Hunter	Roemer
Coburn	Hutchinson	Rogers
Collins (GA)	Hyde	Rohrabacher
Combest	Inglis	Ros-Lehtinen
Condit	Istook	Rose
Cooley	Jacobs	Roukema
Costello	Johnson (CT)	Royce
Cramer	Johnson (SD)	Salmon
Crane	Johnson, Sam	Sanford
Crapo	Jones	Saxton
Cremeans	Kasich	Scarborough
Cubin	Kelly	Schaefer
Cunningham	Kennelly	Schiff
Danner	Kim	Seastrand
Deal	King	Sensenbrenner
DeLay	Kingston	Shadegg
Deutsch	Kleczka	Shaw
Diaz-Balart	Klug	Shays
Dickey	Kolbe	Shuster
Dicks	LaHood	Sisisky
Dingell	Largent	Skeen
Dooley	Latham	Skelton
Doolittle	LaTourette	Smith (MI)
Dornan	Laughlin	Smith (NJ)
Doyle	Lazio	Smith (TX)
Dreier	Leach	Smith (WA)
Duncan	Levin	Solomon
Dunn	Lewis (CA)	Souder
Durbin	Lewis (KY)	Spence
Edwards	Lightfoot	Spratt
Ehlers	Lincoln	Stenholm
Ehrlich	Lipinski	Stockman
English	LoBiondo	Stump
Ensign	Longley	Talent

Tanner	Upton	White
Tate	Volkmer	Whitfield
Tauzin	Vucanovich	Wicker
Taylor (MS)	Walker	Williams
Thomas	Walsh	Wilson
Thornberry	Wamp	Wolf
Tiahrt	Watts (OK)	Young (AK)
Torkildsen	Weldon (FL)	Zeliff
Torricelli	Weldon (PA)	Zimmer
Traficant	Weller	

NAYS—137

Abercrombie	Gonzalez	Obey
Ackerman	Green (TX)	Olver
Andrews	Gutierrez	Ortiz
Baldacci	Hastings (FL)	Owens
Barrett (WI)	Hilliard	Pallone
Becerra	Hinchey	Pastor
Beilenson	Hoyer	Payne (NJ)
Berman	Jackson (IL)	Pelosi
Bevill	Jackson-Lee (TX)	Pomeroy
Blumenauer	Jefferson	Rahall
Bonior	Johnson, E. B.	Rangel
Borski	Johnston	Reed
Brown (CA)	Kanjorski	Roybal-Allard
Brown (FL)	Kaptur	Rush
Brown (OH)	Kennedy (MA)	Sabo
Bryant (TX)	Kennedy (RI)	Sanders
Cardin	Kildee	Sawyer
Clay	Klink	Schroeder
Clayton	LaFalce	Schumer
Clyburn	Lantos	Scott
Coleman	Lewis (GA)	Serrano
Collins (IL)	Lofgren	Skaggs
Collins (MI)	Lowey	Slaughter
Conyers	Maloney	Stark
Coyne	Manton	Stokes
Cummings	Markey	Studds
Davis	Martinez	Stupak
de la Garza	Matsui	Taylor (NC)
DeFazio	McDermott	Tejeda
DeLauro	McHale	Thompson
Dellums	McKinney	Thornton
Dixon	McNulty	Thurman
Doggett	Meehan	Torres
Engel	Meek	Towns
Eshoo	Menendez	Velazquez
Evans	Millender-McDonald	Vento
Farr	Miller (CA)	Visclosky
Fattah	Mink	Ward
Fazio	Moakley	Waters
Fields (LA)	Mollohan	Watt (NC)
Filner	Moran	Waxman
Foglietta	Murtha	Wise
Frank (MA)	Nadler	Woolsey
Furse	Neal	Wynn
Gejdenson	Oberstar	Yates
Gephardt		
Gibbons		

NOT VOTING—15

Cox	Houghton	Myrick
Flake	Knollenberg	Richardson
Ford	Linder	Roth
Gunderson	Livingston	Stearns
Hayes	McDade	Young (FL)

□ 1530

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid of the table.

PERSONAL EXPLANATION

Mr. KNOLLENBERG. Mr. Speaker, on rollcall No. 382. I was in the Rayburn Room. The beeper and the bells failed to function and I missed the above vote. Had I been present, I would have voted ''yea.''

PERSONAL EXPLANATION

Mr. HOUGHTON. Mr. Speaker, I was inadvertently delayed while attending an International Relations Committee hearing with Secretary Christopher, and missed voting on rollcalls No. 381 and No. 382. Had I been there, I would have voted ''yea'' on 381 and ''yea'' on 382.

Mr. KASICH. Mr. Speaker, pursuant to House Resolution 495, I call up the conference report on the bill (H.R. 3734) to provide for reconciliation pursuant to section 201(a)(1) of the concurrent resolution on the budget for fiscal year 1997.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to House Resolution 495, the conference report is considered as having been read.

(For conference report and statement, see Proceedings of the House of Tuesday, July 30, 1996, at page H8829.)

The SPEAKER pro tempore. The gentleman from Ohio [Mr. KASICH] and the gentleman from Minnesota [Mr. SABO] will each be recognized for 30 minutes.

The Chair recognizes the gentleman from Ohio [Mr. KASICH].

Mr. KASICH. Mr. Speaker, I yield 4 minutes to the gentleman from Kansas [Mr. ROBERTS], the distinguished chairman of the Committee on Agriculture.

(Mr. ROBERTS asked and was given permission to revise and extend his remarks.)

Mr. ROBERTS. Mr. Speaker, I thank the gentleman for yielding time to me, and I thank my colleagues for their reluctant attention.

Mr. Speaker, in a year that has been described by many as one of gridlock and finger-pointing and wheel-spinning and even-numbered year partisan rhetoric, we are about to achieve a remarkable accomplishment. This House and the Senate, and now finally the President, have responded to the American public. Simply put, this conference report represents real accomplishment, real welfare reform.

We urged the President to sign this conference report. He has. There are good reasons why. Seventy-five percent of the food stamp reforms in this conference report represent the same things that were proposed by this administration. I do not care whether we are talking about budget savings, the work requirement, the program simplification, the tougher penalties for fraud and abuse, or keeping the program at the Federal level as we go through the welfare reform transition. We have tried to work with the administration. We have done that. The President will sign the bill.

Mr. Speaker, this road has not been easy. We have been working in this House for 18 months. The very first hearing held by me in the Committee on Agriculture was on fraud and abuse, and the critical and urgent need for reform of the Food Stamp Program. The new Inspector General at the Department of Agriculture showed a videotape of organized crime members trading food stamps for cash, and eventually using that cash for drugs and guns. That tape made national news, and it confirmed the suspicions of many taxpayers and citizens.

Following that hearing, our late colleague and dear friend, the chairman of the subcommittee, Bill Emerson, held four extensive hearings and formulated the principles that guided the reform that is now before us.

First, the original Republican plan was to make sure that as we go through welfare reform, no one would go hungry, that we would keep a reformed Food Stamp Program as a safety net so food can and will be provided while States are undergoing this transition.

Second, we wanted to eliminate as much paperwork and redtape and regulation as possible. We wanted to harmonize the welfare and the Food Stamp Program requirements. This bill does that.

Third, having seen the program costs soar from $12 to $27 billion in 10 years, regardless of how the economy has performed, we wanted to take the program off of automatic pilot. We have done that.

Fourth, the food stamps must not be a disincentive to work. In this bill, able-bodied participants, those from ages of 18 to 50 with no dependents, no kids, no children, only the able-bodied, these folks, less than 2 percent of those on food stamps, they must work in private sector jobs and not be rewarded for not working.

Fifth, after hearing firsthand from the Inspector General, we tightened the controls on waste and abuse. We stopped the trafficking with increased and tough penalties.

Mr. Speaker, these principles do represent real reform of the Food Stamp Program. All are incorporated in the conference agreement. I urge my colleagues to vote ''yes.''

I want to thank my colleagues for a tremendous team effort, more especially the gentleman from Ohio [Mr. KASICH], more especially the gentleman from Texas [Mr. ARCHER], more especially the gentleman from Pennsylvania [Mr. GOODLING], and more especially, underscored three times, the gentleman from Florida [Mr. SHAW], who said the work we have accomplished is significant. We have true reform. We have a real welfare reform bill. But now the work really starts. This bill is not perfect. We have a lot ahead of us and a lot of challenges. I urge a ''yes'' vote on the conference report.

Mr. SABO. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Tennessee [Mr. TANNER].

(Mr. TANNER asked and was given permission to revise and extend his remarks.)

Mr. TANNER. Mr. Speaker, I am happy today for several reasons. I think Congress has come together with the administration to take a step forward on certainly what is a pressing national social problem. That is welfare reform. We started out, as the previous speaker said, almost 2 years ago to try to bring together something that could be signed and enacted into law so we could actually change the system that is broken, according to everyone who has observed it, and actually do something about it now.

I want to thank the gentleman from Florida [Mr. SHAW], the gentleman from Ohio [Mr. KASICH], the gentleman from Minnesota [Mr. SABO], and many others here. I particularly want to

thank the gentleman from Delaware, MIKE CASTLE, who came together with me to put together something that would be bipartisan so we could get off of this partisan gridlock that we have been suffering from.

Mr. Speaker, in our motion to instruct conferees we asked for two or three things: One, a safety net for kids. That has been accomplished with Medicaid and food stamps. The safety net is there for children. The unfunded mandate problem has been partially taken care of, with the States being allowed to continue with waivers, and also because the Medicaid situation is intact, there will not be a lot of costs transferred to county hospitals across our country. We also asked that savings go to the debt. That has not been accomplished, but as the previous speaker said, we will continue to work on that.

The most important difference between the conference agreement and the two bills that have previously been vetoed, in my judgment, is that we protect innocent children. This bill no longer treats a 4-year-old child like he or she is a 24-year-old irresponsible adult. To me that was critical. That is not a part of welfare reform. That is just compassionate public policy. This bill has done that.

I once again thank the Republican conferees for their hard work, the gentleman from Florida [Mr. SHAW] and others. I also urge a ''yes'' vote. Let us make this a red letter day.

Mr. CAMP. Mr. Speaker, I yield such time as she may consume to the gentlewoman from New Jersey [Mrs. ROUKEMA].

(Mrs. ROUKEMA asked and was given permission to revise and extend her remarks.)

Mrs. ROUKEMA. Mr. Speaker, I rise in support of this legislation, and want to associate myself with the statement of the chairman of the Committee on Agriculture, the gentleman from Kansas [Mr. ROBERTS], particularly as it applied to the Food Stamp Program. My opposition and stated principle in the last round of this bill before it went to conference was expressing a concern of what it did to innocent children in that regard. I rise in support. It has been corrected, and I support the conference agreement.

Mr. Speaker, as someone who has advocated a ''tough love'' approach to welfare reform legislation, this goes a long way toward reforming our broken welfare system as we return the system to its original purpose—a temporary safety net, not a way of life.

Furthermore, as a pioneer in the battle to also reform our child support enforcement system, I am very pleased to see that the reforms I have been pushing for almost 4 years now—which represent the heart and soul of the U.S. Interstate Commission on Child Support's final report—have been included in the package before us today.

Ensuring that these child support enforcement reforms were included in this bill acknowledges what I've been saying for years: Effective reform of our interstate child support enforcement laws must be an integral component of any welfare reform plan that the 104th Congress sent to President Clinton.

Research has found that somewhere between 25 and 40 percent of welfare costs go to support mothers and children who fall onto the welfare rolls precisely because these mothers are not receiving the legal, court-ordered support payments to which they are rightfully entitled.

With the current system spending such a large portion of funding on these mothers, children are the first victims, and the taxpayers who have to support these families are the last victims.

The plan before us also puts teeth into the laws that require unwed mothers to establish paternity of their children at the hospital, thereby laying the groundwork for claiming responsibility for their actions and families.

The core of the welfare reforms incorporated into this bill are clearly defined work requirements for welfare beneficiaries—which is essential to moving people off of the welfare rolls—strict time limits—thereby giving welfare recipients a strong incentive to find a job—and more flexibility for States to design welfare programs that fit the needs of their people.

In addition, this welfare reform plan protects the safety net for children by including a rainy day fund to help the families in States suffering from recession or economic downturns.

The enhanced flexibility that States will receive under this plan is meritorious, provided that the safety net is maintained in order to protect families who truly need temporary assistance—not a lifetime of handouts generation after generation.

For example, while I support the concept of giving States more flexibility in designing their own welfare programs, I am very pleased to see that this bill contains strong maintenance of effort provisions which will require States to continue their commitment to the Nation's safety net.

Under no circumstances should a block grant reform allow States to simply administer welfare or any other program using only Federal moneys—this bill avoids that problem with its tough maintenance of effort language.

I was very distressed by the fact that House version of this bill opened a significant loophole in the Food Stamp Program by giving States the option of using block grants for this critically-important aspect of our Nation's safety net.

Given that I was deeply concerned about giving a blank check to the Governors for the Food Stamp Program would result in innocent children going hungry, I opposed the House plan last week.

But again I am very pleased to see that, once again, the Senate has saved the House of Representatives from itself by rejecting this proposal, and successfully retaining its position on this issue in the final bill.

Additionally, this legislation does take a modest step in the right direction by allowing States to use their own money, or social services block grant funds—to provide families on welfare with vouchers—instead of cash benefits—to pay for essential services needed by the family, that is, medicine, baby food, diapers, school supplies—if a State has terminated the family's cash benefits as part of its sanction program.

This is the right thing to do because even if a welfare recipient is playing by all of the rules and has not found a job when the time limits become effective, the use of vouchers for services plays an important role in helping the family and its children keep their head above the water-line.

There should be no question that we must enact strong welfare reform legislation this year. The American people are correctly demanding that we restore the notion of individual responsibility and self-reliance to a system that has run amok over the past 20 years.

Although I have strongly supported some welfare reforms that have been described as ''tough love'' measures for several years now, I want to reiterate that my goal has always been to require self-reliance and responsibility, while ensuring that innocent children do not go hungry and homeless as a result of any Federal action.

Finally, I am most supportive of the improvements the conference gave to the Medicaid Program. This is an enlightened and humane response to genuine medical needs.

Mr. Speaker, this bill is not perfect. But, it represents the first major reform of our broken-down welfare system in generations. We have been given a historic opportunity that I hope and trust we will not squander. We owe no less to our children. I urge my colleagues to join me in voting for final passage of this monumental reform package.

Mr. CAMP. Mr. Speaker. I yield myself such time us I may consume.

(Mr. CAMP asked and was given permission to revise and extend his remarks.)

Mr. CAMP. Mr. Speaker, I rise in support of the conference agreement.

Today, the Congress is again presented with the opportunity to adopt meaningful welfare reform. Over the past 19 months, my colleagues and I have written, debated, and adopted proposals to reform our current welfare system. Our efforts, however, were twice vetoed by the President.

Since launching the war on poverty in 1965, over $5 trillion has been spent to eliminate poverty in America. Some 31 years later and despite billions and billions of dollars, poverty in America has worsened and our children grow and mature in an environment with little hope and opportunity.

The proposal before us today reforms a welfare system that has trapped millions in a

cycle of poverty. Our current welfare system punishes families and children by rewarding irresponsibility, illegitimacy and destroying self-esteem. For too long, the Federal Government has defended the current system and turned away as millions of families and children became trapped in a cycle of despair, dependence, and disappointment.

This bill accomplishes several important goals. First, it time limits welfare to 5 years. The Federal and State governments have an obligation to assist those in need but our current system has become a way of life instead of a temporary helping hand for those experiencing hard times.

Second, our bill requires work. The Washington welfare system has also robbed recipients of their self-esteem by merely providing a check. This proposal requires each recipient to work for their benefits, thereby instilling the pride of employment and allowing each recipient to earn a paycheck. This sense of accomplishment and independence increases the individual's self-esteem and often influences the children who can see firsthand the benefits of a strong work ethic. For those continuing to experience hard times, however, the bill allows States to exempt up to 20 percent of the welfare caseload from the time limit.

Most importantly our bill helps those families and individuals working to improve their lives. We provide more funding for child care than current law and more than requested by the President. This funding is extremely important in allowing families to work while ensuring their children receive the proper care. We also protect our children by ensuring eligibility for Medicaid. For those families moving from welfare to work, we continue assistance so they don't have to worry about losing health care coverage if their incomes increase.

Compassion is not the sole property of Washington and our bill creates a Federal-State partnership in meeting the needs of welfare recipients. States will have the power and opportunity to design and implement new innovative programs that best meet the needs of residents. I urge my colleagues to support the conference report.

Mr. Speaker, I ask unanimous consent that the gentleman from Florida [Mr. SHAW] be allowed to control the time and to yield.

The SPEAKER pro tempore (Mr. RIGGS). Is there objection to the request of the gentleman from Michigan?

There was no objection.

Mr. SHAW. Mr. Speaker, I yield 1 minute to the gentlewoman from Washington [Ms. DUNN], a member of the Committee on Ways and Means.

Ms. DUNN of Washington. Mr. Speaker, this is a good bill. I am very pleased that the President has announced that he is going to sign this bill. I want to commend Members on both sides of the aisle for their hard work. We have worked for a long time to put a good bill together.

To those who are concerned with protecting the children, so were we. We spent a lot of time, a lot of thought, a lot of effort on protecting the children. We have come up with a bill that in the child care portion of the bill provides over $4 billion more to help those mothers who are trying to get off welfare into the workplace, with the peace of mind to know their children will be taken care of, $4 billion more than in the current welfare system.

On the child support portion of the legislation, where we all know that in this Nation today $34 billion are owed, ordered by the court to be paid to custodial parents, we have tightened up this system. Those children are often the children that go on welfare—30 percent of their parents leave the State to avoid paying money to support their own flesh-and-blood children. We have solved this problem. So it is my great joy to say support this bill, and thanks for all the help.

Mr. SABO. Mr. Speaker, I yield 1½ minutes to the distinguished gentlewoman from California [Ms. WOOLSEY].

(Ms. WOOLSEY asked and was given permission to revise and extend her remarks.)

Ms. WOOLSEY. Mr. Speaker, we all agree that the welfare system does not work for the welfare recipients and for the taxpayers. The challenge we face as lawmakers is to improve the system so we can invest in getting families off welfare and into jobs that pay a liveable wage, and also to answer the ''what ifs''. What if a mother on welfare cannot find a job? What if she is not earning enough to take care of her family? What if she cannot find child care for her 6-year-old?

Unfortunately, this conference report will not ensure families can live on the jobs that they get, that they will earn a liveable wage, and this conference has made sure that it does not answer our ''what ifs''. It kicks families off of assistance, even if parents are trying hard to find a job. It does not even invest in the education and training parents need to get jobs that pay an actual liveable wage.

Even though the House and Senate agreed that single parents with kids under 11 should not leave their children home alone if there is no child care, the majority went ahead without discussion and lowered that age to under 6.

□ 1545

How many of my colleagues would leave their 6-year-old home alone?

I ask my colleagues, do not take this vote lightly. Do not leave any child behind. The lives of millions of children are at stake. It will be too late tomorrow if the what-ifs are not answered today.

Mr. SHAW. Mr. Speaker, I yield 2 minutes to the gentleman from Pennsylvania [Mr. GOODLING], the chairman of the Committee on Economic and Educational Opportunities.

(Mr. GOODLING asked and was given permission to revise and extend his remarks.)

Mr. GOODLING. Mr. Speaker, as I have said many times, you cannot fix something, you cannot change something unless you first admit it is broken and first admit that you need to change it. Finally, both sides of the aisle came forward and indicated that we do have a broken system, that we have as a matter of fact put millions of Americans into a bind and took away their opportunity to ever have a chance at the American dream.

Now, the tough part then came as to how do you fix it. Of course we had differing opinions. Our committee started out with the idea that welfare must be a safety net, not a way of life; there must be a very clear emphasis on work and on getting those on welfare into work. There must be a strong measure to stop abuses of the system. We need to return power and flexibility to the States. Welfare should not encourage, it should discourage destructive personal behavior that contributes so clearly not only to welfare dependence but to a host of social problems.

Mr. Speaker, this is a good, balanced welfare reform bill. We have been very generous in providing money for child care. We have protected the nutrition program. We have established strong work requirements. And we have at long last addressed the tremendous problem of out-of-wedlock births and absentee fathers.

Mr. Speaker, I commend all those who have worked so hard to bring about this welfare reform effort. I want to especially mention from the Committee on Economic and Educational Opportunities, the gentleman from California [Mr. CUNNINGHAM], the gentleman from Delaware [Mr. CASTLE], the gentleman from Arkansas [Mr. HUTCHINSON], the gentleman from Missouri [Mr. TALENT], and the gentlewoman from Kansas [Mrs. MEYERS]. I strongly support the legislation. I urge all to vote for it because at long last we move forward in transforming welfare to a program of work and opportunity.

Mr. SABO. Mr. Speaker, I yield 2 minutes to the gentleman from Texas [Mr. STENHOLM].

(Mr. STENHOLM asked and was given permission to revise and extend his remarks.)

Mr. STENHOLM. Mr. Speaker, I rise in support of this conference report. In doing so, I want to pay particular thanks to the gentleman from Florida [Mr. SHAW] for making this an inclusive conference, at least from the perspective of those of us on this side of the aisle, and also the gentleman from Louisiana [Mr. MCCRERY] and the gentleman from Delaware [Mr. CASTLE]. They have been very good to work with, at least in listening to those of us on this side of the aisle who had major problems with previous bills before the House and thought we had constructive suggestions of how to make it better. We were listened to, and many of the proposals we made are included, of which we are grateful.

To those that suggest that somehow the State waivers portion of this is contrary to the best interest of the work programs of somehow guts work requirements, I only suggest that they read the bill. Read the language which is available, and they will see. Far

from gutting it, it makes it much more workable.

For States like mine, Texas, Utah, Michigan, and others that have already begun experimenting with work programs, this bill, I believe, allows those States and all of us who are interested in making this bill work as we say we wish it to, it allows the flexibility to allow States to experiment, to do pilot projects and pilot programs. In this case it is already happening in my State.

Some of the concerns that we had with unfunded mandates, they have been alleviated as best as can be possible under a conference report. For that we are grateful. In the area of health care providers, protection of children, this is moved in the direction that we feel is much, much more preferable than the bill that originally passed the House.

While this welfare reform conference report is far from perfect, it is clearly preferable to continuing the current system and preferable to welfare legislation considered earlier.

For these reasons I support the welfare reform conference report. I am extremely pleased that the President has agreed to sign it, and I commend those who have worked so hard for so long in order to bring us to this day.

Mr. Speaker, while some of the comments I've heard this afternoon have tended toward the hyperbolic, it truly is the case that the importance of what we are doing today should not be minimized. When this welfare reform proposal is signed into law, the status quo will be fundamentally changed.

This kind of change does not happen by chance. More people than I can mention deserve credit, but in addition to the obvious leadership of President Clinton, Chairman SHAW, and other members of the leadership, I want to express my thanks for the bipartisan efforts of MIKE CASTLE, JOHN TANNER, JOHN CHAFEE, SANDY LEVIN, NANCY JOHNSON, and others.

One of the major reasons I opposed previous welfare reform proposals, and specifically the bill that was most recently before the House, was because of the restrictions it would have placed on the State of Texas. Earlier this year I worked extensively with Governor Bush and the White House to obtain approval of the Texas welfare waiver which includes the best plans of our State for moving people from welfare to work.

President Clinton already has approved waivers allowing 41 States to implement innovative programs to move welfare recipients to work. The House's welfare reform bill would have restricted those State reform initiatives by imposing work mandates that are less flexible than States are implementing. Over 20 States would have been required to change their work programs to meet the mandates in that earlier House bill or face substantial penalties from the Federal Government.

The conference report now allows States that are implementing welfare waivers to go forward with those efforts. Specifically, the conference report allows those States to count individuals who are participating in State-authorized work programs in meeting the work participation rates in the bill, even work programs which otherwise do not meet the Federal mandates in the bill.

I know that some of my colleagues on my side of the aisle have been critical of the State waiver provisions included in this conference report. I must respectfully and forcefully disagree with that sentiment and say that in virtually all cases, I think that conversations with officials from their own States would lead them to supporting this waiver provision.

I am convinced that these various State plans are precisely the best experiments for determining how to put people to work. Frankly, I think the State plans generally are more realistic about the work requirements and are more solidly grounded in the possible, rather than the hypothetical.

Some of us around here have gotten carried away with our rhetoric about being tough on work by getting into a bidding war over who can have work requirements that sound tougher. Our rhetoric about being tough on work has led us to impose work requirements in this bill that virtually no State can implement.

The only work requirements that are meaningful are the work requirements that actually can be met by States. When I have said that previous welfare reform bills were weak on work, I have meant that the bills would not give States the resources to put welfare recipients into work.

The mandates in the bill passed by the House would force States such as Texas to make changes in the plans passed by the State legislature or face severe penalties from the Federal Government.

The important State waiver change included in the conference report gives States necessary additional flexibility in implementing programs to move welfare recipients to work even if they don't meet the mandates in this bill.

The additional flexibility that this bill gives to States in developing work programs will reduce the pressure on States to cut benefits or restrict eligibility for assistance in order to meet the work requirements of the bill. The Congressional Budget Office has reported that States would be forced to tighten eligibility for assistance to needy families or by reducing the size of benefits in order to offset the unfunded mandate in the work programs. Members who are concerned about the impact that welfare reform will have on children should strongly support giving States this flexibility and reducing the unfunded mandates.

Despite some reservations I have about this conference report, I believe it is critical that welfare reform be enacted this year. Failure to do so will signal yet another wasted opportunity to make critically needed reforms. We should enact this conference report and fix the current system now, moving towards a system that better promotes work and individual responsibility.

Mr. SHAW. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Nevada [Mr. ENSIGN], a valued member of the Subcommittee on Human Resources of the Committee on Ways and Means.

(Mr. ENSIGN asked and was given permission to revise and extend his remarks.)

Mr. ENSIGN. I thank the chairman for yielding me the time, and I thank him for all the work he has done on behalf of the welfare recipients in the country.

Mr. Speaker, today is truly independence day for welfare recipients. It is the first day to redefine compassion in America. In Las Vegas, we have a program known as Opportunity Village. It is an incredible program for the mentally disabled. It is a public-private partnership. The primary premise for the program is that it is compassionate enough to care enough about mentally disabled people to where the community works together to find these people jobs.

It is an incredible situation to walk down there and to see the joy that these people have in being able to work every day so that they do not become a drain on society. They feel good about themselves. Today is the first day welfare recipients are going to start feeling good about themselves, and the children are going to start feeling good about their parents.

My mom, when I was young, was divorced, supporting three kids, with very little money, just virtually no child support. I watched her every single day get up and go to work. She taught me a work ethic that has carried through my entire life with myself and my brother and sister. We have robbed that of welfare families. This bill starts giving that work ethic back to the American people.

The Wall Street Journal did a poll. Ninety-five percent of all presidents of companies had their first job by the time they were 12 years of age. Compassion, work ethic, today; vote for this bill. It is a good bill for America, and today is a great day for America.

Mr. SABO. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from California [Ms. WATERS].

Ms. WATERS. Mr. Speaker, someday more politicians will approach tough decisions such as welfare reform with more care and integrity. This is not that day. Someday politicians will place children above politics. This is not that day. Someday politicians will place truth above personal gain. This is not that day.

Too many Democrats and Republicans will run for reelection on this so-called welfare reform legislation. The truth is this bill does nothing to train mothers for work, to develop jobs, to help recipients become independent. This bill is welfare fraud, not welfare reform. This bill penalizes poor working families and will drive more children into poverty. Only time will reveal the shame of what happened this day, and only history will record the blatant lack of courage to simply do the right thing.

Mr. SABO. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Florida [Mrs. MEEK].

(Mrs. MEEK of Florida asked and was given permission to revise and extend her remarks.)

Mrs. MEEK of Florida. Mr. Speaker, let no one fool you. This bill is not about reforming welfare. It is not about that. It is about saving money and trying your very best to influence

the American public that we have balanced the budget. I would not mind this. I want to see welfare reform. But this is not the way to do it. What we are doing here is hurting children. Every time I stand here, I talk about that. These are all children. The conference report did much worse than the Senate. You allow the States, and I come from a State that will, you are allowing a State to cut 25 percent of their 1994 spending levels without any penalty. When the Florida legislature gets ready to cut, they are going to cut this particular program. The parents of children ages 6 to 11 will have to work without assurance of child care at all. Who is going to take care of the children? Are they going to run all over the world and get into trouble? Yes. The transfer of funds from transfer assistance to work, the Senate bill did better than that. The conference bill allows them to divert funds.

I am hoping that people listen to this bill because what this conference bill does is worse than the Senate bill and it should not be passed. Mr. Speaker, this is a travesty to the American public.

Mr. SHAW. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut [Mrs. JOHNSON], a distinguished member of the Committee on Ways and Means.

Mrs. JOHNSON of Connecticut. I thank the gentleman from Florida for yielding me the time and commend him on his extraordinary leadership now over 4 years in getting this bill to the President.

Mr. Speaker, this bill is about work, responsibility, hope, and opportunity. I wish I had the time here today to answer some of the concerns that have been raised about day care and jobs and all of those things. I think this bill addresses them. But I would like to discuss two issues that have not received much attention but are integral to our underlying goal of helping families become self-sufficient: Child support enforcement and Medicaid.

First, I am very pleased to say that this bill retains current eligibility standards for families on Medicaid. All families now on Medicaid will continue to get Medicaid. Furthermore, all families in the future that meet today's criteria will continue to get Medicaid even if their State redefines their welfare program with more constricted criteria.

Regarding the Medicaid transition period, under current law when a family leaves the welfare rolls to work, they are guaranteed 1 year's transitional Medicaid benefit. In the future, this will be absolutely true. We retain current law in this regard. Medical coverage is often one of the biggest barriers to families leaving welfare, especially since lower paying jobs are less likely to have employer-provided health coverage. By keeping the transition period policy constant, we are enabling families to go to work without worrying about losing their medical benefit.

Second, this bill contains landmark child support provisions. Today in America 3.7 million custodial parents are poor; of those 3.7 million, fully three-quarters receive no child support. Of those who have child support orders in place, which is only 34 percent of the women, only 40 percent receive the payment they should receive. This is catastrophic for women and children, and this bill fixes that system, an enormous advance for women and children and a way off welfare.

Mr. SABO. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Florida [Mrs. THURMAN].

Mrs. THURMAN. I thank the gentleman from Minnesota for yielding me this time.

Mr. Speaker, I rise today to congratulate my friends from the other side of the aisle for their wisdom in adopting the position of the bipartisan Castle-Tanner coalition in maintaining the Federal commitment to food stamps.

My colleagues were right to eliminate the optional block grant that would have forced States to turn away hungry families with children. They were right to modify the Kasich food stamp amendment in favor of a provision that provides assistance to laid-off and downsized workers.

Of course, I still believe it would have been more beneficial if this bill realized that people who cannot find jobs still need to eat. But my colleagues have come a long way, and it is significant improvement over the first attempt at welfare reform. I am happy that my friends from the other side of the aisle listened to us and made these important changes along with others such as Medicaid coverage and vouchers. I look forward to the opportunity for us to continue in a bipartisan spirit to look at the future of these programs and to ensure that people that we are trying to help to get to work are able to do so.

My colleagues so aptly put in a provision so that we do a review every 3 years. We need to make sure we follow through with that.

Mr. SHAW. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Florida [Mr BILIRAKIS], a valued member of the Committee on Commerce.

(Mr. BILIRAKIS asked and was given permission to revise and extend his remarks.)

Mr. BILIRAKIS. Mr. Speaker, as representatives of the people we do not get as many opportunities as we would like to do something that would truly help improve the lives of the people we serve. This bill presents us with just such an opportunity. This conference report is more than just a prescription for much needed welfare reform, however. It is what I hope will be the first step in our bipartisan efforts to improve the public assistance programs on which disadvantaged families depend.

After all, welfare as we know it means more than AFDC. It includes food stamps, housing assistance and energy assistance, and it includes medical assistance. That is right. For millions of Americans, Medicaid is welfare. That is because income assistance alone is not sufficient to meet the pressing needs of disadvantaged families.

For States, too, Medicaid is welfare. In fact, it makes up the largest share of State public assistance funding. As a share of State budgets, Medicaid is four times larger than AFDC.

□ 1600

If President Clinton does the right thing and signs this welfare reform bill into law, Medicaid will still be caught up in the choking bureaucratic red tape of Federal control, and that is why the Medicaid Program must be restructured if States are to fully succeed in making public assistance programs more responsible and effective.

Mr. Speaker, I commend my colleagues on both sides of the aisle for their commitment to true welfare reform, and I look forward to continuing our efforts to making all sources of public assistance work better for those who need a helping hand up.

Mr. SABO. Mr. Speaker, I yield such time as he may consume to the gentleman from Illinois [Mr. JACKSON].

(Mr. JACKSON of Illinois asked and was given permission to revise and extend his remarks.)

Mr. JACKSON of Illinois. Mr. Speaker, I rise in strong opposition to this deadly and Draconian piece of garbage which will do nothing to reform the conditions of poverty and unemployment suffered by our Nation's most vulnerable.

As I listen to the debate on the floor of this body today, I felt compelled to make clear to the American people exactly what this bill will do to our Nation's families and our Nation's future. Despite the deceptive rhetoric that we have heard on the floor today, let us be clear—at its core, this bill unravels a 60-year guarantee of a basic human safety net for our Nation's poorest and most vulnerable children and their families.

The President and many Members of the 104th Congress have decided to cut welfare as they know it—to children, immigrants and the poorest Americans—but they have left intact welfare as we know it—welfare to America's largest corporations. We cannot and must not balance the budget on the backs of the least of these.

Mr. Speaker, I have heard Members on this floor urge support of this deadly measure, cloaking its defense in terms like ''This is for the good of the poor.'' How can this be anything but bad for the poor, when we know that in my Home State of Illinois alone, 55,800 children will be pushed below the poverty line as a result of this bill, and 1.3 million children will be similarly impacted nationwide.

Please know, Mr. Speaker, that I will not join demopublicans and republicrats in this mean-spirited attack. you can rest assured that I will work to continue to provide equal protection under the law for our Nation's poor, our disabled, our immigrants and our children.

Posturing tough on welfare mothers is viewed as good politics at least by a press

corps that admires cynicism. But ending welfare as I know it is a good idea if done well. So before you push more poor kids and their mothers out on the streets let's apply "Two Years and You're Off" to dependent corporations and find a real jobs program for all Americans. Perhaps conservative Republicans and Democrats and posturing Presidents should begin to beat up on the welfare king for a change.

Mr. SABO. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from New York [Mrs. MALONEY].

Mrs. MALONEY. Mr. Speaker, this conference report is dangerous and unrealistic. I do not believe the American people will tolerate a policy of ending support to a single mom who has played by the rules, tried to find a job for 2 years and could not.

Our unemployment rate is over 5 percent, and that does not include millions of welfare recipients. This conference report does not require the Government to create jobs. The result will be the world's wealthiest nation putting families out on the street to fend for themselves. Will we tolerate destitution and call it reform?

Republicans say the States will solve these problems. Already Philadelphia, as reported yesterday in the paper, has stopped providing shelter beds for single homeless people due to Federal and State welfare cuts. I am not predicting that Republican welfare reform will put people out on the street. I am pointing out that it already has.

Oppose this conference report.

Mr. SHAW. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Delaware [Mr. CASTLE], who has done a great deal in this conference in bringing the two sides together.

Mr. CASTLE. Mr. Speaker, I cannot thank the gentleman from Florida [Mr. SHAW] enough. At a time when somebody had to listen, he did. We do not always do that in this building, and it is just a tremendous honor to him that we are passing this bill today.

I thank the gentleman from Tennessee, Congressman JOHN TANNER, not a finer person to work with I know in the House, who acted in a bipartisan way when I think we needed that in order to bring this bill into line.

I thank the President, who I understand is going to sign this legislation. I believe he is doing the right thing for a variety of reasons.

I believe the safety net was put back into place that we have talked about in several ways in the area of Medicaid, food stamps, and the ability of States to set up voucher systems after 5 years. I think they can deal with that.

I have believed strongly, in my fight for welfare reform for 12 years now, that this is the opportunity. Everyone talks about this in a very draconian sense. I believe this is opportunity for women, for children, in some instances for men, and for families. It is opportunity because we are going to take people who have not had a true chance to live the American life in terms of their education and background and we are giving them that chance.

It is an experiment. We may have to come back to it, but I congratulate everybody.

Mr. SABO. Mr. Speaker, I yield 1 minute to the distinguished gentleman from South Carolina [Mr. CLYBURN].

Mr. CLYBURN. Mr. Speaker, I thank the ranking member for yielding me this time.

Mr. Speaker, 2 years and you are out is not a bad proposition in and of itself, but in this bill it relies on that tried-and-true adage if you give a man a fish you may feed him for a day, if you teach a man how to fish he may feed himself for a lifetime.

In this bill, Mr. Speaker, only 50 percent of those 2-years-and-you-are-outers can reasonably expect any chance at training. In this era of personal responsibility, this legislation asks our most vulnerable citizens to do more, but our States are being required to do less.

Mr. Speaker, this is not the best we can do, and it is not the best we can afford. I urge a no vote, Mr. Speaker.

Mr. SABO. Mr. Speaker, I yield 1 minute to the distinguished new mom from Arkansas, Mrs. LINCOLN.

(Mrs. LINCOLN asked and was given permission to revise and extend her remarks.)

Mrs. LINCOLN. Mr. Speaker, I thank the gentleman for yielding me this time and for his kind remarks.

I think we can find that no one will argue that our current welfare system needs changed and today we have the opportunity to pass legislation that will hopefully move our Nation's low-income citizens from passively accepting a welfare check to actively earning a paycheck.

Welfare reform has been one of my top priorities since first coming to Congress, especially reform of the SSI disability program or the crazy check problem.

I have worked diligently with members of the Blue Dog Coalition, with the Chairman of the Subcommittee on Human Resources, the task force, and with Members of both sides of the aisle to find a reasonable solution to those who truly need SSI assistance and welfare reform, hoping we can crack down on the abuse in the system while making provisions for those who need it.

Although this conference report is not a perfect bill, it represents a significant improvement over our status quo. No one should get something for nothing, and if the American people are going to be generous with their tax dollars, they should get something in return.

Mr. Speaker, this legislation provides responsible reform through the three main goals we started with: State flexibility, personal responsibility, and work. I urge my colleagues to support this provision, a lot of hard work in a bipartisan spirit.

Mr. SHAW. Mr. Speaker, I yield such time as he may consume to the gentleman from Virginia [Mr. GOODLATTE].

(Mr. GOODLATTE asked and was given permission to revise and extend his remarks.)

Mr. GOODLATTE. Mr. Speaker, I thank the gentleman for yielding me this time, for his fine work on this bill, and I rise in strong support of the welfare reform conference report.

Mr. SABO. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Hawaii [Mrs. MINK].

Mrs. MINK of Hawaii. Mr. Speaker, I thank the ranking member of the Committee on the Budget for yielding me this time.

I intend to vote against this conference report. The Urban Institute tells us that over a million children will be put into poverty as a result of this legislation. We are told by our own Republican Congressional Budget Office that it is underfunded insofar as the work requirements.

If indeed we want our people on welfare to go to work, is it not fair to expect that there will be dollars there to provide them jobs, not to cut them adrift after 2 years without any cash support whatsoever?

That is what the consequence of this bill will do. It will force people out on the streets, literally, with no cash assistance whatsoever and without the promise of any assistance in finding jobs.

The women on welfare want to work. Look at any study that has been issued. These studies tell us that over 60 percent of the young mothers on welfare are out there looking for jobs and half of them do find them and they get off welfare. These people who say that the women stay there 13 years on welfare are simply not telling the truth.

Mr. SHAW. Mr. Speaker, I yield 1½ minutes to the gentlewoman from North Carolina [Mrs. MYRICK], the former mayor of Charlotte.

Mrs. MYRICK. Mr. Speaker, the President's decision to sign this welfare reform bill is really great news for working Americans and for people in need. The welfare bill will really reform and empower the States to be creative in solving their own problems and it will help end the cycle of dependency and poverty, which really truly helps millions of children with a decent fulfilling future.

As a former mayor, I know firsthand these ideas work because we had pilot programs in our area where we were moving people out of public housing and into home ownership and off of welfare with child care help and really giving them their dignity back again.

It is a sin not to help someone who genuinely, truly needs that help through no fault of their own, but it is also a sin to help people who do not need help. So this bill is going to encourage that personal responsibility that we are all so proud of and give people their dignity back.

Mr. SABO. Mr. Speaker, I yield 1 minute to the distinguished gentleman from North Dakota [Mr. POMEROY].

Mr. POMEROY. Mr. Speaker, I rise to support this legislation. I believe this

bill is clearly an improvement over the current system.

I voted against the previous GOP bills because I believed they inadequately protected children and were weak on work. Unlike those bills, this conference report does not deprive kids on Medicaid of their health care coverage.

The conference report allows States to provide vouchers for children's necessities when their parents reach the time limit on benefits. The conference report removes the optional food stamp block grant and provides families with high rent or utility bills an adjustment for more grocery money than the earlier House versions allowed. I remain concerned that funding for job training may not be adequate yet, and that may need to be addressed in the future.

A lot of us have worked hard to improve the various welfare reform proposals we have considered. Real welfare reform has meaningful protections for children, has a tough work requirement and demands personal responsibility. While this bill is not perfect, it fits those parameters and begins a process of reforming welfare.

Mr. SHAW. Mr. Speaker, I yield 1 minute to the gentleman from Louisiana [Mr. MCCRERY], a most valuable member of the Subcommittee on Human Resources of the Committee on Ways and Means.

Mr. MCCRERY. Mr. Speaker, I thank the chairman of the subcommittee for yielding me this time and congratulate him on the great work in getting this welfare reform bill to the floor today. I also commend the President today for agreeing to sign this most historic bill.

I want to talk for just a second about a part of the bill that I helped write, and I have gotten several calls today and yesterday, and some of my colleagues have, regarding the SSI for children's provisions in this bill.

I want to assure all those teachers who brought this problem to my attention and to the attention of other of my colleagues this is being taken care of in this welfare reform bill. We do away with a very subjective qualifying criteria that allows children to qualify for a disability when they really should not be on the program and replaces it with very definitive medical criteria that will be much, much superior to the current system.

So I want to thank the gentlewoman from Arkansas, BLANCHE LAMBERT LINCOLN, the gentleman from Wisconsin, GERALD KLECZKA, and others who helped me to bring to the attention of this body the very serious problems with the SSI disability for children.

Mr. SABO. Mr. Speaker, I yield 1 minute to the gentleman from California [Mr. FARR].

In addition, Mr. Speaker, I ask unanimous consent to yield the remainder of the time on our side to the gentleman from Florida [Mr. GIBBONS] and that Mr. GIBBONS be permitted to manage that time and to yield time to others.

The SPEAKER pro tempore (Mr. MCINNIS). Is there objection to the request of the gentleman from Minnesota?

There was no objection.

The SPEAKER pro tempore. The gentleman from California [Mr. FARR] is recognized for 1 minute.

(Mr. FARR of California asked and was given permission to revise and extend his remarks.)

Mr. FARR of California. Mr. Speaker, everybody in this Congress wants welfare reform. That is not the debate. But not everybody in the Congress wants to shift the cost from Federal Government to local government.

We usually ask ourselves as lawmakers to look before we leap. I do not think we have done that here on the welfare reform bill. We have asked to be quoted by Governors, but Governors do not administer welfare, communities do. Counties and cities do. Has anyone asked the mayors and county supervisors? Well, I did.

In California we are going to shift 230,000 people who are legal residents of the United States who are disabled. They are cut off. They live in our community. Where are they going to go? What will this bill do to help them?

This bill goes on. It hurts the people in our neighborhoods, people who go to school with our children. What can we do with a bill that hurts children, that hurts the disabled, that hurts the elderly? In the Congress of the richest Nation in the world, what we can do is vote ''no'' on this bill and say we can do a better job.

We want welfare reform, but a welfare reform bill that just plows the problem on the community is not reform at all. I ask for a ''no'' vote.

Mr. Speaker, I insert the following material for the RECORD:

COUNTY OF SANTA CRUZ,
HEALTH SERVICES AGENCY,
Santa Cruz, CA, July 17, 1996.

Re recommendation to oppose H.R. 3507 and S. 1795 denying eligibility for federal programs for legal immigrants.

Hon. SAM FARR,
U.S. House of Representatives, Washington, DC.

DEAR CONGRESSMAN FARR: On behalf of Santa Cruz County, we are asking for your assistance and intervention in deleting from H.R. 3507 and S. 1795, requirements which deny eligibility for federal programs to legal immigrants. These two bills are moving forward under the heading of welfare reform and in their present form, are expected to save the Federal government $23 billion over seven years. At least $9 billion of this total would be achieved by eliminating services to legal immigrants in California. Santa Cruz County with less than 1% of the state's population, because of its population history, dependence on agriculture and demographics, expects an adverse financial impact far in excess of its population share.

While the federal budget will experience some relief, the budgets of local governments, especially over-taxed budgets such as Santa Cruz's, will be severely impacted. These important issues demand thoughtful, coordinated planning and implementation to assure the least negative impact on those taxpayers who fund local government services and those residents who look to local government for care.

These two legislative proposals, regardless of their noble intent, will savage local government and cause severe personal and societal disruption. For these reasons, we urge that you oppose these measures as long as they contain these unacceptable provisions which deny eligibility for legal immigrants.

Very truly yours,

CHARLES MOODY,
Health Services Administrator.
WILL LIGHTBOURNE,
Human Resources Agency Administrator.

CALIFORNIA LEGISLATURE,
Sacramento, CA, July 18, 1996.

Hon. SAM FARR,
U.S. House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE FARR: We are writing to convey major concerns raised by the most recent proposed welfare legislation currently being considered by Congress.

SERVICES FOR AGED AND DISABLED LEGAL IMMIGRANTS

Denying Federal benefits to legal immigrants disproportionately harms California communities. Over 230,000 non-citizen legal immigrants currently receive SSI in California, excluding refugees. This aid is provided to the aged, blind and disabled, who could not support themselves by going to work if their SSI benefits ended. Under H.R. 3507, SSI and Food Stamps would be denied to non-citizens already legally residing in California as well as to new legal entrants, unlike the immigration reform legislation currently under consideration in Congress, which permits continued benefits for existing legal residents.

The proposed bar on SSI and Food Stamps for all legal immigrants, and the denial of other Federal means-tested programs to new legal entrants for their first five years in the country would have a devastating effect on California's counties, which are obligated to be the providers of last resort. It is estimated that these proposed changes would result in costs of $9 billion to California's counties over a seven-year period. At a minimum, the very elderly, those too disabled to become citizens and those who become disabled after they arrive in this country should be exempted from the prohibition on SSI—if for no other reason than to lessen to counties the indefensible cost of shifting care from the Federal government to local taxpayers for a needy population admitted under U.S. immigration laws.

PROTECTION OF CHILDREN

While we agree that welfare dependence should not be encouraged as a way of life, it is essential in setting time limits on aid that adequate protections be provided for children once parents hit these time limits. Some provision must be made for vouchers or some other mechanism by which the essential survival needs of children such as food can be met. The Administration has suggested this sort of approach as a means of ensuring adequate protection for children whose parents hit time limits on aid.

California's child poverty rate was 27 percent for 1992 through 1994, substantially above the national rate of 21 percent. H.R. 4, which was vetoed by the President, would have caused an additional 1.5 million children to become poor. Though estimates have not been produced for H.R. 3507, it is likely that it also would result in a significant additional number of children falling below the poverty level.

ADEQUATE FUNDING FOR CHILD CARE

Funds provided for child care are essential to meet the needs of parents entering the

work force while on aid and leaving aid as their earnings increase. For California to meet required participation rates, about 400,000 parents would have to enter the work force and an additional 100,000 would have to increase their hours of work. Even if only 15 percent of these parents need a paid, formal child care arrangement, California will need nearly $300 million per year in new child care funds.

Thank you for your consideration of these concerns. If your staff have any questions about these issues, they can contact Tim Gage at (916) 324–0341.Sincerely,

Bill Lockyer,
President Pro Tempore, California Senate.

RICHARD KATZ,
Democratic Floor Leader, California Assembly.

NATIONAL IMMIGRATION LAW CENTER—OVERVIEW OF CURRENT LAW AND WELFARE REFORM IMMIGRANT RESTRICTIONS—104TH CONGRESS

	Current Law	Welfare Reform Reconciliation Act of 1996 (H.R. 3734) as passed by the House	Personal Responsibility, Work Opportunity Act of 1966 (H.R. 3734) as passed by the Senate	Differences/Comments
Programs barred to most legal immigrants including current residents	None	Denied until citizenship: SSI, Food Stamps, and Medicaid.	Denied until Citizenship: SSI, and Food Stamps.	Medicaid: House bars Medicaid to most legal immigrants. Senate imposes lesser restrictions on immigrant access to Medicaid. The Senate Medicaid provisions affect about half as many people after six years.
		Current recipients: phased in over one year. Exemptions Refugees, asylees, withholding of deportation during 1st 5 years only. Veterans and family members. Immigrants who work 40 ''qualifying quarters'' (as defined for Title II Social Security) and did not receive any means-tested assistance in any of those quarters. Minor children get credit for quarters worked by parents; spouses get credit for work if still married or if working spouse is deceased.	Current recipients: phased in over one year. Exemptions Refugees, asylees withholding of deportation during 1st 5 years only. Veterans and family members. Immigrants who work 40 ''qualifying quarters'' (as defined for Title II Social Security) and did not receive any means-tested assistance in any of those quarters. Minor children get credit for quarters worked by parents; spouses get credit for work if still married or if working spouse is deceased.	Refugees/Asylees: Most refugees and asylees have been here more than five years and would be subject to the bar.
State option to bar current legal residents and future legal immigrants.	States may not discriminate against legal immigrants in the provision of assistance.	Programs: State have option to bar both current residents and new immigrants from: AFDC, title XX, and all entirely state funded means-tested programs.	Programs: State option to bar both current residents and new immigrants from: Medicaid, AFDC, title XX, and all entirely state funded means-tested programs.	Identical provisions. The definitions of ''means-tested'' programs was deleted from the Senate bill because of the ''Byrd rule''.
Five Year prospective bar (on future legal immigrants).	None.	Provision: Bars AFDC and most federal means tested programs to legal immigrants who come after date of enactment for 1st 5 years after entering the U.S. Exceptions: Emergency Medicaid. Immunizations & testing and treatment of the symptoms of communicable diseases. Short-term non-cash disaster relief. School Lunch Act programs. Child Nutrition Act programs. Title IV foster care and adoption payments. Higher education loans & grants. Elementary & Secondary Education Act. Head Start. TPA. At AG discretion, community programs (such as soup kitchens) that do not condition assistance on individual income or resources and are necessary to protect life or safety.	Provision: Bars AFDC and most federal means tested programs to legal immigrants who come after date of enactment for 1st 5 years after entering the U.S. Exceptions: Emergency Medicaid. Immunization & testing and treatment of communicable disease if necessary to prevent the spread of such disease. Short-term non-cash disaster relief. School Lunch Act programs. Child Nutrition Act programs. Certain other emergency food and commodity programs. Title IV foster care and adoption payments. Higher education loans & grants (including those under the Public Health Services Act). Elementary & Secondary Education Act. At AG discretion, community programs (such as soup kitchens) that do not condition assistance on individual income or resources and are necessary to protect life or safety.	Communicable Diseases: House permits doctors to be reimbursed for treating symptoms of communicable diseases even if the disease later turns out not to have been communicable. Nutrition: Senate permits food banks and others who administer emergency food programs to avoid spending volunteer resources to verify citizenship. Head Start and ITPA: House does not restrict legal immigrant access to these programs. Student Assistance Under the Public Health Services Act: These programs were added to the Senate bill by floor amendment sponsored by Senator Paul Simon (D-IL). The definition of ''means-tested'' programs was deleted from the Senate bill due to the ''Byrd rule.''
Programs restricted by deeming (impacts most family-based immigrants).	AFDC, Food Stamps, and SSI.	Provision: Virtually all federal means-tested program must deem future immigrants.	Provision: Virtually all federal means-tested programs must deem future immigrants.	Identical provisions.
		Exempted programs: Same programs exempted from deeming as from the 5-year prospective bar (see above). State and local programs: Programs that are entirely state funded may deem (or ban) current legally resident immigrants as well as future legal immigrants (except for those exempt from federal deeming and programs that are equivalent to federal programs exempted from deeming).	Exempted programs: Same programs exempted from deeming as from the 5-year prospective bar (see above). State and local programs; Programs that are entirely state funded may deem (or ban) current legally resident immigrants as well as future legal immigrants (except for those exempt from federal deeming and programs that are equivalent to federal programs exempted from deeming).	Neither bill exempts non-profit organizations from burdensome verification requirements (as does the Senate immigration bill).
Length of deeming period/ retroactivity.	3 years (SSI 5 years until 10/1/96).	Current residents: same as current law.	Current residents: same as current law.	Identical provisions.
		Future immigrants: until citizenship unless an exemption applies (e.g. 40 quarters).	Future immigrants: until citizenship unless one of the exemptions applies (e.g. 40 quarters).	
Immigrants exempt from deeming.	Disabled after entry (SSI only).	Immigrants who work 40 ''qualifying quarters'' (as defined for Title II Social Security) and did not receive any means-tested assistance in any of those quarters.	Immigrants who work 40 ''qualifying quarters'' (as defined for Title II Social Security) and did not receive any means-tested assistance in any of those quarters.	Identical provisions.
	Sponsor is receiving Food Stamps (Food Stamps only).	Minor children get credit for quarters worked by parents; spouses get credit for work if still remarried or if working spouse is deceased.	Minor children get credit for quarters worked by parents; spouses get credit for work if still married or if working spouse is deceased.	About half of the legal immigrants who will be cut off of SSI under these bills have been in the U.S. more than ten years.
		Veterans, exempt from SSI, Medicaid and Food Stamp bar, are not exempt from deeming.	Veterans, exempt from SSI, Medicaid and Food Stamp bar, are not exempt from deeming.	There is no exemption for battered spouses or children in either bill.
Affidavits of support provision.	Affidavits of support are unenforceable against the sponsor.	Enforceable to recover money spent on most means-tested programs.	Enforceable to recover money spent on most means-tested programs.	The requirement that only the petitioner may be the sponsor precludes all other close relatives from obligating themselves to support the immigrant.
		Sponsor liable for benefits used until citizenship, unless immigrant works 40 ''qualifying quarters'' is credited for work of spouse or parent. For definition of ''qualifying quarter,'' see Immigrants Exempt from Deeming above. Enforceable against sponsor by sponsored immigrant or government agencies until 10 years after receipt of benefits. Sponsor fined up to $5,000 for failure to notify when sponsor moves.	Sponsor liable for benefits used until citizenship, unless immigrant works 40 ''qualifying quarters'' is credited for work of spouse or parent. For definition of ''qualifying quarter,'' see Immigrants Exempt from Deeming above. Enforceable against sponsor by sponsored immigrant or government agencies until 10 years after receipt of benefits. Sponsor fined up to $5,000 for failure to notify when sponsor moves.	This entire section was deleted from the Senate bill because of the Byrd rule.
		Only the petitioner may qualify as a sponsor.	Only the petitioner may qualify as a sponsor.	
Treatment of ''Not qualified'' immigrants.	Eligibility of classes of immigrants the INS does not plan to deport varies by program.	Definition: ''Not qualified'' = all but LPR, refugee, granted asylum, deportation withheld, parolee for > 1 year.	Definition: ''Not qualified'' = all but LPR, refugee, granted asylum, deportation withheld, parolee for > 1 year.	Child Nutrition: The House would require the schools, churches, charities, and clinics that operate school lunch programs and WIC clinics to verify immigration status and turn away ineligible children. The Senate exempts child nutrition programs from these requirements.
	Undocumented immigrants ineligible for cash assistance and all major federal programs. Exemptions include: emergency Medicaid, public health, child nutrition, Child care, child protection, and maternal care, emergency services.	Prohibition: Not qualified barred from: Social Security (affects new applicants only), unemployment, all federal needs-based programs, and any governmental grant, contract, loan, or professional or commercial license (nonimmigrants may receive license or contract related to visa.)	Prohibition: Not qualified barred from: Social Security (affects new applicants only), unemployment, all federal needs-based programs, and any governmental grant, contract, loan, or professional or commercial license (nonimmigrants may receive license or contract related to visa.)	

NATIONAL IMMIGRATION LAW CENTER—OVERVIEW OF CURRENT LAW AND WELFARE REFORM IMMIGRANT RESTRICTIONS—104TH CONGRESS—Continued

	Current Law	Welfare Reform Reconciliation Act of 1996 (H.R. 3734) as passed by the House	Personal Responsibility, Work Opportunity Act of 1966 (H.R. 3734) as passed by the Senate	Differences/Comments
		Exceptions: Emergency Medicaid. Short-term emergency relief. Immunizations and testing and treatment of the symptoms of communicable diseases.	Exceptions: Emergency Medicaid. Short-term emergency relief. Immunizations and testing and treatment of communicable disease if necessary to prevent the spread of such disease. School Lunch Act programs. Child Nutrition Act programs. Certain other emergency food and commodity programs.	No Battered Women's Exception: Beneficiaries of the Violence Against Women Act (VAWA) self-petitioning provisions are treated the same as persons who are unlawfully in the U.S.
		Current recipients of housing or community development funds. At AG discretion, community programs (such as soup kitchens) that do not condition assistance on individual income or resources and are necessary to protect life, or safety. State and Local Programs: Immigrants who are not lawfully present may not participate in state or locally funded programs unless the state passes a law after enactment affirmatively providing for such eligibility (state has no option to provide assistance to ''not qualified'' immigrants who are here lawfully).	Current recipients of housing or community development funds. At AG discretion, community programs (such as soup kitchens) that do not condition assistance on individual income or resources and are necessary to protect life, or safety. State and Local Programs: Immigrants who are not lawfully present may not participate in state or locally funded programs unless the state passes a law after enactment affirmatively providing for such eligibility (state has no option to provide assistance to ''not qualified'' immigrants who are here lawfully).	
Verification and reporting.	Agencies such as battered women's shelters, hospitals, and law enforcement agencies may keep immigration information confidential if they feel such confidentiality is advisable given their mission. For example, a law enforcement agency may assure a timid witness that he or she will not be deported as a result of coming forward to report a crime.	No Confidentiality: No state or local entity may ''in any way'' restrict the flow of information to the INS.	No Confidentiality: No state or local entity may ''in any way'' restrict the flow of information to the INS.	Identical provisions.
		Required Verification: All federal, state and local agencies that administer non-exempt federal programs must verify immigrant eligibility ''to the extent feasible'' through a computerized database. Required Reporting: SSI, Housing, and AFDC agencies must make quarterly reports to INS providing the name and other identifying information of persons known to be unlawfully in the U.S.	Required Verification: All federal, state and local agencies that administer non-exempt federal programs must verify immigrant eligibility ''to the extent feasible'' through a computerized database. Required Reporting: SSI, Housing, and AFDC agencies must make quarterly reports to INS providing the name and other identifying information of persons known to be unlawfully in the U.S.	The no confidentiality provision endangers witness protection programs and all other endeavors in which confidentiality is necessary to encourage cooperation or participation.

Mr. SHAW. Mr. Speaker, I yield 1 minute to the distinguished gentleman from California [Mr. RIGGS].

Mr. RIGGS. Mr. Speaker, I thank the gentleman for yielding me this time and for his hard work on this very historic and very important legislation.

This legislation curtails food stamp fraud, it limits the access of resident aliens to welfare programs, which just might persuade some visitors to our country who did not come here to work to return home, but, more importantly, it is another step in the process of devolving or sending social services back to the States and getting control back in the hands of local managers who are closer to the problems of the poor.

It addresses a fundamental fairness issue in American society, and that is the resentment of working individuals toward able-bodied individuals who refuse to get off the dole. Most importantly, in my mind, it addresses the problem of welfare dependency and welfare pathology in this country, which has led to soaring rates of family disintegration, illegitimacy in American society, and the other consequences, like youth crime.

This is indeed an historic day in this body and a very, very important piece of legislation, in my view the most important legislation we will enact in the 104th Congress.

□ 1615

Mr. GIBBONS. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, let me say first of all that there are some good things in this legislation that could have and should have become law without being tied to the rest of this fundamentally flawed package. The President has made a mistake in endorsing this legislation and the Congress will make a mistake in passing it.

Essentially, Mr. Speaker, this legislation reduces assets that we need to help those who are the most vulnerable in our society. Seventy percent of all the people on welfare are infants and children. The rest are so disabled one way or another, and they cannot make a go of it. This bill reduces their assets, reduces the assets of the people who we are trying to help to improve and better their situation.

For some reason that we do not thoroughly understand, the bottom three-fifths of all the people in the United States have not made any progress in the last 20 years, economically speaking. The bottom one-fifth have lost 18 percent of their resources that are available to them. This bill further exacerbates that problem and will hurt infants and children. It should not become law. It should be vetoed.

Mr. SHAW. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Connecticut [Mr. SHAYS], a member of the Committee on the Budget.

Mr. SHAYS. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, politicians are elected by adults to represent the children. We need to save our children from crippling national debt, Government debt. We need to make sure that our trust funds, like Medicare, are there for our children. And most importantly, we need to enable, we need to help our children become independent citizens of this great and magnificent country. This bill helps to transform our caretaking, social and corporate welfare state into a caring opportunity society.

I extend tremendous admiration to the gentleman from Florida, [Mr. SHAW] for not giving into those who wanted to weaken the bill so that it would end up not doing anything. We have a caring bill that does this. In the final analysis, it is not what you do for your children but what you have taught them to do for themselves that will make them successful human beings.

It ends this caretaking society and moves toward a caring society where we teach our children and the adults who raise our children how to grow the seeds, how to have the food.

Mr. GIBBONS. Mr. Speaker, I yield 2 minutes to the gentleman from New York [Mr. RANGEL].

(Mr. RANGEL asked and was given permission to revise and extend his remarks.)

Mr. RANGEL. Mr. Speaker, what time is it? It is time for us to get on with our conventions. We better get on with the Democratic Convention and Republican Convention. What do we want to say that we are for? Reform. What is a nagging sore in everyone's problem? Welfare. People who do not work.

What is the bill all about? Well, the bill is supposed to be to protect children. I heard the previous speaker say that. He said that this child will be cut off of welfare if the mother does not

get a job in 2, 3, 4 or 5 years. He did not say it, but I know he read the bill.

The winners in this are the Governors. There is nothing to tell the Governors what to do, and they will be the losers in the long run, but not as bad as the children. They can do what they want with immigrants and with little kids because for 60 years we have said there is a safety net for children. But not before this election.

Who won? Bob Dole? Oh, yes, he said it already. He shoved this one down the President's throat. Three strikes and the President would have been out so he wins because what the heck, he forced the issue.

And who is another winner? My President. He is a winner. He has removed this once again. Everything you come up with, my President says, oh, no you do not. And so here again he is a winner.

So when we look at it, this is a big political victory. The Democrats are happy in the White House. The Republicans are happy because they made him do it. The Governors are happy. They begged for the opportunity to do it their way after all. They are closer to the problem. And the only losers we have now are the kids.

The got no one there to protect them. The religious leaders came out. Obviously they are not as highly registered as some other people, but they said do not do this to our children. They are the weakest. They cannot vote. If my colleagues do not like their mothers and their fathers and their neighborhoods, then get involved in education and job training and make them work. But there are winners and losers and the kids are the losers.

Mr. SHAW. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Texas [Mr. ARCHER], the distinguished chairman of the Committee on Ways and Means.

Mr. ARCHER. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, the only way we can change people's behavior is by changing the system. Franklin Roosevelt warned that giving permanent aid to anyone destroys them. By creating a culture of poverty and a culture of violence, we have destroyed the very people we are claiming to help. Can any serious person argue that the federalization of poverty by Washington has worked?

Government, since 1965, has spent over $5 trillion on welfare, more than we have spent on all the wars that we have fought in this century. And we have lost the war on poverty. With this bill, we can begin to win the war.

We need to come to the realization that dollars alone will not solve the problem. We need to give unemployed people hope and equip them for work so they will be better able to help themselves. As our colleague, the gentleman from Oklahoma, J.C. WATTS, says, they are eagles waiting to soar.

Today we will ask those now receiving welfare to make a deal with the taxpayer. We will provide you with temporary help to get you through the hard times and we will help you feed your family and get the training you need, and in exchange, we ask that you commit yourself to find a job and move back into the economy.

I am pleased to see that the President has finally agreed to join us in our fight to overhaul the broken-down welfare system. It has been a long, arduous road since 1988 when Ronald Reagan first made the effort to do something about work fare and finally we are here.

Mr. President, the poor have suffered long enough and now we have the opportunity to change it all and help the hard-working taxpayers as well.

Mr. GIBBONS. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut [Mrs. KENNELLY].

Mrs. KENNELLY. Mr. Speaker, we all can be proud of the record that many of us have in working on this bill to protect children. Eight months ago we had a welfare conference report on the floor that would have blocked foster care or would have made foster care a block grant, and also food stamps. Today's legislation retains the Federal guarantee for these services.

Eight months ago we had Federal welfare legislation on this floor that would have cut severely disabled children by 25 percent. Today we do not have that flawed two-tiered system.

Eight months ago we considered legislation that would have denied millions of Americans Medicaid because they lost welfare eligibility. Today's legislation, the legislation before us, guarantees continual health coverage for those who are currently entitled to these services.

Eight months ago we voted on legislation that would have underfunded child care. This bill has $4.5 billion in it for child care.

I am not suggesting the legislation is perfect. Most legislation is not perfect. But I predict we will be back on this very floor finding more answers and better answers than we have today. If that is there, I will be involved in these changes. But today we have to decide if this legislation as a whole represents an improvement over the status quo. My answer is: Yes, it does.

While some of the changes here being suggested pose risks, so does the current system. Welfare is clearly broken, offering more dependence than opportunity. We can vote today to at least begin to transform the welfare system. Today we can begin welfare reform, those of us who have worked hard over the months to make the bill, working with those who have had the bill. We now have the bill. We should vote for the bill and get on with welfare reform.

Mr. SHAW. Mr. Speaker, I yield 2 minutes to the gentleman from Texas [Mr. DELAY], the distinguished Republican whip.

Mr. DELAY. Mr. Speaker, I am very pleased to hear that President Clinton has endorsed the welfare bill that will pass the House today. Clearly, the time has come to end welfare as we know it. The welfare system as we know it has been a disaster. The only thing great about the Great Society was the great harm it has caused our children.

With this bill, Mr. Speaker, we make commonsense changes long requested by the American people.

Common sense dictates that able-bodied people work.

Common sense dictates that only Americans should receive welfare benefits in this country.

Common sense dictates that incentives to keep families together.

Common sense dictates that welfare should not be a way of life.

Now liberal Democrats will vainly challenge these simple truths, and even the President could not help himself and has challenged some of these truths, but time and experience has proven them wrong. Welfare has not worked for the people it was supposed to help. Everybody knows that fact. Now is the time to change that system. Some well-meaning people will once again make the claim that welfare reform is mean-spirited. Well, I disagree.

We reform welfare not out of spite but out of compassion. We change this system not because we want to hurt people, but because we want to help people help themselves. And we change this system not to throw children into the streets, but to give children a greater chance to realize the American dream and still maintain a safety net for those truly in need.

Mr. Speaker, I am proud of this Congress for the great work on this historic legislation, and I am pleased that President Clinton has agreed to finally live up to his campaign promise.

Mr. GIBBONS. Mr. Speaker, I yield 1 minute to the gentleman from New York [Mr. NADLER].

(Mr. NADLER asked and was given permission to revise and extend his remarks.)

Mr. NADLER. Mr. Speaker, sadly, it seems clear that this House today will abdicate its moral duty and knowingly vote to allow children to go hungry in America. Sadly, our President, a member of the Democratic Party, the party of Franklin Roosevelt and John Kennedy and Lyndon Johnson, will sign this bill.

Does this bill allocate sufficient funds to provide employment for people who want to work? No.

Does this bill provide adequate child care so parents can leave their children in a safe environment and earn a living? No.

Does this bill ensure that people leaving welfare can take their kids to a doctor when they get sick? No.

Does this bill do anything to raise wages so people who work hard to play by the rules will not have to see their children grow up in poverty? No.

Does this bill reduce the value of food stamps for children of the poorest working people to push these children into poverty and hunger? No.

Mr. Speaker, I know that scapegoating poor children is politically popular this year, but it is not right. We must stand up for our country's children. I urge my colleagues to reject this immoral legislation.

Mr. GIBBONS. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia [Mr. LEWIS].

Mr. LEWIS of Georgia. Mr. Speaker, the bill we are considering today is a bad bill. I will vote against it and I urge all people of conscience to vote against it. It is a bad bill because it penalizes children for the actions of their parents. This bill, Mr. Speaker, will put 1 million more children into poverty. How, how can any person of faith, of conscience vote for a bill that puts a million more kids into poverty. Where is the compassion, where is the sense of decency, where is the heart of this Congress. This bill is mean, it is base, it is downright low down.

We are a great nation. We put a man on the Moon. We have learned to fly through the air like a bird and swim like a fish in the sea. We are the world's only superpower. We did not do this by running away—by giving up. As a nation, as a people—as a government—we met our challenges—we won.

This bill gives up—it throws in the towel. We cannot run away from our challenges—our responsibilities—and leave them to the States. That is not the character of a great nation. I ask you, Mr. Speaker, What does it profit a great nation to conquer the world, only to lose it's soul? Mr. Speaker, this bill is an abdication of our responsibility and an abandonment of our morality. It is wrong, just plain wrong.

It was Hubert Humphrey, who said:

> We can judge a society by how it treats those in the dawn of life, our children, those in the twilight of life, our elderly and those in the shadow of life, the sick and the disabled.

I agree with Hubert Humphrey, my colleagues. What we are doing here today is wrong.

I say to you, all of my colleagues, you have the ability, you have the capacity, you have the power to stop this assault, to prevent this injustice. Your vote is your voice. Raise your voice for the children, for the poor, for the disabled. Do what you know in your heart is right. Vote ''no.''

□ 1630

Mr. GIBBONS. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan [Mr. LEVIN].

(Mr. LEVIN asked and was given permission to revise and extend his remarks.)

Mr. LEVIN. Mr. Speaker, the status quo is gone.

The current system does not meet the American values of work, opportunity, responsibility, and family.

We have been wrestling for a long time with what should replace it.

The key always has been the linkage of welfare to work, within a definite time structure, and with sensitivity to the children of the parent who needs to break out of a cycle of dependency, for her/his good, for the child's and for the taxpayer.

The challenge has been to find a new balance, that combines State flexibility with national interest.

The first two bills vetoed by the President failed to address effectively work and dealt insensitively with children.

If the AFDC entitlement was going to be replaced by a block grant—which was already beginning to happen through Federal waivers—after the vetoes we successfully pressured the Republican majority to make substantial improvements in day care, health care, benefits for severely disabled children and to retain the basic structure of foster care, food stamps and the school lunch program.

In a word, this is a different bill than those vetoed by the President.

The bill before us is at its very weakest in two areas essentially unrelated to AFDC—food stamps and legal immigrants. Reform was needed in these areas, but surely not punishment nor a mere search for dollars, as was true of the majority's approach.

The question is whether the defects in those areas should sink changes in our broken welfare system.

On balance, I believe it is better to proceed today with reforms in the welfare system, with a commitment to return on a near tomorrow to the defects in this bill.

I hope in the next session there will be a Congress willing to address these legitimate concerns with President Clinton.

Mr. SHAW. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Louisiana [Mr. HAYES], a valued member of the Committee on Ways and Means.

Mr. HAYES. Mr. Speaker, folks at home simply wonder if they can tell the difference between a disabled veteran from a real war and someone who has become disabled because of a fake war on poverty, converting food stamps into drugs, why cannot the Government. They want to know, if they can tell the difference between a young woman whose husband has walked out on them, leaving them a child with no recourse, and a teen who becomes pregnant because of a system that rewards it, why cannot the Government?

Today this body answers that it can tell the difference. The Senate can tell the difference. And I am very pleased to understand that the President is going to sign the bill that allows people at home to at least know we have that judgment to make that difference.

Mr. GIBBONS. Mr. Speaker, I yield such time as he may consume to the gentleman from Maryland [Mr. HOYER].

(Mr. HOYER asked and was given permission to revise and extend his remarks.)

Mr. HOYER. Mr. Speaker, I rise in support of the bill.

America's welfare system is at odds with the core values Americans believe in: Responsibility, work, opportunity, and family. Instead of rewarding and encouraging work, it does little to help people find jobs, and penalizes those who go to work. Instead of strengthening families and instilling personal responsibility, the system penalizes two-parent families, and lets too many absent parents off the hook.

Instead of promoting self-sufficiency, the culture of welfare offices seems to create an expectation of dependence rather than independence. And the very ones who hate being on welfare are desperately trying to escape it.

As a society we cannot afford a social welfare system without obligations. In order for welfare reform to be successful, individuals must accept the responsibility of working and providing for their families. In the instances where benefits are provided, they must be tied to obligations. We must invest our resources on those who value work and responsibility. Moreover, we must support strict requirements which move people from dependence to independence. Granting rights without demanding responsibility is unacceptable.

The current system undermines personal responsibility, destroys self-respect and initiative, and fails to move able-bodied people from welfare to work. Therefore, a complete overhaul of the welfare system is long overdue. We must create a different kind of social safety net which will uphold the values our current system destroys. It must require work, and it must demand responsibility.

Today, the House will take a historic step as it moves toward approving a welfare reform conference report which takes significant steps to end welfare as we know it. The bill is not perfect. But, at the insistence of the President and congressional Democrats, significant improvements to require work and protect children have been made. It is because of these important changes that I will vote in favor of this bill.

This bill requires all recipients to work within 2 years of receiving benefits. The bill requires teen parents to live at home or in a supervised setting, and teaches responsibility by requiring school or training attendance as a condition of receiving assistance.

When the House Ways and Means Committee marked up its first welfare bill 1½ years ago, Democrats proposed an amendment to exempt mothers of young children from work requirements if they had no safe place for their children to stay during the day. The amendment was defeated by a unanimous Republican vote. I am pleased that the conference report prohibits States from penalizing mothers of children under 6 if they cannot work because they cannot find child care.

A year and a half ago, Ways and Means Committee Republicans defeated Democratic amendments to strengthen child support enforcement provisions, because committee Republicans felt those sanctions were ''too hard'' on deadbeat dads. I am pleased that this conference report includes every provision in the President's child support enforcement proposal, the toughest crackdown on deadbeat parents in history.

A year and a half ago, the Republican welfare bill included a child nutrition block grant that would have caused thousands of children in Maryland to lose school lunches—for some of those children, the only meal they would receive in a day. I am pleased that the conference report maintains the guarantee of school meals for our neediest kids.

As recently as last week, the House Republican bill eliminated the guarantee of food stamps for poor children and assistance for children who had been neglected or abused. I am pleased that this bill prohibits the block grants which dismantle food stamp and child protection assistance.

Like many Americans, I continue to have concerns about some of the provisions in this bill. We must be certain that both the Federal and State governments live up to their responsibilities to protect children who may lose assistance through no fault of their own. We must make sure that legal immigrants, who have paid taxes and in some cases defended the United States in our armed services, are not abandoned in their hour of need. And it is not enough to move people off of welfare—we must move them into jobs that make them self-sufficient and contributing members of society.

This bill supports the American values of work and personal responsibility. It has moved significantly in the direction of the welfare reform proposals made by Congressman DEAL and Congressmen TANNER and CASTLE, both of which I supported. I applaud this important step to end welfare as we know it, and intend to vote in favor of this bill.

Mr. GIBBONS. Mr. Speaker, I yield 1 minute to the gentleman from Rhode Island [Mr. KENNEDY].

Mr. KENNEDY of Rhode Island. Mr. Speaker, just hearing my colleague, the gentleman from Georgia, JOHN LEWIS, speak so passionately, I think should move anyone who listened to his speech. Over 30 years ago it was JOHN LEWIS who was fighting against States rights, States rights meaning justice dependent on geography. How you were treated depended on what State you lived in.

And yet our Republican friends who are offering this welfare reform, as they call it, are willing to embrace States rights; what their block grant plan means is that again justice will depend on geography. In my State of Rhode Island, over 40,000 kids in poverty are going to be put at a disadvantage under the block grant system because when you take away the money that is entitled to kids based upon their poverty, you leave it to the whim of the States.

I can tell you, each State is under pressure to lower the bar so that you can squeeze people even more. This is wrong.

When Mr. SHAW and Mr. ARCHER say that dollars will not do it alone, I want to ask the Republicans, what are they going to substitute when a poor child needs food, what are they going to substitute for the money that they are supposed to be providing through these programs?

Mr. SHAW. Mr. Speaker, I yield 1 minute to the gentlewoman from California [Ms. PELOSI].

Ms. PELOSI. Mr. Speaker, I thank the gentleman for yielding the time.

I rise in opposition to the welfare bill. If this bill passed today, it will be a victory for the political spin artists and a defeat for the infants and children of America.

We all agree that the welfare system must be reformed. But we must make sure that that reform reduces poverty, not bashes poor people. The cuts in this bill will diminish the quality of life of children in poor families in America and will have a devastating impact on the economy of our cities.

Food and nutrition cuts will result in increased hunger. Local government will be forced to pay for the Federal Government's abdication of responsibility. How can a country as great as America ignore the needs of America's infants and children who are born into poverty?

The Bible tells us that to minister to the needs of God's children is an act of worship; to ignore those needs is to dishonor the God who made them.

Mr. Speaker, let us not go down that path today.

Mr. GIBBONS. Mr. Speaker, I yield such time as he may consume to the gentleman from New York [Mr. TOWNS].

(Mr. TOWNS asked and was given permission to revise and extend his remarks.)

Mr. TOWNS. Mr. Speaker, vote no on this pain and shame that we are inflicting on young people, a garbage bill.

This agreement along with the other vetoed welfare bills amount to nothing short of a rollcall of pain and shame that will be dumped on those Americans who are clearly in need of a social service safety net.

And to add to that pain, legal immigrants will bear 40 percent of the cuts in welfare even though they make up only 5 percent of the population receiving welfare benefits.

No one is satisfied with the way welfare policy is constructed or practiced. The Federal Government doesn't like it; the local administrators don't like it; the social workers don't like it; the majority of the taxpayers don't like it and the recipients don't like it. There is no doubt that the welfare system in this country needs to be changed. Clearly reform is necessary. However, the overall scope of the proposed reforms will victimize those Americans most in need of assistance.

I urge a ''no'' vote on this conference agreement.

Mr. GIBBONS. Mr. Speaker, I yield 45 seconds to the gentlewoman from Florida [Ms. BROWN].

Ms. BROWN of Florida. Mr. Speaker, this was a bad House bill, a bad Senate bill and the conference report did not fix it. It is still bad.

You can judge a great society by how it treats its children, its senior citizens. This bill guts our future. I urge my colleagues to vote against it.

Mr. Speaker, I rise to oppose this conference report. The House welfare reform bill was a bad bill, the Senate bill was a bad bill and the conference report does not fix it. This legislation is so bad that it can't be fixed.

This bill will have a horrible impact on the children in my State. In Florida, at least 235,000 children would be denied benefits under this legislation. In Florida alone, 48,000 would be pushed deeper into poverty. Children will be hungrier if this bill becomes law.

In Florida, 111,926 children would be denied aid in the year 2005 because of the 5 year time limit. In Florida, 42,714 babies would be denied cash aid in the year 2000 because they were born to families already on welfare. In the year 2000, 80,667 children in Florida would be denied benefits if the State froze its spending on cash assistance at the 1994 levels.

In addition to the travesty this bill does to our children, this bill will pull the rug out from under our seniors who are legal immigrants. For a State like Florida whose population has such a large number of legal immigrants, the impact will be extremely high.

There is another troubling aspect of this bill we need to look at. No victim of domestic violence, no matter how abused nor how desperate, could know that if she left her abusive spouse, that she would be able to rely upon cash assistance for herself or for her children—even for a short period of time until she was able to secure employment.

I have always believed that the sign of a great society is how well it treats its most vulnerable—children and seniors. Our children are America's future. This bill prevents the future generation from meeting its potential to contribute to American society and instead dooms today's poor children to deeper poverty and no chance to take their place as productive members of our society.

Mr. SHAW. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, I come over here to do something I have never done before; that is, to trespass on the Democrat side. I hope that they will give me their understanding in my doing so, because I do not do it out of smugness or arrogance. I do it out of coming together.

We have heard a lot of name calling, a lot of rhetoric, a lot of sound bites that we have heard all through this debate. We have come down a long road together. It was inevitable that the present welfare system was going to be put behind us.

Today we need to bring to closure an era of a failed welfare system. I say that and I say that from this side of the aisle because I know that the Democrats agree with the Republicans. This is not a Republican bill that we are shoving down your throats. We are going to get a lot of Democratic support today. I think the larger the support, the more chance there is for this to really work and work well.

The degree of the success that we are going to have is going to be a victory for the American people, for the poor. It is not going to be a victory for one political party. It is time now for us to put our hands out to one another and to come together to solve the problems of the poor.

Without vision, the people will perish. Unfortunately, we have not had vision in our welfare system now for many, many years. It has been allowed to sit stagnant. We have piled layer upon layer of humanity on top of each other. We have paid people not to get married. We have paid people to have children out of marriage. We have paid people not to work.

This is self-destructive behavior. We know that. We all agree with that.

I know we have heard many, many speakers: My friend, the gentleman from Georgia, JOHN LEWIS, thinking that we are going the wrong way; my friend, the gentleman from New York, CHARLIE RANGEL, saying that we are going the wrong way.

I also see some of my colleagues who have fought for different changes within the welfare bill within the Subcommittee on Human Resources of the Committee on Ways and Means, now coming to closure, where they do not believe this is a perfect bill. And I can stand here and say it is not a perfect bill, but it is as good as this Congress can do. It is as good as we can come together.

We have included the Governors in balancing out their interests and in seeing what they have been successful with and how they feel that they can be successful. We have talked to many of the Members on the Democrats' side, and to my Republican colleagues I say, we are not through. We have another long road ahead of us. We need to get to a technical corrections bill as we see problems arise within this bill that we are going to be passing today.

It was unexpected to hear that the President was going to endorse this bill and announced his signature of it. But let us now be patient with each other. Let us work with each other and let us bring this awful era of a failed welfare system to closure.

Mr. GIBBONS. Mr. Speaker, I yield the balance of my time to the gentleman from Maryland [Mr. CARDIN].

The SPEAKER pro tempore (Mr. MCINNIS) The gentleman from Maryland [Mr. CARDIN] is recognized for 2½ minutes.

Mr. CARDIN. Mr. Speaker, I thank the gentleman from Florida [Mr. GIBBONS] for yielding me the time.

Let me say to my friend, the gentleman from Florida [Mr. SHAW], first, congratulations on a job very well done and come on back over on this side of the aisle a little bit more frequently. I think that if we would have started working together in a bipartisan spirit, we could have had a better bill today, and we could have gotten here a little bit sooner. But I thank the gentleman very much for the way in which he has provided leadership on this issue. I know it has been heartfelt, and I know he has worked very, very hard.

□ 1645

Mr. Speaker, I support the conference report because I think it is important that we return welfare to what it was originally intended to be, and that is a transitional temporary program to help those people that are in need. The current system does not do that. We cannot defend the current system.

But let me make it clear to my colleagues, the bill before us is a far better bill than the bill that was originally brought forward by the Republicans 2 years ago, the bill that was vetoed twice by the President. We have a better bill here today.

It is a bill that provides for major improvement in child support enforcement, something all of us agreed to; provides protective services for our children, which was not in the original bill; provides health insurance to people coming off of welfare, something that is very important; day care services, another important ingredient that people are going to get off welfare to work. Food stamps are in much better condition than the bill that was vetoed by the President. There is a Federal contingency fund in case of a downturn of our economy, and we have maintenance of effort requirements on our States so we can assure that there are certain minimum standards that are met in protecting people in our society.

The bottom line is that this bill is better than the current system.

It could have been better, and I regret that. I am not sure there is enough resources in this bill to make sure that people get adequate education and job training in order to find employment, and I look forward to working with the gentleman from Florida [Mr. SHAW] to make sure that this becomes a reality.

But I do urge my colleagues to support the conference report because bottom line: It is far better than the current system.

Yes, we are going to take a risk to get people off of welfare to work, but the current system is not fair either to the welfare recipient or the taxpayer.

This conference report is far better, and I urge my colleagues to support it.

Mr. SHAW. Mr. Speaker, I yield the balance of my time to the distinguished gentleman from Ohio [Mr. KASICH], chairman of the Committee on the Budget.

The SPEAKER pro tempore (Mr. MCINNIS) The gentleman from Ohio is recognized for 5¾ minutes.

Mr. KASICH. Mr. Speaker, I would like to initially congratulate the gentleman from Florida [Mr. SHAW] for his relentlessness in being able to pursue welfare reform and he deserves the lion's share of the credit, along with the gentleman from Texas [Mr. ARCHER], who has done an outstanding job, and although I do not see him on the floor, our very able staff director, Ron Haskins, who has probably lived with this bill for about a decade, feeling passionately about the need to reform welfare.

As my colleagues know, it was pretty amazing today to watch the President of the United States come on television and say that he was going, in fact, to sign this welfare bill. The reason why it is so amazing today is that because the American people, during all of my adult lifetime, have said that they want a system that will help people who cannot help themselves, but they want a system that is going to ask the able-bodied to get out and begin to work themselves. This has been delayed and put off, with a million excuses as to why we could not get it done.

I just want to suggest to my friends who are in opposition, and I respect their opposition; many of them just did not talk; many of them were not able to talk, as they were beaten in the civil right protests in this country. I respect their opposition. But the simple fact of the matter is that this program was losing public support.

Mr. Speaker, the cynicism connected to this program from the folks who get up and go to work every day for a living, and I do not mean the most fortunate, I mean those mothers and fathers who have had to struggle for an entire lifetime to make ends meet, they have never asked for food stamps, the have never asked for welfare, they have never asked for housing, and they are struggling. They are counting their nickels. They do not take the bus transfer because it costs a little extra money, and they walk instead so they can save some more money to educate their children. These people were becoming cynical, they were being poisoned in regard to this system, and they were demanding change.

Mr. Speaker, we all know here, as we have watched the Congress, the history of Congress over the decades, that when the American people speak, we must deliver to them what they want. They said they wanted the Vietnam war over. It took a decade, but they got it, and public cynicism and lack of support was rising against this program. It was necessary to give the people a program they could support.

But I also want to say that the American people have never, if I could be so bold as to represent a point of view, have never said that those who cannot help themselves should not be helped. That is Judio-Christianity, something that we all know has to be rekindled. Our souls must once again become attached to one another, and the people of this country and Judeo-Christianity siad it is a sin not to help somebody who needs help, but it is equally a sin to help somebody who needs to learn how to help themselves.

But I say to my friends who oppose this bill:

This is about the best of us. This is about having hopes and dreams. After 40 or 50 years of not trusting one another in our neighborhoods and having to vacate our power and our authority to the central government, to the Washington bureaucrats, this is now about reclaiming our power, it is about reclaiming our money, it is about reclaiming our authority, it is about rebuilding our community, it is about rebuilding our families, it is about cementing our neighborhoods, and it is about believing that all of us can march to that State capitol, that all of us can go into the community organizations and we can demand excellence, we can demand compassion, and that we can do it better.

We marched 30, 40 years ago because we thought people were not being treated fairly, and we march today for the very same reason. What I would say, and maybe let me take it back and say many of my friends marched. I was

too young, but I watched, and I respect it. What I would suggest at the end of the day, however, is that we all are going to have to stand up for those who get neglected in reform, but frankly this system is going to provide far more benefits, far more hope, restore the confidence in the American people that we have a system that will help those that cannot help themselves and at the same time demand something from able-bodied people who can. It will benefit their children, it will help the children of those who go to work.

America is a winner in this. The President of the United States has recognized that. He has joined with this Congress, and I think we have a bipartisan effort here to move America down the road towards reclaiming our neighborhoods and helping America.

And I would say to my friends, we will be bold enough and humble enough when we see that mistakes are being made, to be able to come back and fix them; but let us not let these obstacles stand in the way of rebuilding this program based on fundamental American values. Support the conference report.

Mr. BENTSEN. Mr. Speaker, I rise in support of this welfare reform conference report. This bill is far from perfect, but it does move us down the road toward reforming the welfare system to help families in need.

I have long advocated and agree with provisions requiring work and encouraging self-sufficiency and personal responsibility.

This legislation is an improvement over more extreme earlier bills. It includes necessary provisions which I and others fought for during the last 2 years because they are important to working families, children, and fast-growing states such as Texas. It provides some transitional health care benefits and child care assistance. It retains the Federal guarantee of health care and nutritional assistance for children. It eliminates the Republicans' proposal to raise taxes on working families by cutting the earned income tax credit. It provide a safety net, albeit minimal, for high growth states such as Texas, Florida, and California and for recessions. It lets States give noncash vouchers to families whose welfare eligibility has expired, so they can buy essentials for children. None of these provisions were contained in previous so-called welfare reform.

While I am supporting this legislation, I am troubled by the elimination of benefits for legal immigrants who have participated in the workforce and paid taxes. Harris County, TX, which I represent, currently faces a measles epidemic. Future prohibitions on Medicaid for such instances would result in the State and county facing tremendous cost increases. I have no doubt that Congress will be forced to revisit this issue in part at the behest of States as we may be creating huge unfunded mandates. Unfortunately, while this bill contains many positive reforms which I support, it also contains many misguided provisions for which the only motivation is monetary, not public policy.

Mrs. FOWLER. Mr. Speaker, the American welfare system was intended to be a safety net for those who fall on hard times. Unfortunately, it has become an overgrown bureaucracy which perpetuates dependency and denies people a real chance to live the American dream.

I am pleased that President Clinton has just announced he would sign the Republican welfare bill. We knew that when it got this close to the election, this President would choose the path of political expediency, as he always does.

This legislation is not about saving money, it is about saving hope and saving lives, while reforming a broken system and preserving the safety net.

The bill encourages work and independence, and discourages illegitimacy. I urge my colleagues to vote for fairness, compassion, and responsibility. Pass the conference agreement on H.R. 3437.

Mrs. SMITH of Washington. Mr. Speaker, I strongly support the Personal Responsibility and Work Opportunity Act of 1996 (H.R. 3734). This landmark piece of welfare reform legislation emphasizes responsibility and compassion. It provides a helping hand and not a handout. Americans today want a future filled with hope. Parents want to be able to take care of themselves and their children. They want to teach their kids how to take responsibility for their lives.

This legislation reverses welfare as we know it. Today, the average length of stay for families on welfare in 13 years. The cycle of dependency must stop.

Congress' welfare reform legislation also has tough work requirements. Families must work within 2 years or lose their benefits. Work is the beginning of dignity and personal responsibility. Single mothers who desire to work but cannot leave their children home alone will be provided with child care assistance. In fact, the Personal Responsibility and Work Opportunity Act provides $14 billion in guaranteed child care funding.

Two parent families are encouraged through this plan. It takes two people to make a baby. Strong paternity requirements and tough child support measures ensure that deadbeat parents will take responsibility for their actions.

This welfare reform package is estimated to save the American taxpayers $56.2 billion over the next 6 years. It is a balanced approach that gives the States more autonomy and flexibility in crafting solutions. The Personal Responsibility and Work Opportunity Act promotes work while also guaranteeing families adequate child care, medical care, and food assistance. It is compassionate while promoting the dignity of Americans through an honest day's work. I urge my colleagues to support this bill.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today to speak out against a great injustice, an injustice that is being committed against our Nation's children, defenseless, nonvoting, children, I am referring of course to the conference agreement on H.R. 3734, the Personal Responsibility and Work Opportunity Act.

We speak so often in this House about family values and protecting children. At the same time however, my colleagues on the other side of the aisle, have presented a welfare reform bill that will effectively eliminate the Federal guarantee of assistance for poor children in this country for the first time in 60 years and will push millions more children into poverty.

A recent study by the Urban Institute estimated that the welfare legislation passed by the House would increase the number of children in poverty by 1.1 million, or 12 percent. The analysis estimated that families on welfare would lose, on average, about $1,000 a year once the bill is fully implemented. More than a fifth of American families with children would be affected by the legislation.

This partisan legislation is antifamily and antichild. The Republican bill continues to be weak on work and hard on families. Without adequate funding for education, training, child care and employment, most of our Nation's poor will be unable to avoid or escape the welfare trap. Even before the adoption of amendments increasing work in committee, the Congressional Budget Office [CBO] estimated that the Republican proposal is some $9 billion short of what would be needed in fiscal years 1999 through 2002 to provide adequate money for the States to carry out the work program.

Furthermore, the increase in the minimum work hours requirement, without a commemsurate increase in child care funding, will make it almost impossible for States to provide child care for families making the transition from welfare to work. True welfare reform can never be achieved and welfare dependency will never be broken, unless we provide adequate education, training, child care, and jobs that pay a living wage.

I am particularly concerned that, like the House bill, the conference agreement prohibits using cash welfare block grant funds to provide vouchers for children in families who have been cut off from benefits because of the 5-year limit. We must not abandon the children of families whose benefits are cut off. We must continue to ensure that they will be provided for and not punished for the actions of their parents.

Many more children will be hurt by the bill's denial of benefits to legal immigrants. Low-income legal immigrants would be denied aid provided under major programs such as SSI and food stamps. States would also have the option of denying Medicaid to legal immigrants. They would also be denied assistance under smaller programs such as meals-on-wheels to the homebound elderly and prenatal care for pregnant women. Under this bill, nearly half a million current elderly and disabled beneficiaries who are legal immigrants would be terminated from the SSI Program. Similarly, the Congressional Budget Office estimated that under the House bill, which is similar to the conference agreement, approximately 140,000 low-income legal immigrant children who would be eligible for Medicaid under current law would be denied it under this legislation. Most of these children are likely to have no other health insurance. I cannot believe we would pass legislation that would result in even one more child being denied health care that could prevent disease and illness.

This bill also changes the guideline under which nonimmigrant children qualify for benefits under the SSI Program.

As a result, the CBO estimates that by 2002, some 315,000 low-income disabled children who would qualify for benefits under current law would be denied SSI. This represents 22 percent of the children that would qualify under current law. The bill would reduce the total benefits the program provides to disabled children by more than $7 billion over 6 years.

Mr. Speaker, mandatory welfare-to-work programs can get parent off welfare and into jobs, but only if the program is well designed

and is given the resources to be successful. The GOP bill is punitive and wrongheaded. It will not put people to work, it will put them on the street. Any restructuring of the welfare system must move people away from dependency toward self-sufficiency. Facilitating the transition off welfare requires job training, guaranteed child care, and health insurance at an affordable price.

We cannot expect to reduce our welfare rolls if we do not provide the women of this Nation the opportunity to better themselves and their families through job training and education, if we do not provide them with good quality child care and, most importantly, if we do not provide them with a job.

Together, welfare programs make up the safety net that poor children and their families rely on in times of need. We must not allow the safety net to be shredded. We must keep our promises to the children of this Nation. We must ensure that in times of need they receive the health care, food, and general services they need to survive. I urge my colleagues to oppose this dangerous legislation and to live up to our moral responsibility to help the poor help themselves.

Mr. BLILEY. Mr. Speaker, it is with pleasure that I take this opportunity to address the welfare reform conference report before us today. This measure will do exactly what its name promises: promote personal responsibility and work opportunity for disadvantaged Americans. More important, it will replace the despair of welfare dependency with the pride of independence.

This measure is critical to welfare reform initiatives taking place in the States. In my State, the Virginia Independence Program has already helped two-thirds of all eligible welfare recipients find meaningful jobs and restore hope to their lives.

This legislation will enable Virginia to continue its highly successful statewide reform program. And it will allow other States to create similar initiatives—without having to waste time and money seeking a waiver from the Federal Government.

I am also proud of the role that the Commerce Committee has played in crafting this landmark initiative. Although the Medicaid reform plan designed by the Nation's Republican and Democrat Governors is not a part of this legislation, the conference report does include important Medicaid provisions.

In particular, the conference report guarantees continued coverage for all those who are eligible under the current AFDC Program. It also ensures that eligible children will not lose the health coverage they need. And it requires adult recipients to comply with work requirements in order to remain eligible for Medicaid benefits.

Mr. Speaker, I would like to close by congratulating all those who helped to shape this historic measure. It deserves our full support, and it should be signed by the President.

Mr. COSTELLO. Mr. Speaker, today this body will take a large step in making sweeping reform in our welfare system. By passing the welfare reform agreement, we move toward a system that emphasizes work and independence—a new system that represents real change and expanded opportunity. Although this bill is not perfect, it is our best chance in years to enact welfare reform that represents an opportunity to improve the current system.

Sadly, our current system hurts the very people it is designed to protect by perpetuating a cycle of dependency. For those stuck on welfare, the system is not working. It is clear that we cannot and should not continue with the status quo. The status quo has fostered an entire culture of poverty. Our current system does little to help poor individuals move from welfare to work.

It is clear the best antipoverty program is a job. To that end, this bill encourages work. It requires welfare recipients to work after 2 years and imposes a 5-year lifetime limit on welfare benefits. The bill turns Aid to Families with Dependent Children [AFDC] into a block grant program, allowing States to create their own unique welfare programs to best serve their residents. The bill maintains health care benefits for those currently receiving Medicaid because of their AFDC eligibility and provides $14 billion for child care so parents can go to work without worrying about the health and safety of their children. In addition, this bill preserves the earned income tax credit which has been successful in helping working families.

Mr. Speaker, I voted against the Republican welfare reform bill when it was before this House. That bill represented a drastic departure from the actual intent of welfare—to help the most vulnerable in our society in their time of need. The House bill eliminated the safety net of Medicaid and food stamps for many children. It was mean in spirit and should not have passed. The conference agreement that is before us today, however, is much more reasonable. Children will have the guarantee of health care coverage through Medicaid even as their parents transition to work. Further, unlike the House bill, States will not be able to opt out of the Federal Food Stamp Program. The conference agreement is a far better bill than the measure passed by the House. It is a bold, yet compassionate step in helping foster independence.

I am pleased the President has indicated he will sign this bill into law. I applaud the President—who has worked on this issue for years, even before it was politically fashionable—for continuing to insist that the bill be improved before signing it into law. While the President and I agree that this bill is by no means perfect, it is a good starting point. We can begin the process of moving toward a system that encourages and rewards work for all able-bodied citizens.

Mr. TORRES. Mr. Speaker, I rise in opposition to this antifamily, antichildren bill. There are so many parts of this bill that should concern us. I could stand here all day and describe, in detail, how this bill falls short of our shared goal of welfare reform.

For example, consider the effects on our Nation's most unfortunate children. I say unfortunate because these children are being sacrificed by election year politics simply because they came from poor families. Their already difficult lives will be made impossible due to food stamp reductions, loss of SSI assistance, and no guarantee of Federal assistance when time runs out for them and their families. The effect will be to drown an additional 1.1 million children in poverty.

Like I said, I could go on and on. But, I won't waste your time discussing what we all know: that block grants aren't responsive to a changing economy and inadequate child-care provisions make welfare-to-work a very difficult journey.

I will tell you what this so-called reform will mean to California, and how my State is being asked to absorb 40 percent of the proposed cuts. Why? Because California is home to the largest immigrant population in our country and this bill denies legal immigrants Federal assistance. It does not take much to do the math and understand the consequences of denying food stamps, supplemental security income, or Medicaid to our legal immigrant population. There are no exceptions for children or the elderly, regardless of the situation.

The needs of these taxpaying, legal residents will not vanish because the Federal Government looks the other way. The children will still be hungry, the elderly will still get sick, and the disabled will still have special needs. Someone will have to provide these services, and it will be our cities and counties who are forced to pick up the tab. And for California, the bill will be approximately $9 billion over 7 years.

My district of Los Angeles County is home to some 3 million foreign-born residents. County officials estimate that denying SSI to legal immigrants could cost the county as much as $236 million per year in general relief assistance. More importantly, this translates into no Federal assistance for the elderly or disabled children.

These costs would continue to rise with the loss of Medicaid coverage for legal immigrants. More than 830,000 legal immigrants in California would lose Medicaid coverage, including 286,000 children. Overall, the total number of uninsured persons in California would rise from 6.6 million to 7.4 million. Under this bill, these people would turn to county hospitals for care. And the costs of that care will be shifted to local governments already operating on shoe string budgets. In Los Angeles County, this could mean as much as $240 million per year.

To say this is unfair is an understatement. Legal residents, who play by the rules and contribute over $90 billion a year in taxes, do not deserve this. They deserve what they earn; to be treated with the same care and provided with the same services enjoyed by the rest of the tax-paying community.

I encourage my colleagues to oppose these short-sighted cuts and unfair rule changes: Say no to a bad deal and vote against this report.

Mr. ORTON. Mr. Speaker, I am pleased to rise in support of this welfare reform bill. I commend this Congress for creating a flexible reform bill that will allow Utah and other innovative States to continue their successful welfare reform efforts.

My greatest concerns during the course of the welfare reform debate have been to transform the system to a work-based system, to ensure that States like Utah have the flexibility to continue their successful reform efforts, and to protect innocent children. I have worked diligently with colleagues on both sides of the aisle to craft a bill that accomplishes these goals, and I am pleased to say that Congress has finally passed a bill that achieves them.

I am extremely pleased that this bill contains a provision that allows Utah to continue its successful welfare reform efforts. Under the bill that passed the House 2 weeks ago, Utah would have had to change its program to meet the restrictive Federal requirements contained in the bill. Moreover, CBO estimated that the earlier bill imposed $13 billion in unfunded costs on States unless they restricted eligibility or decreased assistance to those in need.

Both the National Governors' Association and the State of Utah expressed concerns about these unfunded costs. I worked with members of the conference committee to address these concerns, and now we have a bill that really is flexible.

The bill that passed the House today contained several of the provisions proposed by myself and others who have worked over recent months to find bipartisan common ground on welfare reform. For instance, this conference report is much more flexible than the earlier House bill because it allows States with waivers to use their own participation definition in meeting Federal work participation requirements. It also reduces the unfunded costs in the bill substantially. Unlike the House version, the conference report maintains current protections against child abuse, guarantees that children do not lose their Medicaid health care coverage as a result of the bill, and provides States with the option to provide noncash assistance to children whose parents have reached the time limit. Finally, it improves upon maintenance of effort provisions and enforcement of work participation rates.

It wasn't long ago that we were debating H.R. 4, an extreme proposal that would have eliminated 23 child protection programs like foster care and child abuse protection and replaced them with a block grant that contained $2.7 billion less funding than provided under current law. H.R. 4 would have eliminated nutrition programs like school lunch, school breakfast, the Summer Food and Adult Care Food Program, the Women, Infants and Children Program, and the Homeless Children Nutrition Program, and replaced them with two block grants that provided $6.6 billion less funding for nutrition than provided under current law. Although claims were made that there were no cuts to certain popular programs like school lunch, the truth was a State would have to eliminate or severely reduce all other programs in order to fully fund these high profile programs.

Even in the House version of welfare reform passed 2 weeks ago, children could have lost their Medicaid coverage as the result of the bill; current child abuse protections were eliminated and States were prohibited from providing noncash assistance to children whose parents have reached the time limit. I am pleased that the conference report has corrected these provisions and protected children.

Previous bills, which I opposed, treated 4-year-old children like 40-year-old deadbeats. This bill is far better for children and far more flexible for States than any of the other welfare reform proposals that have been passed by this Congress. We finally have a bill that should be signed into law.

Mr. TANNER. Mr. Speaker, there is virtually universal agreement that our current welfare system is broken and must be dramatically overhauled. Americans are a compassionate people, eager to lend a helping hand to hard workers experiencing temporary difficulties and especially to children who are victims of circumstances beyond their control. But Americans also are a just people, expecting everyone to contribute as they are able and to take responsibility for themselves and their families. It is the balancing of these two concerns that makes correcting our welfare system a challenge, but a challenge which must be met.

This welfare reform conference report is far from perfect, but it clearly is preferable to continuing the current system and preferable to welfare legislation considered earlier this Congress. For these reasons, we support the welfare reform conference report and have encouraged the President to sign it.

We have opposed previous welfare reform proposals because we believed that they offered empty, unsustainable promises of moving welfare recipients to work. Additionally, earlier bills were seriously deficient in their protections for children and other truly vulnerable populations. We have decided to support this final conference report because it is considerably better than the welfare reform bill (H.R. 4) appropriately vetoed by the President last year and it also makes significant improvements to the bill passed by the House last week. The conference committee agreed with our proposals giving States additional flexibility in moving welfare recipients to work, allowing States to use block grant funds to provide vouchers, and providing other protections for children.

This conference report incorporates several improvements proposed by the National Governors' Association to H.R. 4 in its final form. it provides $4 billion more funding for child care that will assist parents transitioning to work. It doubles the contingency fund for States facing larger welfare rolls caused by economic downturns. The latest bill returns to a guaranteed status children eligible for school lunch and child abuse prevention programs. The reductions in benefits for disabled children contained in last year's H.R. 4 are eliminated, and greater allowances are made for hardship cases, increasing the hardship exemption from the benefit time limits to 20 percent of a State's caseload.

Several changes proposed in the Castle-Tanner alternative were subsequently made to the bill passed by the House in July. The amount States must spend on child care was increased. Additionally, States will be required to assess the needs of welfare applicants and prepare an individual responsibility contract outlining a plan to move to work. Also, an increase in the State maintenance of effort for States that fail to meet the participation rates was added to the bill. All of these changes strengthen the effort of moving welfare recipients to work.

The conference report further improved the bill. The conferees adopted our suggestions providing additional State flexibility in developing work programs and adding additional protections for children. We were disappointed that the conference did not incorporate constructive suggestions that were made regarding penalties for failure to meet work requirements and, unfortunately, an authorization for additional work funds was eliminated because of parliamentary ''Byrd rule'' considerations in the Senate. On balance, however, the conference report produced a bill that is significantly better than the bill passed by the House.

President Clinton already has approved waivers allowing 41 States to implement innovative programs to move welfare recipients to work. The House's Welfare Reform bill would have restricted those State reform initiatives by imposing work mandates that are less flexible than States are implementing. Over 20 States would have been required to change their work programs to meet the mandates in that earlier House bill or face substantial penalties from the Federal Government.

The conference report now allows States that are implementing welfare waivers to go forward with those efforts. Specifically, the conference report allows those States to count individuals who are participating in State-authorized work programs in meeting the work participation rates in the bill, even work programs which otherwise do not meet the Federal mandates in the bill.

States such as Tennessee and Texas that have just received waivers will be permitted to begin implementing these reforms and States like Utah and Michigan which have a track record in moving welfare recipients into self-sufficiency will be able to continue their programs. We will work to ensure that States will continue to have this flexibility when their waivers expire if the State plan is successful.

Another key goal we have maintained throughout the debate is protecting innocent children. The earlier House bill would have treated a 4-year-old child the same as a 24-year-old deadbeat by prohibiting States from using block grant funds to provide vouchers after the time limit for benefits to the parents had expired. The conference report reverses this extreme position. In addition, the conference report moderates the impact of the food stamp cuts on children by maintaing a guaranteed status for children and by increasing the housing deduction to $300 a month for families with children.

Third, we have been concerned about the impact of health coverage to individuals and payments to health providers as a result of welfare reform. The House bill effectively would have denied Medicaid to thousands of individuals, removing $9 billion of Medicaid assistance from the health care system and resulting in a cost shift to health care providers that would affect the cost, availability, and quality of care of to everyone. While the correction is less than we had hoped, the conference report effectively reduces this cost shift to health care providers by more than half. The conference report also contains language very similar to the Castle-Tanner bill continuing current Medicaid eligibility rules for AFDC-related populations, ensuring that no one loses health care coverage as a result of welfare reform.

As we began by saying, this conference report is far from perfect and we continue to have concerns about the impact of several provisions. Although the report provides States with additional flexibility in implementing work programs, the work provisions in the bill still may impose unfunded mandates on States that will make it more difficult to move welfare recipients to work. Given the unfunded mandates in the bill, the provisions penalizing States for failing to meet participation rates by reducing funding to the State are counterproductive. The contingency fund in the conference report, while much stronger than the contingency fund in H.R. 4, will not be sufficient to respond to a severe national or regional recession.

The conference report contains a requirement that Congress review the impact of the bill 3 years. This review process will allow Congress to make a number of changes that we feel certain will be necessary to fulfill successful welfare reform.

Despite these reservations, we believe that it is critical that welfare reform be enacted this year. Failure to do so will signal yet another wasted opportunity to make critically needed

reforms. We should enact this conference report and fix the current system now, moving toward a system that better promotes work and individual responsibility.

Mr. ROYCE. Mr. Speaker, as I was reading the papers this morning I noticed some stories that claimed that this welfare reform proposal is not such a big change—that its significance has been overrated. That all sides are coming to a consensus and it's not such a big deal after all.

In the short term, that's how it may look. But in the long term, we are making a fundamental change to the status quo—we've gone beyond questioning the failed policies of the past—we are implementing a whole new approach. We are beginning to replace the welfare state with an opportunity society.

Ideas have consequences and bad ideas have bad consequences. The Great Society approach may have been well-intentioned, but the impact was tragic. We have done a disservice to those who have fallen into the welfare trap. The incentives have been all wrong and the logic backward.

We need a welfare system that saves families, rather than breaking them. And that's what this bill does.

Our welfare system has deprived people of hope, diminished opportunity and destroyed lives. Go into our inner cities and you will find a generation fed on food stamps but starved of nurturing and hope. You'll meet young teens in their third pregnancy. You'll meet fatherless children. You'll talk to sixth graders who don't know how many inches are in a foot. And you'll talk to first-graders who don't know their ABC's.

It's time for Washington to learn from its past mistakes. It's time to reform our welfare system, to encourage families to stay together and to put recipients back to work.

That's what our plan does. Four years ago, President Clinton promised to end welfare as we know it, and I am pleased that he has committed to sign our bill into law.

Our plan calls for sweeping child support enforcement. We end welfare for those who won't cooperate on child support. We strengthen provisions to establish paternity. We force young men to realize they will be required to provide financial support for their children by requiring States to establish an automated State registry to track child support information.

One of the key elements of our welfare reform bill is ending fraudulent welfare payments to prisoners and illegal immigrants—saving $22 billion.

Each year, millions of taxpayer dollars are illegally sent to prisoners in State and local jails through the Supplemental Security Income Program. In fact, in one case, infamous ''Freeway Killer'' William Bonin illegally collected SSI benefits for 14 years while on San Quentin's death row.

This bill removes the Washington-based intermeddling and bureaucratic micromanagement that has resulted in welfare programs that build a welfare population but do not relieve the suffering of those who are poor. We do not want to maintain the poor, we want to transform them. That's exactly what this bill would do.

Mr. SABO. Mr. Speaker, today we will debate legislation to radically change our welfare system. We will hear a lot about the fundamental principles that should govern the way we help those truly in need. And while I agree with those who say our welfare system must work better for the American people, we need to remember that something much more profound than rhetoric is at stake.

There is no denying that we should encourage work and parental responsibility. And I have long argued that States and localities can deliver some services better than we can at the Federal level. But, there are also other principles that we need to remember when we discuss welfare.

We need to remember that the safety net for vulnerable people is fundamentally important to our society. There has long been widespread support among Americans of all political views that the Government should help people who are too sick, too old or too young to help themselves—particularly when they don't have families who can take care of them. This is why the safety net was developed in the first place and has had the continued support of Republicans such as Richard Nixon and Ronald Reagan as well as Democrats.

I congratulate the Republican majority for its attempts to reform welfare, but I believe this legislation fails in many ways. Simply labeling this bill welfare reform cannot disguise the fact that it shreds the national safety net for millions of vulnerable people.

The Urban Institute has estimated that 1.1 million children will be pushed into poverty because of this legislation. More than a fifth of American families with children will be hurt by it. They also note that almost half of the families affected by this bill are already employed.

The provision to cut off food stamps after 3 months for unemployed people without dependents is unprecedented and unnecessarily harsh. These are some of the most vulnerable people in our country. Under this measure, even if they are trying to find work, if they don't succeed they will go hungry.

And, personally, I find the treatment of legal immigrants mystifying. My parents were immigrants. They, like many others, came to this country, worked hard, and contributed to their community. Today's immigrants are no different. They come to this country, they work hard, and they pay taxes. If they should fall upon hard times, why shouldn't we help them just like we help each other? Under the terms of this bill we aren't allowed to help them. They lose food stamps and SSI even if they have been paying taxes and living legally in this country for years. And new immigrants will be denied Medicaid.

Equally as disturbing as this bill's reduction in its Federal commitment to a national safety net is the pressure it puts on States to reduce their commitments to help vulnerable people. The reduction in State match set by the bill and the flexibility to shift 30 percent of basic block grant moneys to other uses will exacerbate pressures within State governments to pull their own resources out of these programs. That combined with the cuts in Federal dollars will lead to a sharp reduction in resources available for needed services and benefits.

The logical end result of all these interactions is significant cost-shifting to local governments. Because of the deep cut in Federal resources and potential reductions in State support, localities will need to spend more of their own funds to help move people from welfare to work and to provide needed services while that process is occurring. Many local officials including the Republican mayor of New York, Rudolph Giuliani, have expressed alarm at the hundreds of millions of dollars in additional costs their cities and residents will have to bear. Clearly, this will mean higher property taxes for working families all over the country.

We should reform our welfare system. But we must do it in a way that does not simply shift costs and that does not abandon the safety net for people who are truly in need. Unfortunately, Mr. Speaker, this bill badly fails that test and America will be the worse for it. We can and should do better.

Mr. CLAY. Mr. Speaker, I condemn both the process and the substance of the Republican conference agreement on welfare. As the 104th Congress draws to a close, the Republican majority has not wavered from its autocratic role of this institution nor from its vicious indifference to our Nation's poor and infirm.

Like my other Democratic colleagues, I was systematically denied any meaningful role on that conference. The time and location of conference negotiations have been a closely-held secret among Republicans. This most antidemocratic process is an affront to the people of the 1st Congressional District of Missouri who send me here to represent their concerns on all matters of political discourse. Time and time again, this new Republican majority has interfered with my ability to fully represent the interests of my constituents.

As a matter of policy and substance, this conference report is an evil charade. From the outset, I had little expectation that the final product of the conference would mean reasonable, viable, and compassionate welfare reform. After all, both the House and Senate bill contained unrealistic work requirements, woeful funding for meaningful workfare, and the very real risk of throwing millions of children into poverty.

The Republican majority has no real interest in truly reforming welfare. Then real objective is to steal $60 billion from antipoverty and antihunger programs in order to help finance their tax cuts and other gifts to the wealthy—Robin Hood in reverse. I can think of no more desperate, shameful act than to use the poor, especially children and the elderly, in a game of political chicken.

Mr. Speaker, I cannot in good conscience support a welfare reform bill that will punish those who, through no fault of their own, must turn to their Government for help in times of need.

Mr. CUNNINGHAM. Mr. Speaker, I proudly rise to support the conference report for H.R. 3734, the Personal Responsibility and Work Opportunity Act.

As chairman of the House Subcommittee on Early Childhood, Youth and Families, as a former teacher and coach, and as a dad, I understand the need to take into account the needs and interests of children. I cannot imagine a policy that is crueler to children than the current welfare system. Certainly it was born of the good intention to help the poor. But in the name of compassion, we have unleashed an unmitigated disaster upon America. Today's welfare system rewards and encourages the destruction of families, and childbirth out of wedlock. It penalizes work and learning. It poisons our communities and our country with generation after generation of welfare dependency. It robs human beings of hope and life and any opportunities at the American Dream.

In the name of compassion, and with good intentions, the welfare status quo is mean and

extreme to children. It is mean and extreme to families. It is mean and extreme to the hard-working Americans who foot the bill.

Thus, without a doubt, we must replace this mean, extreme, and failed system of welfare dependency with work, hope, and opportunity. We can and must do better as Americans. And we will, by adopting this compassionate, historic legislation.

Our measure makes welfare a way up, not a way of life. It replaces Washington-knows-best with local control and responsibility. It replaces a system that rewards illegitimacy and destroys families, with a family-friendly fighting chance at the American Dream.

Now, President Clinton promised in his 1992 campaign to end welfare as we know it. He also made several other promises, including starting his administration with middle class tax relief. Unfortunately, the President has not kept his promises. He raised taxes. And twice, he has vetoed legislation to fulfill his own promise to end welfare. The President who pledged to end welfare as we know it has twice vetoed legislation to end welfare for illegal aliens.

Let me speak for a moment about illegal aliens. Illegal immigration is breaking our treasury, burdening California, and trying America's patience. It is wrong for our welfare system to provide lavish benefits for persons in America in violation of our laws.

I am proud that the Personal Responsibility and Work Opportunity Act ends welfare for illegal aliens. It ends eligibility for Government programs for illegal aliens. It ends the taxpayer-funded red carpet for illegal aliens. Our plan is to send a clear message to those who jump our borders, violate our laws, and reside in America illegally: Go home. Stop freeloading off of hard-working American taxpayers.

Let me address the matter of legal immigrants. America is a beacon of hope and opportunity for the world. That is why we continue to have the most generous system of legal immigration that history has ever known. It is in America's interest to invite those who want to work for a better life, and have a fighting chance at the American Dream. But we will not support those who come to America to be dependent upon our social safety net. Thus, our legislation places priority on helping American citizens first, and represents the values held by Americans.

For we are determined to liberate families from welfare dependency and get them work and a chance at the American Dream. We understand that for many single parents, child care can make the difference between being able to work or not. That's why or bill provides more and better child care, with less bureaucracy and redtape, and more choices and resources for parents striving for a better life.

Here are the facts: This conference report provides $22 billion for child care over 7 years. That amounts to $4.5 billion over current law, and $1.7 billion more than President Clinton's plan recommends. And we dramatically increase resources for child care quality improvement. By investing in quality child care, we provide more families the opportunity to be free from welfare dependency and to strive for the American Dream.

In the end, this bill is what is about the best of America. We are a compassionate people, united by common ideals of freedom and opportunity. The great glory of this land of opportunity is the American Dream. Families trapped by welfare, and especially their children, have had this dream deferred. We can do better. And we do, through this legislation, because this is America. I urge the adoption of the conference report on H.R. 3734.

Mr. BILIRAKIS. Mr. Speaker, I would like to join in supporting the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. As representatives of the people, we do not get as many opportunities as we would like to do something that will truly help improve the lives of the people we serve.

This bill presents us with just such an opportunity.

The landmark welfare reform plan before us today will bring education, training, and jobs to low-income Americans. It will replace welfare dependence with economic self-reliance. And it will create more hopeful futures for the children of participants.

This conference report is more than just a prescription for much-needed welfare reform. It is what I hope will be the first step in our bipartisan efforts to improve the public assistance programs on which disadvantaged families depend.

Last February, the Nation's Republican and Democrat Governors unanimously endorsed welfare and Medicaid reform plans. And although the conference report before us today will give States the tools they need to improve their public assistance programs, our work is not done.

After all, welfare as we know it means more than AFDC. It includes food stamps, housing assistance, and energy assistance. And it includes medical assistance.

That's right—for millions of Americans, Medicaid is welfare. That is because income assistance alone is not sufficient to meet the pressing needs of disadvantaged families.

For States, too, Medicaid is welfare. In fact, it makes up the largest share of State public assistance funding. As a share of State budgets, Medicaid is four times larger than AFDC.

If President Clinton does the right thing and signs this welfare reform bill into law, Medicaid will still be caught up in the choking bureaucratic redtape of Federal control. That is why the Medicaid program must be restructured if States are to fully succeed in making public assistance programs more responsive and effective.

I commend my colleagues on both sides of the aisle for their commitment to true welfare reform. And I look forward to continuing our efforts to making all sources of public assistance work better for those who need a helping hand up.

Thank you.

Mr. REED. Mr. Speaker, today's vote is about change. Today we begin the move from a status quo that no one approves of to a reformed and improved welfare system. Our current welfare system traps too many families in a cycle of dependency and does little to encourage or help such individuals find employment. Both welfare recipients and taxpayers lose if the status quo is maintained.

I have repeatedly stated that meaningful welfare reform should move recipients to work and protect children. Just 2 weeks ago, I supported a bipartisan welfare plan, authored by Republican Representative Michael Castle and Democratic Representative John Tanner, which I believe met these goals.

The conference agreement on H.R. 3734 is not perfect, but it is a good first step into an era of necessary welfare reform. This legislation contains many useful and necessary improvements over the previous welfare proposals put forth by the Republican majority. In fact, this legislation has moved several steps closer to the Castle-Tanner bill.

The agreement ensures that low-income mothers and children retain their Medicaid eligibility; provides increased child care funding; removes the optional food stamp block grant; removes the adoption and foster care block grant; and allows States to use a portion of their Federal funding to provide assistance to children whose families have been cut off welfare because of the 5-year time limit.

While this legislation attempts to protect children from the shortcomings and failures of their parents, it does not fulfill all of my goals for welfare reform. I am concerned that H.R. 3734 fails to provide adequate Federal resources for States to implement work programs, nor does it contain adequate resources for States and individuals in the event of a severe recession.

In addition, the legislation makes cuts in food stamps for unemployed individuals willing to work and contains legal immigrant provisions that will deny access by legal immigrant children to SSI, food stamps, and other benefits. These concerns should be rectified by this and subsequent Congresses. I am committed to realizing this goal, and therefore, I am pleased that the President plans to propose legislation to repeal many of these provisions.

Furthermore, several States are currently working on plans to reform their welfare reform systems. We must ensure that these efforts are accommodated by this legislation.

This is the first Republican proposal which adequately acknowledges the need to protect children, while emphasizing work. Rhode Island, through the work of a coalition of State officials, business leaders, and advocacy groups, has crafted a welfare reform plan that also accomplishes these goals. Should H.R. 3734 prove detrimental to Rhode Island or the children of Rhode Island, I will work to make necessary changes to further strengthen the Nation's welfare reform efforts.

Mr. GOODLATTE. Mr. Speaker, I rise in strong support of this conference report. Despite the slanderous accusations by the advocates of the current welfare state, our welfare reform plan is compassionate and humane, two adjectives rarely used to describe the current welfare program.

Our welfare reform plan ends welfare as a way of life and gives back welfare recipients their self-worth. By replacing welfare with work, current recipients will realize that they have talents in which to make a productive and self-reliant life. They are so used to the government providing for them that they never believed they could provide for themselves and their families.

We know this transition isn't going to be easy; nothing worth having is easy. That is why our welfare reform plan continues government assistance as long as they are making a good-faith effort to be a productive member of society.

We separate from bona fide eligible welfare candidates those who have been convicted of a felony or those that refuse to become citizens. For too long, those that have been trying to make their own way but are suppressed by the big thumb of government have been represented by those welfare recipients that

make the headlines. By denying convicted felons and noncitizens taxpayer-funded assistance we take away the scourge previously associated with all welfare benefits. We create a new benevolent program and therefore a positive and refreshing atmosphere for its recipients.

Along with increased sense of self-worth that necessarily comes with a pay check that isn't a donation comes a greater sense of personal responsibility. Our reform promotes self-responsibility in an attempt to half rising illegitimacy rates. Once we diminish illegitimacy we can truly end the cycle of dependency created by our current welfare state.

As a condition for benefit eligibility, a mother must identify the father. This will ensure that single parents get the support they need and remind fathers that their children is their responsibility, not the State's.

Our welfare reform plan gives power and flexibility back to the States. I think this is the provision that gives the proponents of the current welfare state the most heartburn. The block grants give the power and flexibility once enjoyed by big government advocates to our Nation's Governors and State legislatures. Non longer will Washington power brokers be able to dictate who gets and how much they get. Rather, those who know the solutions for their unique challenges won't have to wait for bureaucratic approval to put their programs in action.

Mr. Speaker, not only is this reform plan historic, it is futuristic. This plan ends welfare as we know it and helps us see a society which encourages all of its members to be productive and self-reliant.

Mr. FRANKS of Connecticut. Mr. Speaker, this welfare reform conference bill brings us one step closer to fixing a welfare system that has been broken and in need of major repairs. We have had a welfare system that has caused generations of American citizens to live in poverty and become consumed by a condition of hopelessness and despair. We have had a welfare system that has created dependency upon a monthly stipend instead of employment as a viable solution to overcome poverty.

I strongly believe in the American dream where each individual is given the opportunity to work, provide for their family, and participate in our society. The current welfare system has taken that dream away from too many Americans.

The conference committee bill represents the change that will place the welfare program back into the hands of the States so that States can implement programs that best fit the needs of their welfare constituents. The bill will reinforce the American principle in which parents are responsible for the well-being of their children. Welfare recipients will be required to identify the absent father, and all able-bodied parents will be expected to work to provide for the needs of their children. The bill strengthens child support enforcement so that absent fathers will be located and required to pay child support.

The conference committee bill encourages States to implement the debit card for disbursement of welfare funds and food stamps. No longer will welfare recipients be able to use welfare funds to purchase illegal drugs. The bill will bring greater accountability in the spending of American taxpayer's money.

This conference committee bill will lead to greater self-sufficiency. The bill will give families who have had to live in poverty a new chance for a better life and an opportunity to participate in the American dream.

I urge support for the conference committee bill.

Mrs. COLLINS of Illinois. Mr. Speaker, I have heard of a rush to anger and a rush to judgment. What we have here is a rush to the floor. We're told an agreement on a conference committee report to H.R. 3734 was made near midnight last night. I haven't seen the conference report and don't know what's in the conference agreement. I read what's in the National Journal's Congress Daily/A.M. edition and the Congressional Quarterly's House Action Reports ''Conference Summary.'' The Congressional Quarterly Action Report includes the disclaimer that they haven't seen the conference agreement report either, but prepared a morning briefing anyway, using information provided by committee staff. Well, excuse me.

I don't consider it appropriate to rely only on some nebulous statement written by someone who hasn't read the report before casting my vote on behalf of my constituents. I want to have a copy of the legislation available and that's why we have the rule that we don't vote on a conference agreement the same day it is reported.

In my 23 years in the Congress, I have been accustomed to reading and studying legislation before I cast my vote on behalf of the Seventh District of Illinois, a responsibility I take very seriously. The House has rules governing debate, rules designed to keep us from rushing to judgment. Those rules dictate that we don't vote on conference reports the same day they are filed so that we have time to study the provisions. That's why there is a two-thirds majority vote requirement to overturn that rule.

So why are we being asked to waive the time requirement and go immediately to a vote on this conference report? We are told we will have 1 hour of debate on the rule that will give us 1 hour of debate to consider a special rule to waive the two-thirds vote requirement. Why? Because once again the Gingrich Republicans are trying to force legislation through the process without adhering to the safeguards established to protect the American people and the legislative process.

I object to this rule and urge my colleagues to defeat this rule so that America has a chance to look at what we are being asked to approve as new changes, major revisions really, in the provisions and control of public assistance programs that provide a safety net for the needy and vulnerable among us. I owe it to my constituents to study legislation and weigh the measure before casting my vote for them. Let's get back to reasoned debate, let's follow the rules, just like we are going to ask the recipients of the benefits provided or denied under this bill to follow. Let's stop changing the rules as it suits the desires of the Gingrich Republicans. I urge my colleagues to defeat this motion to change the rules. I yield back the balance of my time.

Mr. BLUMENAUER. Mr. Speaker, there is perhaps no more urgent issue in America today than ending welfare dependency.

In place of a welfare program built around welfare checks, we need a program built around helping people get paychecks. We need to move people toward work and independence. And we need to be tough on work and protective of children.

When the work on welfare reform started last year, the Republican proposals were weak on work, tough on kids, and the President was right to veto them.

Unfortunately, the bill before us today, while a significant improvement on the earlier versions, still falls short in both regards.

On work, the bill is, in fact, too weak, for it underfunds employment assistance by $13 billion. According to the Congressional Budget Office, a $13 billion shortfall is a guarantee that no State can meet the employment requirements in this bill. So we have missed an opportunity to make these poor families self-supporting.

On children, the bill is, in fact, too weak in its child care provisions; it is too harsh in the manner children are punished for the failures of their parents; and it is far too extreme in its potential to push an additional 1 million children into poverty.

I am also deeply concerned by the fundamental premise of this legislation. There are many Governors, in many States, who today are sincerely committed to using a welfare block grant to raise the well-being and quality of life of people within their States. And as I listen to them, I hear a haunting echo of a situation which occurred some years ago when many well-intended State legislators, myself included, voted to transition the mentally ill in Oregon into mainstream society. The concept seemed solid, as the welfare block grant seems to many Governors. But when the 1980's recession hit Oregon, the commitments we made to the mentally ill—similar in so many ways to the commitment the Governors today are making to their welfare recipients—simply came undone. And today, many years later, the mentally ill of Oregon still live on the streets, and Oregon's neighborhoods and local governments are struggling under the burden of serving this neglected population.

This, Mr. Speaker, is what I fear we face when the next recession rumbles through this land. When times get tough, and resources grow scarce, and the contingency funds are drawn down, who will be hurt the most? Will it be our schools? Our ports? Our highway funds? Our economic competitiveness programs? Or will it be those who are struggling to find a route out of poverty?

I fear without adequate planning, safeguards, standards, and funding, welfare reform will likewise turn into a nightmare not just for the poor, but for the people in our community ill-equipped to deal with the consequences of another experiment that backfires.

Mr. POSHARD. Mr. Speaker, I rise in support of this conference agreement on welfare reform. This is truly an important moment in my legislative career and in the history of the House. I trust our judgement today will be proven wise in years to come.

I have supported welfare reform with my work and with my votes during this session. I voted for the bill proposed by my colleague from Georgia, Congressman DEAL, and for the bill most recently proposed by a bipartisan coalition led by Congressmen CASTLE and TANNER.

By voting for those bills, and opposing the bills which were passed but vetoed by the President, we have been able to move toward a sensible middle ground, a tough yet humane bill which is worthy of our support. I will enter into the RECORD at this point a number of improvements which helped earn my support for this legislation.

Unlike the House bill, the Conference Agreement forces states wanting to transfer funds between block grants to transfer those funds specifically into child care and social services block grants.

The Agreement allows states the flexibility to implement pilot welfare programs like the one being put into place in Illinois. [A part of the Castle-Tanner Plan] However, states many use federal funds to provide vouchers and health and food stamp benfits to children through the five year time limitation mandated in the bill. After that, states have the option of continuing benefits in the form of a voucher.

The Conference Agreement provides additional flexibility in meeting the work requirements by allowing states that are implementing plans under federal waivers to count individuals who are participating in work programs under the waiver in meeting the work participation rates in the bill, even if the hours of work or the definition of work in the state plan do not meet the mandates in the bill.

The Agreement does not include the House provision that would have prohibited states from using block grant funds to make cash payments to families that have an additional child while on welfare.

Unlike the House bill, the Conference Agreement does not give states the option to receive food assistance in the form of a block grant, instead of under the regular Food Stamp program. The bill retains the current Food Stamp program. [A major part of the Castle-Tanner Plan]

The Conference Agreement decreased the amount cut from the Food Stamp program by $2.3 billion. (The Agreement cuts the Food Stamp program by $23.3 billion over six years.)

Tightens SSI eligibility criteria to restrict eligibility to children who meet the medical listings. However, individualized functional assessment and references to maladaptive behavior are repealed. [Criteria contained in Castle-Tanner Plan] All children meeting medical listings will be eligible for SSI benefits.

The House bill restricted Food Stamps benefits for able-bodied, unemployed adults who have no dependent and who are between the ages of 18 and 50—limiting Food Stamp benefits for this group to three months over their lifetime up to age 50. The Agreement provides such individuals with Food Stamps for three months out of every three years, with the possibility of another three months within that period. [Moved closer to the Castle-Tanner Plan]

Under the agreement, all families currently receiving welfare and Medicaid benefits will continue to be eligible for the Medicaid program. In addition, there is a one year transition period for Medicaid for those transitioning into the workforce.

The Conference Agreement does not deny Medicaid benefits for legal immigrants retroactively and applies the ban on benefits for five years instead of until citizenship to legal immigrants.

The Agreement retains the current Family Preservation and Support program, which is a preventive program designed to teach improved parenting skills before a child must be removed to foster care. The House bill would have replaced the program with a block grant.

The Agreement includes $500 million more than the House bill for a fund to reward states that are effective in moving people from welfare to work, preserving two-parent families, and reducing the out-of-wedlock births.

I come from a rural area. I know times can be tough. But I also grew up on a farm where we worked for everything we ever had, and where we took care of each other. Most of the people I represent in the 19th district have similar backgrounds. They know that jobs can be lost or families can break apart and that we need to look after our neighbor. But they also want that neighbor to take responsibility for their behavior and for them to look for work if they're able.

This bill helps us respect those old-fashioned traditions in a modern world. It helps us move people from welfare to work, helps us save money in the program, and gives the states the flexibility to meet the needs of their people.

We should be prepared to revisit this bill if in fact children are left behind as some critics fear. But today, we should embrace this proposal with courage and faith, confident that we are changing not only the construct but also the culture of welfare.

Mr. DURBIN. Mr. Speaker, I rise in support of reforming the welfare system. As the American people know, the current welfare system is in desperate need of reform. For public aid recipients trapped in the system, for those who exploit the welfare system, and for the taxpayers who foot the bills, an overhaul of welfare in America is a high priority.

The fundamental problem with our current system is that for many people welfare becomes more than a helping hand; it becomes a way of life. For some who enroll in the primary welfare program, Aid to Families with Dependent Children [AFDC], welfare becomes a trap they cannot escape. Some are afraid to lose the health benefits they receive through Medicaid. Others are unable to secure child care to enable them to go to work. We must eliminate these barriers and chart a clear path for welfare recipients to go after a paycheck instead of a welfare check. Welfare should be viewed as temporary assistance, not a lifestyle.

I believe welfare benefits should be cut off for recipients who are unwilling to pursue work, education or training. I also believe we must strengthen child support enforcement. Billions of dollars in child support payments go uncollected each year. By establishing paternity at birth and pursuing deadbeat parents, we can reduce the number of families impoverished by the failure of non-custodial parents to fulfill their financial responsibilities.

The legislation before the House today makes many of the changes needed to reform the welfare system. It will move people from welfare to work, and it provides child care funding and Medicaid to help people make the move from a welfare check to a paycheck. It maintains nutritional guarantees. And it includes child support provisions to press deadbeat parents to meet their responsibilities so their children do not end up on welfare.

This legislation is better than the Gingrich bill which I opposed 2 weeks ago. The Gingrich bill eliminated the Federal guarantee of nutritional assistance. The Gingrich bill denied Medicaid to legal immigrants. The Gingrich bill denied benefits to children born to parents on welfare. And the Gingrich bill did not allow States to provide vouchers for children when their parents exceeded time limits. The legislation before us today does not include any of these problems.

This legislation is also far better than the Gingrich bill I opposed last year. Last year's Gingrich bill would have block-granted and reduced funding for the nutrition program for Women, Infants and Children; school lunches and breakfasts; and the Child and Adult Care Food Program. It would have eliminated the critical nutrition, education and health services that are an important part of the WIC program's effectiveness in increasing the number of healthy births. It would have eliminated the assurance of food assistance for many children, leaving many of them without enough food to eat. And it would have eliminated the assurance of sound nutrition standards for these programs.

Last year's Gingrich bill also would have eliminated the guarantee of Medicaid coverage for millions of women and children on AFDC. It would have terminated most Federal day care programs and replaced them with a block grant to States. It would have cut overall child care funding and caused many families to be denied day care assistance. Without day care, many parents would be forced to quit their jobs and enter the welfare system. It also would have eliminated many of the health and safety standards that have previously been required of day care providers receiving Federal funds, and put many children's lives at risk. And it would have cut funding for foster care, adoption assistance, child abuse prevention and treatment and related services, and turned these programs over to the States in a block grant. Today's bill does not contain these enormous flaws.

The legislation before the House today is far from perfect. It has significant problems that must be corrected, and I will work with the President to ensure that these problems are effectively addressed. I support effective requirements on the sponsors of legal immigrants who apply for benefits, but I do not believe that people who live legally in our country should be treated unfairly. The legislation before the House today is unfair to legal immigrants who play by the rules and contribute to the progress of our country, just as all of our ancestors have done. And the legislation before us today cuts nutritional assistance too deeply, which will be harmful to children and may force some working families to continue to choose between paying the rent and putting food on the table.

I will vote for the legislation that is now before the House because it makes many of the changes that must be made to change welfare from a way of life to a helping hand. And I will work with the President to correct the problems in this legislation that have nothing to do with welfare reform.

Mr. FAZIO of California. Mr. Speaker, I rise to express my support for the conference agreement before us and to voice my gratitude to the many members of the Democratic Caucus who have worked long and hard over the last 2 years on this difficult issue.

These members, including XAVIER BECERRA, LYNN WOOLSEY, JOHN TANNER, CHARLIE STENHOLM, SANDY LEVIN, BOB MATSUI, MARTIN SABO, and many, many others, have worked long and hard to improve the welfare reform bill that we are considering today. They have increased the awareness of their colleagues and have worked for a whole range of improvements which have moderated some of the bill's original provisions. I truly appreciate their efforts.

While this conference agreement isn't perfect, it represents a step in the right direction. This agreement acknowledges the view that

welfare should be a second chance for those in need, not a way of life.

This agreement sets a 5-year time limit on receiving benefits, includes tough welfare-to-work requirements, and allows States to decide how best to meet the needs of their citizens.

I am pleased to see that the conference agreement moved toward the President's position on a number of important issues, especially the removal of a provision that would have allowed States to opt out of the food stamp program. This will help keep the nutritional safety net intact for our kids. In addition, I am pleased that strong child support enforcement provisions have been included in this agreement.

The agreement that we're voting on today is the first step toward a much-needed overhaul of our welfare system. It stresses both fiscal and personal responsibility and it breaks the cycle of dependence.

I urge my colleagues to support this conference agreement.

Mr. STOKES. Mr. Speaker, I rise in opposition to H.R. 3734, the Personal Responsibility and Work Opportunity Act, a bill which would dramatically overhaul our Nation's welfare system.

On July 18, 1996, I joined with 170 of my colleagues to show my staunch opposition to H.R. 3734. After reviewing the product of the conference committee, my position remains unchanged.

During this session of Congress, our Republican colleagues assured us a family friendly Congress. They promised us that our children would be protected from harm. However, this bill is not about helping our families, nor is it about saving our children. The primary purpose of this bill is to achieve more than $61 billion in budget cuts. And unfortunately, those who will suffer most from this legislation will be those who need assistance the most, our children, and the poor.

Seven months ago, President Clinton was forced to veto a welfare bill which, much like the bill before us today, would place an alarming number of children into poverty. According to the Urban Institute, H.R. 3734 would push 1.5 million children into poverty. I appeal to President Clinton to veto this measure which abandons the Federal commitment and safety net that protects America's children.

H.R. 3734 slashes more than $61 billion over 6 years in welfare programs. This bill guts funding for the Food Stamp Program, cuts into the SSI protections for disabled children, drastically cuts child nutrition programs, and slashes benefits for legal immigrants. Mr. Speaker, I find these reductions in quality of life programs appalling.

Mr. Speaker, I believe most of us agree that our Nation's welfare system is in the need of reform. But do we reform the system by denying benefits to legal immigrants who, despite working hard and paying taxes, fall upon hard times? How can we demand that welfare recipients work 30 hours a week, yet provide inefficient job training and job services—essential components in contributing to longevity in the workplace? In short, how can we justify punishing children and their families simply because they are poor?

If we are truly to talk about the reform of welfare, if we are going to talk about increasing opportunities for our low-income residents, we cannot expect productive changes for our community by taking away from those who already have very little.

Mr. Speaker, I can understand and support a balanced and thoughtful approach to addressing the reform of our Nation's welfare system. However, I cannot support this legislation which would shatter the lives of millions of our Nation's poor.

The pledge to end welfare as we know it is not a mandate to act irresponsibly and without compassion. On behalf of America's children and the poor, I urge my colleagues to vote against H.R. 3734.

Mrs. COLLINS of Illinois. Mr. Speaker, I rise in opposition to the conference agreement on H.R. 3734, legislation that revises our current law providing welfare to needy children, individuals, and families in America. This welfare revision does little more than poke holes in the safety net that is called welfare. In my opinion, this legislation is a desperate—and unsuccessful—attempt to claim reform when it is an illogical revision. Change merely for change's sake can lead to chaos, damage, and injury.

This bill reportedly contains changes to our welfare system that will ensure insecurity and forecast fear on the part of the many vulnerable, loving parents out there trying their best to provide for their children a safe, secure, and nurturing environment.

Some of my constituents in the Seventh District of Illinois are among the poorest of the Nation. For the 23½ years that I have served in this body, I have fought strong and sometimes bitter battles for the benefit of the vulnerable, the disenfranchised, the young, old, disabled, and poor. That is what I hope to be remembered for when I retire from the House at the end of the year.

So, I feel I have an obligation to rise today in opposition to the conference agreement developed in the 11th hour by a few secretly selected Members of Congress. I continue to be concerned that we are applying Band-Aid policy and control instead of prevention and early intervention. The funds provided in current law attempt to address, and/or remedy, the symptoms of poverty: joblessness, hunger, domestic violence, child abuse and neglect, illiteracy; but until and unless we set about strategically to address the causes, we go far short of adequate to eradicate the problem and then wonder why we are losing the fight.

I was contacted this morning by the Day-Care Council of Illinois, located in Chicago, who reminded me that President Franklin Roosevelt, under whose leadership the safety net for our most vulnerable children and families was established some 60 years ago once said: ''The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little.''

We do too little when we take away the Federal oversight of funds that are channeled into State and local coffers in the form of block grants; reduce the Food Stamp program in the name of budget deficit; deny benefits to legal immigrants; and make children-having-children continue to live in housing environments that failed them as teenage parents instead of supporting communities in their efforts to provide stable, dependable support systems. Whether that support is supplied by the teen parent's biological or substitute parent, or a publicly funded shelter, should be the decision of that child-parent, not the Federal Government.

Block granting welfare benefits is likely to block grant suffering. I can only hope that if this legislation passes, sufficient Federal criteria and oversight can make them work. The States have asked for block grants and will be called upon to demonstrate that they can act responsibly to all vulnerable populations in a non-discriminatory manner. My fear and recollection of contemporary history is that many of them will not.

On the issue of Medicaid eligibility, until and unless Congress can achieve meaningful health care reform to provide for universal access to health care financing, there must be Medicaid eligibility for the unemployed, uninsured families who receive public assistance. The well-being of our children is what public welfare should be all about; and we should focus on how best we can prevent and protect the vulnerable children of our Nation from experiencing poverty and despair, against hunger and sickness, and against fear and helplessness.

I urge my colleagues to reject this rush to agreement. I yield back the balance of my time.

Ms. VELÁZQUEZ. Mr. Speaker, I rise today in opposition to the welfare conference agreement. This bill is an outrage. It constitutes the latest chapter in the right wing majority's all-out attack on children and the poor.

Let's get real. Less than 2 percent of Federal dollars are spent on assisting poor women and children. Yet radicals are ramming a bill down our throats that does nothing more than single out and punish children in the name of deficit reduction.

Many on the other side of the aisle are under the false assumption that all we need to do to eliminate poverty is take food and money away from poor people. But I have news for you—this sink or swim approach will not work. According to the Urban Institute this bill would push 1.1 million children into poverty and eliminate their ability to count on basic income support.

The worse tragedy of all is that this cruel bill comes up short on jobs. Cutting financial assistance to poor families without money for job creation, job training and day care will not force recipients to swim but cause millions of poor children to drown.

The real problem is that in poor areas like the one I represent, there simply are not enough jobs for people. In fact in some areas in NYC there are 14 applicants for every one fast-food job.

Let's end this charade. I implore my colleagues, on both sides of the aisle, to support fairness and basic decency and reject this heartless legislation.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the conference report.

There was no objection.

The SPEAKER pro tempore. The question is on the conference report.

Pursuant to House Resolution 495, the yeas and nays are ordered.

The vote was taken by electronic device, and there were—yeas 328, nays 101, not voting 5, as follows:

[Roll No. 383]

YEAS—328

Ackerman	Baesler	Barr
Allard	Baker (CA)	Barrett (NE)
Andrews	Baker (LA)	Bartlett
Archer	Baldacci	Barton
Armey	Ballenger	Bass
Bachus	Barcia	Bateman

Bentsen
Bereuter
Bevill
Bilbray
Bilirakis
Bishop
Bliley
Blute
Boehlert
Boehner
Bonilla
Bono
Borski
Boucher
Brewster
Browder
Brownback
Bryant (TN)
Bryant (TX)
Bunn
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cardin
Castle
Chabot
Chambliss
Chapman
Chenoweth
Christensen
Chrysler
Clement
Clinger
Coble
Coburn
Collins (GA)
Combest
Condit
Cooley
Costello
Cox
Cramer
Crane
Crapo
Cremeans
Cubin
Cunningham
Danner
Davis
de la Garza
Deal
DeFazio
DeLay
Deutsch
Dickey
Dicks
Dingell
Doggett
Dooley
Doolittle
Dornan
Doyle
Dreier
Duncan
Dunn
Durbin
Edwards
Ehlers
Ehrlich
English
Ensign
Everett
Ewing
Fawell
Fazio
Fields (TX)
Flanagan
Foley
Forbes
Fowler
Fox
Franks (CT)
Franks (NJ)
Frelinghuysen
Frisa
Frost
Funderburk
Furse
Gallegly
Ganske
Gejdenson
Gekas
Geren
Gilchrest
Gillmor
Gilman
Gingrich
Goodlatte
Goodling
Gordon
Goss
Graham
Greene (UT)
Greenwood
Gutknecht
Hall (TX)
Hamilton
Hancock
Hansen
Harman
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hefner
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Holden
Horn
Hostettler
Houghton
Hoyer
Hunter
Hutchinson
Hyde
Inglis
Istook
Johnson (CT)
Johnson (SD)
Johnson, Sam
Jones
Kanjorski
Kaptur
Kasich
Kelly
Kennelly
Kildee
Kim
King
Kingston
Kleczka
Klink
Klug
Knollenberg
Kolbe
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Levin
Lewis (CA)
Lewis (KY)
Lightfoot
Lincoln
Linder
Lipinski
Livingston
LoBiondo
Longley
Lowey
Lucas
Luther
Manton
Manzullo
Martini
Mascara
McCarthy
McCollum
McCrery
McHale
McHugh
McInnis
McIntosh
McKeon
Meehan
Metcalf
Meyers
Mica
Miller (FL)
Minge
Molinari
Montgomery
Moorhead
Moran
Morella
Murtha
Myers
Myrick
Neal
Nethercutt
Neumann
Ney
Norwood
Nussle
Obey
Orton
Oxley
Packard
Pallone
Parker
Paxon
Payne (VA)
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pombo
Pomeroy
Porter
Portman
Poshard
Pryce
Quillen
Quinn
Radanovich
Ramstad
Reed
Regula
Richardson
Riggs
Rivers
Roberts
Roemer
Rogers
Rohrabacher
Rose
Roth
Roukema
Royce
Salmon
Sanford
Sawyer
Saxton
Scarborough
Schaefer
Schiff
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Sisisky
Skaggs
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Solomon
Souder
Spence
Spratt
Stearns
Stenholm
Stockman
Stump
Stupak
Talent
Tanner
Tate
Tauzin
Taylor (MS)
Taylor (NC)
Thomas
Thornberry
Thornton
Thurman
Tiahrt
Torkildsen
Torricelli
Traficant
Upton
Vento
Visclosky
Volkmer
Vucanovich
Walker
Walsh
Wamp
Ward
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
White
Whitfield
Wicker
Wilson
Wise
Wolf
Wynn
Young (AK)
Zeliff
Zimmer

NAYS—101

Abercrombie
Barrett (WI)
Becerra
Beilenson
Berman
Blumenauer
Bonior
Brown (CA)
Brown (FL)
Brown (OH)
Clay
Clayton
Clyburn
Coleman
Collins (IL)
Collins (MI)
Conyers
Coyne
Cummings
DeLauro
Dellums
Diaz-Balart
Dixon
Engel
Eshoo
Evans
Farr
Fattah
Fields (LA)
Filner
Foglietta
Frank (MA)
Gephardt
Gibbons
Gonzalez
Green (TX)
Gutierrez
Hall (OH)
Hastings (FL)
Hilliard
Hinchey
Jackson (IL)
Jackson-Lee (TX)
Jacobs
Jefferson
Johnson, E. B.
Johnston
Kennedy (MA)
Kennedy (RI)
LaFalce
Lantos
Lewis (GA)
Lofgren
Maloney
Markey
Martinez
Matsui
McDermott
McKinney
McNulty
Meek
Menendez
Millender-McDonald
Miller (CA)
Mink
Moakley
Mollohan
Nadler
Oberstar
Olver
Ortiz
Owens
Pastor
Payne (NJ)
Pelosi
Rahall
Rangel
Ros-Lehtinen
Roybal-Allard
Rush
Sabo
Sanders
Schroeder
Schumer
Scott
Serrano
Slaughter
Stark
Stokes
Studds
Tejeda
Thompson
Torres
Towns
Velazquez
Waters
Watt (NC)
Waxman
Williams
Woolsey
Yates

NOT VOTING—5

Flake
Ford
Gunderson
McDade
Young (FL)

☐ 1710

Mr. SCHUMER changed his vote from ''yea'' to ''nay.''

So the conference report was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. SHAW. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous matter on the conference report on H.R. 3734.

The SPEAKER pro tempore (Mr. ARMEY). Is there objection to the request of the gentleman from Florida?

There was no objection.

REPORT ON RESOLUTION WAIVING POINTS OF ORDER AGAINST CONFERENCE REPORT ON H.R. 3603, AGRICULTURE, RURAL DEVELOPMENT, FOOD AND DRUG ADMINISTRATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 1997

Mr. GOSS, from the Committee on Rules, submitted a privileged report (Rept. No. 104–730) on the resolution (H. Res. 496) waiving points of order against the conference report to accompany the bill (H.R. 3603) making appropriations for Agriculture, Rural Development, Food and Drug Administration, and Related Agencies programs for the fiscal year ending September 30, 1997, and for other purposes, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION WAIVING POINTS OF ORDER AGAINST CONFERENCE REPORT ON H.R. 3517, MILITARY CONSTRUCTION APPROPRIATIONS ACT, 1997

Mr. GOSS, from the Committee on Rules, submitted a privileged report (Rept. No. 104–731) on the resolution (H. Res. 497) waiving points of order against the conference report to accompany the bill (H.R. 3517) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 1997, and for other purposes, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION WAIVING POINTS OF ORDER AGAINST CONFERENCE REPORT ON H.R. 3230, NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 1997

Mr. GOSS, from the Committee on Rules, submitted a privileged report (Rept. No. 104–732) on the resolution (H. Res. 498) waiving points of order against the conference report to accompany the bill (H.R. 3230) to authorize appropriations for fiscal year 1997 for military activities of the Department of Defense, to prescribe military personnel strengths for fiscal year 1997, and for other purposes, which was referred to the House Calendar and ordered to be printed.

☐ 1715

INTERNATIONAL DOLPHIN CONSERVATION PROGRAM ACT

Mr. GOSS. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 489 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 489

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 1(b) of rule XXIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 2823) to amend the Marine Mammal Protection Act of 1972 to support the International Dolphin Conservation Program in the eastern tropical Pacific Ocean, and for other purposes. The first reading of the bill shall be dispensed with. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Resources. After general debate the bill shall be considered for amendment under the five-minute rule. In lieu of the amendment recommended by the Committee on Resources now printed in the bill, it shall be in order to consider as an original bill for the purpose of amendment under the five-minute rule the amendment in the nature of a substitute printed in the Congressional Record

and numbered 1 pursuant to clause 6 of rule XXIII. That amendment shall be considered as read. No other amendment shall be in order except a further amendment printed in the report of the Committee on Rules to accompany this resolution, which may be offered only by Representative Miller of California or his designee, shall be considered as read, shall be debatable for one hour equally divided and controlled by the proponent and an opponent, and shall not be subject to amendment. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. Any Member may demand a separate vote in the House on any amendment adopted in the Committee of the Whole to the bill or to the amendment in the nature of a substitute made in order as original text. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

The SPEAKER pro tempore (Mr. EWING) The gentleman from Florida [Mr. GOSS] is recognized for 1 hour.

Mr. GOSS. Mr. Speaker, for the purposes of debate only, I yield the customary 30 minutes to the gentleman from California [Mr. BEILENSON], pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purposes of debate only.

(Mr. GOSS asked and was given permission to revise and extend his remarks and include extraneous material.)

Mr. GOSS. Mr. Speaker, the Rules Committee last week found itself in an unusual situation: A request for modified closed rule on a bill reported from the Resources Committee—although the Ways and Means Committee also had jurisdiction over a portion. As you know, bills reported from the Resources Committee are traditionally considered under open rules. So what's different about H.R. 2823, the International Dolphin Conservation Program Act? Most importantly, this bill would essentially codify an international agreement between 12 nations known as the Declaration of Panama. Any significant changes to the language of H.R. 2823 and that agreement is lost. It is worth mentioning that the negotiations that produced this agreement could serve as a model for environmental policymaking because just about every viewpoint in the tuna/dolphin debate was represented at the table. These negotiations not only involved the governments of 12 nations, but they also included representatives from the environmental community and the fishing industry. The result is a package that enjoys unusually broad support: From the administration and Vice President AL GORE to the Resources Committee Chairman DON YOUNG. From Greenpeace to the tuna fishermen.

In recognition of the fragile nature of this agreement, the Rules Committee has reported a modified closed rule that allows for a vote on the bill, preceded by an amendment to be offered by the gentleman from California [Mr. MILLER] or his designee, and one motion to recommit, with or without instructions. It had originally been the intention of the Rules Committee to allow a vote on a full substitute, but the minority specifically requested that the Miller amendment be made in order instead. The rule was agreed to in committee with voice vote without dissent.

Mr. Speaker, if you cherish the dolphin populations of the eastern Pacific, as I do, then you will agree it is vital that we move forward with this legislation. During the coming debate, you will hear differing viewpoints on how this legislation may impact dolphins—the administration's experts, the Resources Committee, and the Center for Marine Conservation all happen to believe that this bill will save dolphins' lives, and do so more effectively than current law—I think that's pretty good credentials. H.R. 2823 backs up that claim by mandating that every tuna boat operating in the eastern Pacific carry an observer to certify that not a single dolphin was killed when the tuna nets were hauled up. Even one dolphin death would prevent the entire catch from being sold in the United States as Dolphin safe. Under today's standards American consumers do not have this kind of guarantee. However, this proposal is not just about saving dolphins; it's about preserving endangered marine species like the sea turtles, as well as billfish and juvenile tunas. In Florida, we certainly treasure our dolphins—but we also take special care to protect other marine populations, and I am pleased that H.R. 2823 will address the eastern Pacific ecosystem as a whole, not just one aspect of it. You will hear the argument that one of the techniques allowed under this agreement, encirclement—with divers that release any dolphins before they are caught in the net, is harmful. But those who put forth this argument might not mention the enormous damage done by so-called safe fishing methods such as log sets and school sets. As the Resources Committee's report says:

> The bycatch of other marine species associated with these two fishing techniques is significantly higher than the bycatch associated with the encirclement technique. School sets generate approximately 10 times the amount of bycatch and log sets generate approximately 100 times the bycatch of juvenile tunas and other marine species.

So the message should be clear: If you want to protect dolphins, turtles, and other marine life, you should support this rule and vote for the International Dolphin Conservation Program Act.

Mr. Speaker, I reserve the balance of my time.

Mr. BEILENSON. Mr. Speaker, I thank the gentleman from Florida [Mr. GOSS] for yielding the customary half hour debate time to me; and I yield myself such time as I may consume.

Mr. Speaker, as the gentleman from Florida has explained, this is a modified closed rule for the consideration of H.R. 2823, the International Dolphin Conservation Program Act.

Even though we do not prefer rules that are this restrictive, and of course our colleagues who are now in the majority always railed bitterly against them when we were in the majority, it appears that the nature of this debate probably does not require a completely open rule.

On the other hand, it is also proper to point out that with a bill so narrow in scope as this one, it is difficult to understand why we need a rule with such strict limits.

In any case, we should support this rule. It should provide for adequate discussion of the principal controversy at issue here.

Mr. Speaker, the dolphin protection bill has created a great deal of controversy within the environmental community which was, after all, responsible for calling our attention to the serious problem of the slaughter of dolphins by the tuna fishing industry in the first place. If it had not been for several environmental organizations, the public would not have known about the way the dolphins were routinely trapped and killed by the giant nets used by tuna fleets.

But thanks to many organizations that are deeply concerned about the fate of our entire marine ecosystem, Congress passed legislation embargoing all tuna caught by that method, known as encirclement.

Because of that embargo, other big tuna-fishing countries felt the economic pressure, and after meeting with U.S. officials to develop a voluntary international agreement, pledged to adopt safer fishing methods. These new techniques have been dramatically successful. The result is that dolphin mortality has declined from over 100,000 in 1991 to a little bit more than 3,000 in 1995.

Because of that success, the United States, several environmental groups and 11 other nations met in Panama last year to develop a binding international agreement, the terms of which are reflected in H.R. 2823, that rewards these efforts by lifting the United States embargo. The agreement and the bill would also reward any batch of tuna caught without a single dolphin death, to be verified by on-board observers, with the dolphin-safe label that is so important commercially.

Mr. Speaker, H.R. 2823 has bipartisan support in the Congress. It has been endorsed by the Clinton administration, which helped negotiate the binding international agreement to lock in the dramatic reductions in dolphin deaths that have been achieved and to protect other marine species that are unfortunately threatened by alternative tuna fishing practices.

That so-called Declaration of Panama was signed by 12 nations in October 1995. Environmentalists believe, some environmentalists, not all, that this enforceable international agreement is the only way to protect marine

resources for the long term. We cannot, they believe, continue to act alone. It would be impossible to protect dolphins and other species if we did.

Again, Mr. Speaker, this is a modified closed rule and one that might better have been somewhat less restrictive or limited. But we hope the terms of the rule will not prevent us from hearing all of the arguments about this legislation. We are supportive of the rule. We think it is a fair rule.

Mr. Speaker, I reserve the balance of my time.

Mr. GOSS. Mr. Speaker, I yield 3 minutes to the gentleman from greater San Dimas, CA [Mr. DREIER], the distinguished vice chairman of the Committee on Rules.

Mr. DREIER. I thank my friend from Sanibel, FL, the distinguished chairman of the Subcommittee on Legislative and Budget Process, for yielding me this time, and I rise in strong support of this rule.

Mr. Speaker, I am one who enjoys consuming seafood but I am not particularly fond of tuna. But I am very supportive of this measure because it has been a long time in coming.

We have just had a great deal of excitement around here over the last several hours as we have brought about with, I think, 328 votes a bipartisan agreement on welfare reform, but the bipartisanship that exists on that, as the gentleman from Florida [Mr. GOSS] implied, pales in comparison when we look at the parties who are involved in this very important agreement who have disagreed on many, many issues in the past.

The fact of the matter is while my friend, the gentleman from California [Mr. BEILENSON], said that we in the past would rail about rules that are like this, this rule is very clear in that we are dealing with 12 nations who were part of this negotiating process and as he knows under fast track negotiating authority, which this Congress has had in the past but does not have now, we have seen agreement struck where there would be simply an up-or-down vote on measures, and that is the direction in which we are headed with this rule, because we do have, I think, an important environmental concern that is being addressed here and also for other friends of ours in Latin America.

I was talking with some people at the Mexican Embassy and they have been very anxious about this because they want to see us move ahead and proceed with what is a very important agreement not only for the consumers in the United States and Mexico but also for those in the tuna industry and those who are concerned, as we all are, about the safety of dolphins. So when we look at the World Wildlife Federation, at DON YOUNG, I know they do not always come together on issues, I believe that this is a great day as we continue the bipartisan spirit that was in evidence just a few minutes ago. About 6 hours ago the bipartisan spirit was not as in evidence here in the House of Representatives, but I am convinced that when we move to final passage on this rule and the measure that that great bipartisan spirit will be alive and well.

Mr. BEILENSON. Mr. Speaker, I yield 8 minutes to the gentleman from California [Mr. MILLER], the distinguished ranking member of the Committee on Resources.

(Mr. MILLER of California asked and was given permission to revise and extend his remarks.)

Mr. MILLER of California. Mr. Speaker, this legislation that we have begun debating here today, H.R. 2823, the International Dolphin Conservation Program Act, I believe, is a declaration of surrender by this Congress to those who insist that American environmental and labor standards must be destroyed on the altar of free trade.

□ 1730

H.R. 2823 is a complete capitulation to those who believe that U.S. consumers have no rights and our trade competitors must have all the rights when it comes to product disclosure.

This is a bad bill: bad environmental policy, bad trade policy, and bad foreign policy. It does precisely what we were told NAFTA and GATT would not do. It demands that our own laws governing the environment, worker safety, species protection, and a consumer's right to know be sacrificed.

Less than a decade ago, millions of American consumers, led by schoolchildren of this Nation, demanded the creation of dolphin protection programs because of the needless slaughter of hundreds of thousands of marine mammals by tuna fishermen. We passed the Dolphin Protection Act. We required that tuna sold in the United States be dolphin safe.

The U.S. tuna industry, at enormous expense, complied with those requirements, relocated their ships and processing plants, and produced dolphin safe tuna. Those efforts have had a dramatic success. Dolphin deaths last year were a little less than 3,600, compared to 100,000 or more a few years ago.

The dolphin protection law has worked, but the bill before us today would renounce the very program that has achieved the goals we sought when the dolphin protection law was enacted.

Why on Earth would we so grievously weaken the very law that has worked so well? Not on behalf of American consumers, not on behalf of dolphin protection, not on behalf of those interests, but rather on behalf of Mexico, Venezuela, Colombia, and other nations who are trying a little environmental blackmail, and to date it seems to be working.

Those very countries that have continued to fish in violation of the dolphin safe law now demand of this Nation that we weaken our laws so they can sell dolphin unsafe tuna in U.S. supermarkets under a label that the consumer has come to understand as meaning dolphin safe, a label that was enacted by this Congress. This Congress should not now become a party to this deception of that label, and a deception that this act would bring about with respect to the American consumer.

H.R. 2823 implements an international agreement, the Panama Agreement, which was negotiated behind closed doors by five Washington-based environmental organizations and the government of Mexico. This agreement makes major changes to long-standing laws protecting dolphins and informing our consumers.

But let us remember it was negotiated without the knowledge of any elected Member of Congress or other interested parties with a decades-long history on this issue.

It was negotiated without consideration of the American tuna canning companies who in 1990 responded to the demands from our schoolchildren, their parents, and consumers nationwide, and some of the same environmental groups who secretly negotiated this deal. They did it by voluntarily announcing that they would no longer purchase and sell tuna caught by harming dolphins.

It was negotiated without the participation and approval of dozens of environmental organizations with millions of members nationwide who vigorously disagree that this is the best way to protect dolphins, and who strongly support the Studds amendment that will be offered later to retain the current dolphin safe label.

The legislation was drafted with the help of lobbyists hired by the Mexican Government, and presented to the Committee on Resources with the caveat that no amendments could be accepted if they were unacceptable to Mexico. Since when did we start negotiating in this fashion? Since when did we start negotiating in a fashion where privately negotiated agreements are now brought to the Congress and we are told that somehow they are the same as a treaty or an agreement between this Nation and other nations, but this Congress cannot be engaged in the process of amendment?

There are some very serious problems with this legislation. The most important is that it would do exactly what proponents of the trade agreement pledged these pacts would not do: drive down American environmental standards through pressure from countries that do not want to meet those same standards. That is the goal, pure and simple.

Let us be clear. The driving force behind this legislation is Mexico, which does not want to meet the standards of the dolphin safe label that is on every can of tuna sold in this country. Mexico wants to open the floodgates to nonsafe tuna and to desecrate the integrity of the label that has led through consumer preferences.

If we do not accede to this undermining effort, Mexico and other nations

tell us that they will abandon their commitment to this agreement, to fishing dolphin safe, and deliberately resume the slaughter of dolphins. These nations, and many other trading partners, are waiting to see how the U.S. Congress responds to this threat.

This legislation responds by capitulation. We are going to hear a lot of assertions about this legislation, how sensitive it is to dolphins, how it would not allow damage to be done to dolphins. Before Members vote I urge them to consider the following:

This legislation, as currently written, the supporters will tell us that this bill does not allow more dolphins to be killed; that it reduces the number of dolphin deaths. But the fact is, H.R. 2823 allows the number of dolphin deaths to rise by almost 30 percent. There is nothing in this bill about keeping dolphin deaths at today's historic low level. This bill is about allowing more dolphin deaths.

They say that their bill does not allow dolphins to be hurt. Under H.R. 2823, dolphins may be regularly encircled, harassed, and injured. The bill imposes no limit on the amount of injury that could be imposed on dolphins, as long as the dolphins do not actually die in the nets.

We will hear the proponents say that the environmentalists support this legislation. The fact of the matter is that over 80 grassroots environmental organizations vigorously oppose this bill and support the Studds amendment. By contrast, what we have are five Washington-based environmental groups that secretly negotiated this agreement with Mexico who are now supporting it.

Since when is this Congress obligated to accept, unamended, the products of negotiation by environmental organizations and foreign governments?

Lastly, the supporters of this legislation argue that we cannot change the bill because to do so would be to renounce international agreements and damage American credibility. The fact is, there is no international agreement. There is no treaty. This is about going to the negotiations on a possible treaty. This bill requires that we change U.S. law as a condition of going to those negotiations.

It is worth noting that the United States is the only country that is required to make these kinds of changes, to change domestic consumer protection laws to conform with this agreement.

I would hope that the Members of this Congress would see through this effort by Mexico to essentially abolish the dolphin safe protection that we currently have on the books, and would support the Studds amendment that will allow for the protection of the label, the protection of consumer knowledge, and provide for the protection of the dolphins.

Mr. GOSS. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New Jersey [Mr. SAXTON], chairman of the Subcommittee on Fisheries, Wildlife and Oceans.

Mr. SAXTON. Mr. Speaker, first let me thank and commend the Committee on Rules, led by the gentleman from New York [Mr. SOLOMON] and the gentleman from Florida [Mr. GOSS], for bringing this rule to the floor. Let me also commend my friend from Maryland, Mr. GILCHREST, who was the author of this bill, who I think did a very fine job.

Mr. Speaker, when I was sitting in my office of the first day of this session, press reporters called and said, ''How do you think it is going to be serving with a Democrat President, because in your term of being here you have always been able to communicate with and serve with Republican Presidents?'' I said, ''It will be my goal to find places and issues upon which the President the Democrat President, and I can agree.''

This is one of those issues. This is President Clinton's initiative. And as chairman, of the Subcommittee on Fisheries, Wildlife and Oceans, I am pleased to have been able to support a Clinton administration initiative.

I would also just like to point out to the gentleman from California [Mr. MILLER], who used some fairly harsh phrases, phrases like capitulation, and phrases like weakening the law, environmental blackmail, dolphin unsafe tuna, deception, secret negotiations, lobbyists hired by Mexico, I would just say to my friend from California those characterizations of this bill are misleading, untrue, and patently false.

There is not any truth to any of those assertions and that is why I rise in support of this rule and its granting of a modified closed rule to govern debate on H.R. 2823. I realize the Committee on Resources has traditionally requested open rules, but in this case it provides for a total, including the rule, of 4 hours of debate. I believe it is certainly a rule which merits our support.

Let me just in closing say, Mr. Speaker, that this bill is supported by the following organizations. Listen to this. Greenpeace, the Center for Marine Conservation, the Environmental Defense Fund, the World Wildlife Fund, the National Wildlife Federation, and the American Sports Fishing Association, to say nothing of the Clinton administration, and the AFL–CIO.

This is a good rule, it is a good bill, and I urge passage of the rule.

Mr. BEILENSON. Mr. Speaker, I reserve the balance of my time.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume to say that I have two remaining speakers, which I will call on. I have admonished them that this is the rule and they are going to focus on the rule and the merits of the rule and how it might affect the substance. Once we get through that, I hope we can get to a quick oral vote.

Mr. Speaker, I yield 5 minutes to the distinguished gentleman from Maryland [Mr. GILCHREST], the author of this bill.

Mr. GILCHRIST. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, I would like to say very quickly that I appreciate the Committee on Rules understanding the nature of this international agreement to bring forth this type of rule that does allow for one opposing view, but the importance of the agreement underscores the fact that we, as the basic author of the agreement, the United States is the basic author of the agreement, we have not given up any sovereignty whatsoever. We have encouraged other nations, other international nations to better manage the marine ecosystem.

In response to the gentleman from California, I want to make three quick points. As far as his statement in reference to this bill being, this legislation being debated and formulated behind closed doors by people who are fanatics about open trade, well, first, labor groups that are supporting this legislation, environmental groups that are supporting this legislation opposed NAFTA and GATT.

This legislation was created in the full light of day at public hearings in this U.S. Congress. Legislation that was adopted that we are now dealing with was not created by extreme environmental groups without any background in the marine biological sciences. We tapped the best scientists in this country to come up with the best management scheme so that we could not only, as an individual country, the United States, manage our marine ecosystem, but so that we preserved it for generations to come and, by the way, ensure that dolphin deaths were down, hopefully, in a few years, to zero.

We tapped marine biologists with some of the best background that this country has ever seen, and they are the ones that have come to this unanimous consensus that if we are going to deal on this tiny little planet, that by the year 2096 is going to have a population of 17 billion people, and we have 5.5 billion people right now, we had better begin to learn how to get along with our neighbors.

If we are going to deal with a much more complicated regime as global climate change, and we have to deal with our neighbors and create international agreements, we had better understand that the best way to do that is not demagoging an issue but dealing with the matters that people are concerned about, such as dolphin safe tuna. We know that.

We are going to ensure that those dolphin safe labels on every one of those tuna cans reflect that no dolphins were killed or hurt. We are going to ensure that we as a Nation can work with other countries about environmental issues.

□ 1745

So I know that the gentleman from Florida [Mr. GOSS] says that this is a

debate about the rule, and I support the rule 1,000 percent, and I would urge the entire Congress to support this rule.

Mr. GOSS. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from California [Mr. CUNNINGHAM], who is an author of this bill in its original version and was also, interestingly enough, the most fierce representative for his tuna fishermen of anyone I have ever met. Out of that has come this good legislation, and I congratulate him for that.

Mr. CUMMINGHAM. Mr. Speaker, it was characterized that some fly-by-night groups got together and put this thing together. At the Inter-American Tropical Tuna Commission, the IATTC, a La Jolla, CA-based organization, 35 scientists got together and developed the most effective bycatch reduction program ever implemented. It saved dolphin and brought down the numbers. The ''dolphin safe'' label now used in U.S. markets takes a much higher ecological toll on marine life.

Those who read their Congressional Monitor read that tuna fisherman cannot label their tuna ''dolphin safe.'' That is not the case. Many American consumers still mistakenly believe that the Nation's ''dolphin safe'' policies and product labels worked. U.S. fishermen have to have observers on board. None of these other Nations do.

If the Studds-Miller agreement goes back, all of the other Nations that have signed aboard this agreement will no longer be required to have observers. They are going to go on and kill dolphin. Why not? They can sell it abroad. This ties other Nations that the United States has no control over to a ''dolphin safe'' policy.

This is going to save dolphin. And why? Fish from sets of nets where 100 percent of encircled dolphins are released unharmed will qualify as ''dolphin safe.'' No tuna will be labeled safe unless absolutely no dolphins are killed. It has to have 100 percent verification on site as the fish are caught.

Trying to comply with current law, the no-encirclement policy, some skippers have to fish immature tuna. That is killing our future. And that is why we have such broad support in this. It actually enhances the tuna and the crop for later years.

The amendment being offered by the gentleman from Massachusetts [Mr. STUDDS] and the gentleman from California [Mr. MILLER] will destroy the most effective dolphin bycatch resolution. That is why I support this rule, Vice President GORE, and who are the other people who have supported this? The AFL–CIO.

The gentleman from California [Mr. MILLER] said it is destroying our legal policy. If we look at President Clinton, Vice President GORE, five of the administration groups and all five major environmental groups support this because it is going to help save dolphin; and we support that. And when we can come together as a body and throw out the extremes on both sides and arrive somewhere in the middle, work with industry, work with environmental groups, that is good.

Why is the Panama agreement important? Because it does tie those 12 nations to the same observation, the same requirements that the United States has to go through today.

This Congress must support dolphin conservation, the fishermen who perfected their fishing techniques, and the scientists who worked with them to achieve these many accomplishments.

Mr. Speaker, I thank the gentleman from Maryland [Mr. GILCHREST] and the gentleman from Illinois [Mr. PORTER] for their hard work in the face of a lot of lobbying from groups with misinformation. And I would like to thank them for sticking to principle and believing in what they are trying to do.

Mr. Speaker, I have a letter from the President of the United States supporting this legislation, and I would like to submit it for the RECORD.

Mr. BEILENSON. Mr. Speaker, I yield such time as he may consume to the gentleman from American Samoa [Mr. FALEOMAVAEGA].

(Mr. FALEOMAVAEGA asked and was given permission to revise and extend his remarks.)

Mr. FALEOMAVAEGA. Mr. Speaker, American Samoa is in the middle of the South Pacific Ocean, and fishing has been the life blood of Samoans for thousands of years. While today's commercial canning operations bear little resemblance to my father's subsistence fishing, we continue to use the same resource, the Pacific Ocean.

The Samoans are also known as the voyagers, and countless generations ago, my forefathers, using Samoa and Tonga as a base, expanded the known world to include the island groups now known as French Polynesia, which includes the Island of Tahiti, the Cook islands, the Hawaiian Islands, and many of the smaller islands in between. We learned well the ways of the ocean, including who our friends are.

In my lifetime, I have had the opportunity over the years to share the experiences of my ancestors. As a youth I traveled extensively on the waters of the Pacific in vessels voyaging between Tokelau and the Manu's islands. I have even traveled on a purse seiner for 400 miles from Samoa to the southern Tongan Islands. I was also invited to sail on the famous *Hokule'a,* a historical Polynesian sailing canoe built by native Hawaiians and constructed so as to be the same in size and configuration as the ancient sailing canoes. With Nainoa Thompson as our first Polynesian navigator in 200 years, we voyaged on the *Hokule'a* from the Island of Rangiroa in French Polynesia to Hawaii, utilizing noninstrument navigational methods, sailing by the movement of the stars, the ocean waves, and the flight of birds.

During this voyage, I had the opportunity to experience firsthand the interaction among those who live in the sea and those who live on and above it. I developed a greater appreciation for all living things, and confirmed the gentle, helpful nature of dolphins.

In fact, the experience I got from being at sea for weeks at a time is that the dolphins were always there, and I can share with my colleagues that the dolphins are just like humans. Dolphins have been sacred to the Polynesians as far back as our legends recount our history. Ancient Polynesians would rather starve than kill a dolphin.

When people are at sea under sail for weeks, dolphins are of tremendous psychological benefit. I have experienced lack of movement in the doldrums and the intense heat of the tropics, and I can understand how the dolphins would have given early Polynesian travelers a sense of hope. My voyage on the *Hokule'a* gave me an opportunity to contemplate that perhaps the reason God created dolphins was to provide psychological support for sailors at sea.

Samoan legend and modern news reporting all confirm today's common knowledge about dolphins: They are of no threat to mankind, and have on occasions saved the lives of their fellow mammals. In return mankind has hunted them down, killing over 100,000 per year, not for sustenance, but because tuna swim under them.

When this was brought to the attention of the U.S. public, we rose in outrage and put enough economic pressure on the tuna industry to change its methods of fishing. And you have already heard, dolphin deaths have dropped from over 100,000 per year to 3,300 in 1995. This is a significant achievement, and we consumers are to be commended.

Congress did its part as well, placing an embargo on tuna that is caught by methods which harm dolphins, and by enacting legislation which permits the use of the all-familiar ''dolphin safe'' label.

Part of the underlying problem is that tuna in the eastern tropical Pacific Ocean swim under schools of dolphin, and one easy, quick way to catch tuna in the eastern Pacific is to chase dolphins until they are too exhausted to swim any further. Then the dolphins, and the tuna under them, are encircled in a net. It is this chasing and netting procedure that causes the harm to the dolphins.

In the western Pacific Ocean, the tuna do not always swim under schools of dolphin, and tuna are found through the use of modern techniques, including helicopters and sonar. By netting schools of tuna which are not swimming under dolphins, the problem is solved: Consumers get their canned tuna, and no dolphins are killed in the process.

Now, under pressure from foreign governments, it is being proposed that the current statutory and regulatory system be changed. My colleagues will

recall that when we debated the implementing legislation for GATT and the proposed World Trade Organization, many of us pointed out the economic and policy difficulties which passage of the legislation would create. This is an example of the kind of problems we knew we would encounter under regulations of the World Trade Organization, or the WTO.

Today we are being told that our dolphin safe embargo is in violation of the WTO rules, and that if we do not remove our embargo, the United States will be forced to pay significant fines. today we are being asked to forget a sound fisheries management policy that has reduced dolphin kills by 96 percent; we are being asked to forget the sound policy of using the attraction of the consumer market in the United States to alter the behavior of nations less concerned with the preservation of life; and instead we are being asked to give in to the foreign interests.

H.R. 2823 is a bad idea because it rewards those who have the worst record in the killing of dolphins. This bill is nothing more than giving in to blackmail. What the foreign governments are saying is that unless we lift the embargo on canned tuna, they will allow the slaughter of hundreds of thousands of dolphins to resume. If this isn't blackmail—I don't know what is!

Lifting the embargo constitutes only part of the bill. This will also perpetrate a fraud on the American consumer. H.R. 2823 changes the definition of dolphin safe to allow chasing, injury, harassment, encirclement, and capture of dolphins as long as no dolphins are observed dead in the nets. This definition allows tuna which have been caught by encirclement to be sold as dolphin safe in the U.S. market. This, Mr. Speaker, constitutes consumer fraud.

This canneries in American Samoa were the first to announce they would no longer purchase tuna caught in association with dolphin. In large measure, this decision resulted in a marked decrease in the killing of dolphins worldwide—from a high of 115,000 in 1986 to less than 4,000 in 1995. Lifting the tuna embargo on Mexico and changing the definition of dolphin safe will confuse American consumers and undermine the integrity of an American industry which is currently struggling to survive.

Lifting the embargo will also encourage what is left of the U.S. tuna industry to move to foreign countries in which businesses do not have to comply with any of the regulations that apply to U.S. companies located in our States and territories. U.S.-flagged purse seiners and tuna canning facilities in the United States must comply with the higher U.S. standards placed on U.S. companies by Federal law. Most foreign countries do not require the same high environmental and labor standards as the United States, and this works to the disadvantage of U.S. citizens and businesses because it puts pressure on U.S. companies to move overseas to be more competitive. There is proof that this movement to overseas locations is occurring. As a matter of policy, we should be encouraging businesses to locate and expand in the United States, not move to foreign soil.

In 1983, 28.3 million pounds of foreign canned tuna entered the U.S. market above the quota. By 1991, this amount had increased to 237.2 million pounds—a more than eight-fold increase. In 1991, canned tuna from U.S. plants accounted for approximately 50 percent of the U.S. market. By 1993, our market share had been reduced to approximately 39 percent.

Mr. Speaker, lifting the embargo on tuna caught by foreign nations will drive the last nail into the coffin of what remains of the U.S. tuna industry. Thailand, the Philippines, Indonesia, Taiwan, Sri Lanka, and other countries are already able to export their canned tuna to the United States without having to comply with any of the safety, health, or environmental regulations that apply to U.S. companies.

Adding additional countries to this list will have a devastating effect on the largest industry in American Samoa. It is believed that approximately 80 percent of our private-sector employment is associated with the catching, cleaning, canning, and shipping of tuna. Needless to say, closure of these plants would devastate the economy of American Samoa.

Mr. Speaker, now is not the time to turn back the clock. Dolphin deaths worldwide have been reduced by 96 percent because of tough dolphin safe laws in the United States and Europe. The foreign businesses which are behind this harmful bill insist the U.S. change its law to unload their hard-to-market dolphin unsafe tuna in the lucrative U.S. dolphin safe market. This makes a mockery of the term dolphin safe.

Unfortunately, the dolphins cannot be here to make a case for themselves. A few of us are here in the Chamber today to speak on their behalf, and I want to say on behalf of the millions of dolphins at risk, the day will come when mankind will be held accountable for its actions.

This should be an easy vote. By voting against this bill, you will be voting for the dolphins, for U.S. fishermen, for the U.S. boat owners, for the U.S. tuna canners, and against foreign interests. Let us not be governed by foreign interests. Save the dolphins and kill the Gilchrest legislation.

Mr. Speaker, I submit the following for the RECORD:

BOGUS CLAIMS ABOUT TUNA-DOLPHIN BILL

DEAR COLLEAGUE: As the House prepares to debate H.R. 2823, the International Dolphin Act, you should know the truth behind several misimpressions frequently conveyed by supporters of the legislation. A careful examination of the facts provides overwhelming justification for the Studds ''Truth in Dolphin-Safe Labelling Amendment.''

H.R. 2823 supporters say: ''This bill doesn't allow more dolphins to be killed. It will reduce the number of dolphin deaths.''

But the fact is: H.R. 2823 allows the number of dolphin deaths to rise by over 30 percent!

H.R. 2823 supporters say: ''Our bill doesn't allow dolphins to be hurt.''

But the fact is: dolphins may be regularly encircled, harassed and injured under the provisions of the bill!

H.R. 2823 supporters say: ''Environmentalists support this bill.''

The fact is: over 80 grassroots environmental organizations vigorously oppose this bill and support the Studds amendment. By contrast, only the five environmental groups that secretly negotiated this agreement with Mexico support the bill.

H.R. 2823 supporters say: ''We must support this bill, and we can't change this bill, because we would renounce an international treaty and damage American credibility.''

The fact is: no treaty has yet been negotiated, just an agreement to negotiate a treaty! This bill requires that we change U.S. law as a condition of negotiating the international agreement. The U.S. is the only country required to change its domestic consumer protection laws to conform to the pre-treaty agreement.

Congress must not perpetuate a fraud on American consumers. ''Dolphin Safe'' must mean that dolphins are not injured or killed in the hunt for tuna, which is what our constituents believe it means. H.R. 2823 allows an increase in dolphin deaths and the unlimited injuring and harassment of dolphins. That is not ''Dolphin Safe.''

Support the Studds amendment to keep the ''Dolphin Safe'' label honest for American consumers.

☐ 1800

Mr. GOSS. Mr. Speaker, I yield 1 minute to the gentleman from Maryland [Mr. GILCHREST].

Mr. GILCHREST. Mr. Speaker, I would like to submit for the RECORD a letter supporting this legislation from the Maritime Trades Department of the AFL–CIO, the Vice President of the United States that supports this legislation, and a list of scientists that had concern about the tuna-dolphin issue. I would like to submit these for the RECORD.

Very quickly, the gentleman from American Samoa said we were pressured into this legislation by foreign powers. I want to say that we were pressured into this legislation by the marine ecosystem that needs our help in managing those scarce resources.

The ancient Polynesians had values that we should reflect today. The world is much different today than it was during the ancient Polynesians' courageous efforts across the high seas. We want to retain the values of the ancient Polynesians. That is why we are trying to manage the ecosystem on an international basis.

The last point, 10,000 to 40,000 dolphins are killed now in the western tropical Pacific. We are trying to eliminate that down to zero with our legislation.

Mr. Speaker, I include for the RECORD the correspondence to which I referred:

[From the Maritime Trades Department, AFL–CIO]

H.R. 2823 WOULD GIVE U.S. TUNA INDUSTRY A LEVEL PLAYING FIELD

Shortly the House of Representatives will take up H.R. 2823, the International Dolphin Conservation Program Act of 1996, legislation designed to provide a level playing field for the American tuna fishing industry. The Maritime Trades Department, AFL–CIO (MTD), representing affiliates that include fishermen and tuna cannery workers among their ranks, urges Congress to adopt this measure without amendment.

American tuna fishermen have been disadvantaged by amendments to the Marine Mammal Protection Act and Dolphin Protection Consumer Information Act. Since 1992, they have been singularly barred from encircling dolphins during tuna harvesting. This restriction has had the paradoxical effect of forcing off the high seas American boats and crews, who were responsible for developing dolphin saving techniques in the harvesting process. As a result, many American-flag tuna vessels have been sold and placed under convenience registries with less experienced foreign crews that don't share similar environmental concerns. Domestic tuna canneries have been denied sufficient product to operate economically and have experienced periodic shutdowns.

Enactment of H.R. 2823 would help generate conditions conducive to increased participation of American tuna vessels in the Eastern Tropical Pacific. It also provides adequate supplies of quality tuna to enable domestic tuna canneries in California and Puerto Rico to operate full-time. In the process, hundreds of American fishing and related canning jobs will be restored and maintained.

The bill, introduced by Congressman Wayne Gilchrest, also provides strong environmental benefits that underscore longtime congressional interest in eliminating dolphin mortality resulting from tuna harvesting. H.R. 2823 accomplishes this goal through an international regime for protecting dolphins, including observers and other monitoring, verification and tracking of catch, research and enforcement. Moreover, the bill requires reductions in the allowable dolphin mortality rate to a level that guarantees recovery of dolphin stocks. The act also calls for shipboard observers to be responsible for monitoring bycatch of all species, with the goal of reducing total bycatch.

On balance, H.R. 2823 creates an environment that will enhance opportunities for American tuna industry workers, while enhancing international efforts to make tuna harvesting safe for dolphin and other fish species. The MTD urges your support for this legislation.

THE VICE PRESIDENT,
Washington, DC, June 3, 1996.

Hon. WAYNE T. GILCHREST,
House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE GILCHREST: I am writing to thank you for your leadership on the International Dolphin Conservation Program Act, H.R. 2823. As you know, the Administration strongly supports this legislation, which is essential to the protection of dolphins and other marine life in the Eastern Tropical Pacific.

In recent years, we have reduced dolphin mortality in the Eastern Tropical Pacific tuna fishery far below historic levels. Your legislation will codify an international agreement to lock these gains in place, further reduce dolphin mortality, and protect other marine life in the region. This agreement was signed last year by the United States and 11 other nations, but will not take effect unless your legislation is enacted into law.

As you know, H.R. 2823 is supported by major environmental groups, including Greenpeace, the World Wildlife Fund, the National Wildlife Federation, the Center for Marine Conservation, and the Environmental Defense Fund. The legislation is also supported by the U.S. fishing industry, which has been barred from the Eastern Tropical Pacific tuna fishery.

Opponents of this legislation promote alternative fishing methods, such as ''log fishing'' and ''school fishing,'' but these are environmentally unsound. These fishing methods involve unacceptably high by-catch of juvenile tunas, billfish, sharks, endangered sea turtles and other species, and pose long-term threats to the marine ecosystem.

I urge your colleagues to support this legislation. Passage of this legislation this session is integral to ensure implementation of an important international agreement that protects dolphins and other marine life in the Eastern Tropical Pacific.

Sincerely,

AL GORE.

LETTER FROM CONCERNED SCIENTISTS ON THE TUNA/DOLPHIN PROBLEM

We the undersigned scientists recognize the achievements made over the last twenty years to reduce dolphin mortality in the Eastern Tropical Pacific purse seine fishery for yellowfin tuna as well as efforts by U.S. and international scientists to improve the data and estimates of abundance and recruitment for dolphin stocks incidentally taken in this fishery. Specifically, dolphin mortality in this fishery has declined dramatically from 423,678 in 1972 to 4,095 in 1994.

We support efforts domestically and internationally to continue progress to reduce and eliminate dolphin mortality in this fishery. Further, we strongly believe that sound resource management and conservation depend upon reliable science and take into consideration the conservation and management of the ecosystem as a whole. The Declaration of Panama signed, on October 4, by the United States and eleven other nations takes significant steps in this regard. The scientific merits of the Panama Declaration are notable.

First, the Panama Declaration establishes conservative species/stock specific annual dolphin mortality limits at 0.2% to 0.1% of the minimum population estimate (N_{min}) up to 2001 and less than 0.1% of N_{min} thereafter. One way to approach the question of how much mortality dolphin populations can sustain and remain stable or increase is to express harvest as a proportion of net recruitment (i.e. as a proportion of the number of animals added to the population each year minus those that died). Recent estimates of recruitment are 2–6% per year. The Panama Declaration's annual species/stock specific mortality limits are set such a low level as to probably result in substantial increases in dolphin populations in the Eastern Pacific Ocean.

Second, the Panama Declaration establishes for the first time measures aimed at protecting other marine life caught incidentally in the eastern pacific tuna fishery, and represents an important first step towards efforts to reduce bycatch in commercial fisheries and sound ecosystem management.

Third, the Panama Declaration places greater emphasis on science-based management and conservation of tuna, dolphin, and other marine life in the Eastern Tropical Pacific through provisions that strengthen the existing scientific review process; promotes greater interaction between the scientific communities of the nations participating in the eastern Pacific tuna fishery; and places greater reliance on scientific data to inform the conservation and management of the fishery and the incidental take of dolphins and marine life in the fishery.

As scientists, we fully support these scientific principles which provide the basis for the Panama Declaration, and believe that they represent a scientifically sound approach to the management of the tuna fishery and conservation of dolphins.

Sincerely,

Ken Norris, Ph.D., Professor Emeritus, University of California Santa Cruz.

John H. Prescott, Director Emeritus, New England Aquarium, former Chair, Committee of Scientific Advisors, U.S. Marine Mammal Commission.

Lloyd F. Lowry, Ph.D., Marine Mammal Scientist, Alaska Department of Fish and Game.

William E. Evans, Ph.D., President of the Texas Institute of Oceanography, Professor of Wildlife and Fishery of Sciences, Texas A & M University.

David Challinor, Ph.D., Science Advisor National Zoo, Smithsonian Institution.

J. Lawrence Dunn, VMD, Staff Veterinarian, Mystic Marinelife Aquarium.

Daniel P. Costa, Ph.D., Professor of Biology, University of California, Santa Cruz.

Dayton L. Alverson, Ph.D., Natural Resource Consultants.

Terry Samansky, Director of Marine Mammals, Marine World Africa USA.

Edwin S. Skoch, Professor of Biology, John Carroll University, Ecotoxicology & Marine Animal Research Lab.

Brad Fenwick, Professor, Kansas State University, College of Veterinary Medicine.

Wendy Blanshard, Veterinarian, Sea World Enterprises, Surfer's Paradise, Australia.

Sarah Lister, DVM, Johns Hopkins University.

Kathryn J. Frost, Ph.D., Marine Mammal Scientist, Alaska Department of Fish and Game.

Graham Worthy, Ph.D., Professor of Marine Biology, Texas A & M University.

George Woodwell, Ph.D., Past President, Ecological Society of America, Woods Hole Research Center.

David St. Aubin, Ph.D., Researcher, Mystic Marinelife Aquarium.

Jeff Boehm, Vice President Research and Veterinarian Services, Shedd Aquarium.

William Y. Brown, Ph.D., Researcher, Hagler Bailly.

Sarah Paynter, Ph.D., Lecturer, Johns Hopkins University and National Aquarium in Baltimore.

Gwen Griffith, DVM, President, Alliance of Veterinarians for the Environment.

Cecile Gaspar, DVM, Dolphin Quest, Moorea-French Polynesia.

Scott Nachbar, DVM, Aquarium of Niagra Falls.

Mr. BEILENSON. Mr. Speaker, I yield 2 minutes to the gentleman from American Samoa [Mr. FALEOMAVAEGA].

Mr. FALEOMAVAEGA. Mr. Speaker, I appreciate the sentiments expressed by my good friend from Maryland concerning the legislation. But I think as a point of observation that I would like to share with the gentleman about the movement of tuna, not only as a migratory fish, but the fact that the way tuna is being caught in the eastern Pacific is quite different than the problems that we face in the western Pacific, the problems we have along the coastlines, the Latin American countries where the tuna tend to come up closer to the dolphins.

I do not know if it is because of the current or the warmth of the water, whatever it is, that causes this difference in how the tuna survives when it moves, quite different than from the way that we catch tuna in the western Pacific.

The fact is that the tuna tends to go lower in depth and so that when we do the purse seining, the dolphins are not as much affected as opposed to the problems we face in the eastern Pacific.

This is the predicament that we find ourselves under. The fact that because of the differences in temperature, whatever it is, that causes the tuna, the eastern Pacific tuna to go up a little closer to the dolphins so we obviously end up with a very difficult problem there, where our friends from Mexico and other countries that have the tendency, when they do catch the tuna under the dolphins, the dolphins definitely are more affected by it as compared to the problems that we have in the western Pacific.

I say to my good friend while I can appreciate his observations of how my forefathers have given a real sense of appreciation not only for the ocean environment, but the fact that here one of the most beautiful mammals in the world that we see and putting them on a sacrificial altar for the name of expediency and saying that tuna is more important than dolphins, I submit to the gentleman from Maryland, I could not disagree with him more on this issue.

Mr. GILCHREST. Mr. Speaker, will the gentleman yield?

Mr. FALEOMAVAEGA. I yield to the gentleman from Maryland.

Mr. GILCHREST. Mr. Speaker, I understand the nature of the difference between the way in which tuna and dolphins act in the eastern tropical Pacific. We have reduced the dolphin kill in the eastern tropical Pacific to a little over 3000. We have not reduced the kill of dolphins in the western tropical Pacific where we have no management ability.

Mr. GOSS. Mr. Speaker, I have no further requests for time, and I reserve the balance of my time.

Mr. BEILENSON. Mr. Speaker, I yield 4 minutes to the gentleman from New Mexico [Mr. RICHARDSON].

(Mr. RICHARDSON asked and was given permission to revise and extend his remarks.)

Mr. RICHARDSON. Mr. speaker, the Gilchrest approach offers the dolphin a better chance than the alternatives. Let me say that the Studds approach is also in my judgment a good alternative, but this one is much better because we would not be going it alone. Internationally we would be supported by many countries using the approach of WAYNE GILCHREST.

Mr. Speaker, the argument is very simple. If fleets do not receive some reward for their changed behavior soon, they will revert to their old and easier ways of fishing. Dolphin casualties are going to rise. Under this proposal, we are going to keep international monitoring programs all in effect. This legislation is critical for both the environmental and international communities. I hope my colleagues will support this bill that is fair, is necessary. It is moderate and has broad support.

Mr. Speaker, who can be greener than AL GORE, the Vice President of the United States who supports this bill?

This bill is the next step in the process of minimizing the impact of tuna fishing on dolphin populations in the marine ecosystem. In 1972, over 400,000 dolphins died in tuna nets. Last year that number was just over 3,000. The Saxton-Gilchrest bill, of which I am a cosponsor, locks into a place a 99 percent improvement in environmental protection.

Dolphin protection in international waters cannot be carried out by the United States alone. If we go the alternative route, everyone will say, there goes the United States, on its own again. We have to rely upon commitments of several fishing nations to cooperate with us to protect dolphins. With Mexico we have worked very well on this issue. There is a lot of progress. We cannot risk losing this important international coalition. If we do, the United States runs the risk of never being a leader in dolphin protection. then what would happen would be anarchy and more whaling deaths and there would be a whole upsurge of commercialism rather than environmentalism dictating what we should do.

The changes promoted by this bill will give incentives to make tuna fishing less wasteful of nontarget fish and as safe as ever for dolphins. This bill guarantees through the best observer program in the world that every time a net is deployed only tuna that is truly dolphin safe will receive this label. This dolphin-safe certification would be given to any haul of tuna in which no dolphins were killed or seriously injured.

Although there are reasonable concerns from my colleagues that dolphins will be stressed by this fishing technique, this bill that we are supporting, the Saxton-Gilchrest bill, calls for a study on dolphin stress so that we can finally make some solid conclusions about this issue.

The United States must continue to hold the firm line on compliance with sound fishing. This is why this bill will use the same tough trade measures that push countries to improve their fishing methods in the first place.

It is important that we implement the Panama Declaration to reward the efforts taken by our trading partners. if we fail to implement this agreement, there is reason to fear that our trading partners will return to their old ways of fishing. If this happens, dolphin mortality levels will rise.

This bill again is supported by the Clinton administration, National Wildlife Federation, Environmental Defense Fund, World Wildlife Fund, Greenpeace, and 12 nations have agreed to an unprecedented level of marine life protection. I think this is a good bill. It is a good, appropriate step in the interest of sustainable fishing, dolphin protection and the marine ecosystem. I think it has already been stressed that the maritime trade unions of the AFL–CIO support this bill. They have issued a statement.

Mr. Speaker, let us support this bill, but let us say that the approach that the gentleman from Massachusetts [Mr. STUDDS] has proposed I think is a good approach, but not hardly as good as this one that we are pursuing today. Let us give bipartisanism and environmental protection a very strong vote.

Mr. BEILENSON. Mr. Speaker, I yield back the balance of my time.

Mr. GOSS. Mr. Speaker, I yield myself such time as I may consume.

I would like to point out that this has been an almost full hour debate on the rule. I think we have come to the conclusion that this is a very good rule and it is going to lead to some very fine debate, when we get to the debate on this subject, which we are all looking forward to.

I am personally pleased that we have made such great progress in dolphin protection. Six years ago, when there was a merchant marine and fisheries committee, there was some disagreement that led to a better solution. Further disagreements have led to better solutions. This shows that democracy works, this Congress works, and I am proud to be part of it.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore (Mr. EWING). Pursuant to House Resolution 489 and rule XXIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for consideration of the bill, H.R. 2823.

☐ 1811

IN THE COMMITTEE OF THE WHOLE

Accordingly the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 2823) to amend the Marine Mammal Protection Act of 1972 to support the International Dolphin Conservation Program in the eastern tropical Pacific Ocean, and for other purposes, with Mr. COLLINS of Georgia in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. Pursuant to the rule, the bill is considered as having been read the first time.

Under the rule, the gentleman from New Jersey [Mr. SAXTON] and the gentleman from Massachusetts [Mr. STUDDS] each will control 30 minutes.

The Chair recognizes the gentleman from New Jersey [Mr. SAXTON].

Mr. SAXTON. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I thank the Chair for making in order the consideration of this bill, H.R. 2823, which would codify the Panama Declaration. This bill has been the subject of scrutiny by several committees: The Committee on Resources and, of course, our Subcommittee on Fisheries, Wildlife and Oceans, the Committee on Ways and Means, as well as the Committee on Commerce.

Our distinguished chairman, the gentleman from Alaska, DON YOUNG, and the gentleman from Massachusetts, GERRY STUDDS, have both expressed their reluctance to reopen the dolphin-safe tuna issue. They remember the rhetorical battle of the merchant marine and fisheries committee on which we all served, and I remember that battle as well.

The Gilchrest bill will lead 12 nations that currently fish in the eastern tropical Pacific or the ETC to a binding agreement to conserve and protect the entire ecosystem, including dolphins.

The alternative is an increase in school and log sets which result in killing sharks, endangered sea turtles, billfish, and baby tunas.

These pictures exemplify what it is that we are trying to protect. We have endangered Olive Ridley turtles. We have sharks. We have wahoo and billfish and, of course, juvenile or baby tuna. These are all species that we are trying to protect pursuant to this act.

Opponents of the Gilchrest bill will make several arguments. First, they will argue that the change in the status quo will lead to the wholesale slaughter of dolphins in the eastern tropical Pacific. We will show that that is not true.

□ 1815

Second, Mr. Chairman, opponents of the Gilchrest bill will also argue that the status quo will serve the purpose of saving the dolphins. We believe that is not true. Opponents will also claim that this bill will somehow undermine NAFTA, which we also believe is untrue.

So let me just start with the first issue. The first issue with regard to the Gilchrest bill will be that it is a change in the status quo and it will lead to the wholesale slaughter of dolphins. To me this is a disingenuous argument.

In fact, other nations are currently setting on dolphins; in other words, fishing for tuna under dolphins, in the eastern tropical Pacific, as the regular tuna harvesting method. That is going on today, and there is a large-scale slaughter of dolphins today by other countries.

These fishermen have refined their harvesting techniques so that a sizable reduction, however, in dolphin mortality has resulted from hundreds of thousands of dolphin deaths annually to just about 4,500 dolphin deaths today. Scientists say that this is about 4,500 out of a total of more than 9 million dolphin deaths.

These 11 nations, Belize, Columbia, Costa Rica, Ecuador, France, Honduras, Mexico, Panama, Spain, Vanuatu, and Venezuela have all negotiated with the Clinton administration in good faith to set up the framework for a binding agreement to cap dolphin mortality in the eastern tropical Pacific.

Mr. Chairman, the result of these negotiations is the Panama Declaration, and the enactment of this bill is the enactment of our promises under that declaration. The linchpin to the Panama Declaration, on which neither our State Department nor other nations will compromise, is the change in the dolphin safe definition. Without this change, the Panama Declaration, the international treaty, falls apart and so does our chance for a binding international marine conservation agreement to protect dolphins and other marine life.

The opponents also will argue that the Gilchrest bill, that the status quo will better serve the same purpose. Actually that is false. The status quo will no longer exist if the Panama Declaration is scuttled, and other countries will revert to their old practices.

The current agreement under which these nations, known as the LaJolla Agreement, is 100 percent voluntary on the part of all nations. These nations have shown that they will walk away from the voluntary conservation measures outlined in LaJolla without this agreement.

As a matter of fact, in fairness to the opponents, I delayed the subcommittee markup to ensure that all members had an opportunity to express their concerns and have them addressed. The international community expressed its determined disagreement, and I had to personally spend hours meeting with representatives of Latin American countries who threatened to walk away from this process.

The gentleman from Massachusetts [Mr. STUDDS] has an amendment that he will offer at the appropriate time. When we begin debate on the Studds amendment, I will discuss in detail why it will cause the demise of many more dolphins in the eastern tropical Pacific, also known as the ETP, than currently occurs.

Third, as I pointed out, the opponents will also suggest that this somehow is related to NAFTA. They will further claim that if this bill is approved, the United States is telling the world that we will weaken our own environmental laws to avoid violating NAFTA. I voted against NAFTA, and I can assure my colleagues that this bill is not related to NAFTA at all. That assertion is way off the mark. We are changing the law, yes; but we are not, we are not in any way, weakening it. We are strengthening it by enticing other countries already setting on dolphins or fishing on dolphins to participate in this binding international agreement that will reduce dolphin mortality even further.

Let me just repeat. A binding agreement will reduce dolphin mortality even further. Remember the current agreement is voluntary, not binding, and these countries can walk away from it at any time. The NAFTA agreement does not wash, the NAFTA argument does not wash, and neither does the assertion that we are weakening our environmental laws. I cannot fathom how a binding agreement to reduce dolphin mortalities in the ETP can be portrayed as anything, anything but a stunning environmental accomplishment.

At the close of general debate I will be offering a managers amendment that, like the Gilchrest bill, is wholeheartedly supported by the Clinton administration. It is also supported by Green Peace, the American Tuna Owners Association, the Center for Marine Conservation, the Environmental Defense Fund, the World Wildlife Fund, the National Wildlife Federation, the Seafarers International Union, and the American Sportfishing Association.

I will explain the substitute further at that time and urge all Members to do the right thing for all marine creatures in the eastern tropical Pacific and to vote yes.

Mr. Chairman, I reserve the balance of my time.

Mr. MILLER of California. Mr. Chairman, I yield 3 minutes to the gentleman from New Jersey [Mr. PALLONE].

Mr. PALLONE. Mr. Chairman, in an effort to make concessions to foreign fishing interests, the Clinton administration and other proponents of H.R. 2823 are tampering with the standards set under the authority of one of our most fundamental and successful environmental laws, the Marine Mammal Protection Act of 1972. This bill permits the number of dolphin deaths to actually increase up to 5,000 annually and has no provisions, in my opinion, to enforce this limit or specify how this number should decrease over time. I believe it leaves a gaping loophole, with no limitations on injuring or harassing dolphins so long as there are no observed mortalities.

I think also the American people have the right to know that this bill, in my opinion, has not been subject to proper debate and consideration. I know that my colleague from New Jersey talked about the action that took place in the Committee on Resources, but the bill was not referred to the Committee on Commerce which has in the past considered numerous bills relating to the labeling of tuna. Also, I am skeptical that adequate observer coverage can occur on a set by set basis as proposed by this bill, much less that a single observer could monitor nets that are up to a mile long and a hundred feet deep for potential dolphin fatalities.

Proponents are suggesting that bycatch is an important consideration, and I strongly support the need to address bycatch issues for tuna fishing, but by means other than a shifting of fishing effort to practices which place

dolphins at risk. This bill provides no alternative to dolphin sets with a failure to ensure that bycatch mitigation research is done. Setting on logs and debris under which tuna aggregate will continue as two other major commercial tuna species, the skipjack and bigeye tunas are traditionally caught under logs and debris and are not typically found with dolphins. Setting on dolphins is not a real solution to the bycatch issue, and H.R. 2823 does address this.

This bill is yet another rollback of environmentalist legislation, and the threat this bill poses to dolphins is very real in my opinion.

Mr. SAXTON. Mr. Chairman, I yield such time as he may consume to the gentleman from Maryland [Mr. GILCHREST], the author of the bill.

Mr. GILCHREST. Mr. Chairman, I thank the gentleman for yielding this time to me.

What I would like to explain to the Members that will be voting here in the next hour or so is that we have a piece of legislation that has been put together in the light of day by numerous interested parties, by the fishermen who want to catch their fair share of fish, by scientists who understand the complexity of the nature of the marine ecosystem, by elected officials in the United States that want to ensure jobs and ensure environmental quality and ensure the sovereignty of the United States. This bill has absolutely nothing to do with reneging on our environmental policies, this bill has nothing to do with violating the label so consumers understand that they are eating dolphin safe tuna.

Mr. Chairman, this is a bill that puts the best of American together, to join us with 11 other nations to understand the nature of limited resources and a bulging population. This bill understands the nature of trying to get international agreement on sensitive environmental issues. This bill is a first step to understand the nature of complex environmental issues such as global warming that we will have to sit down at the table and find agreements on.

Now the issue here is encirclement, the issue here is encirclement that deals with purse seine nets, and yes, those purse seine nets since the 1950's have killed hundreds and thousands of dolphins in the eastern tropical Pacific, and yes, the United States placed an embargo on that type of encirclement, the United States placed a gear restriction so that we would not import tuna where dolphins were killed. But there are still not only dolphins being killed in the pursuit of tuna, there are tens of thousands of sharks as bycatch. There are immature tuna being caught in other methods that will never stand the chance to spawn, and so the tuna population will continue to diminish.

So we have gotten together in the light of day in LaJolla, CA some years ago to try to figure out, we, as intelligent human beings, trying to figure out how we can manage our resources, feed the world and sustain the environmental marine ecosystem for generations to come.

Now a speaker earlier talked about the Polynesians and their values for life, both human and animal, fish species, mammals and so on. Those same values of respecting life on planet Earth are an inherent part of this piece of legislation, and so encircling dolphins the way it used to be, encircling tuna the way it used to be, killed tens of thousands of dolphins.

In this new method, which is not an end-all to this scheme of things, we are not going to adopt this legislation and have this agreement with 12 other countries and not continue to pursue to understand the nature of how to catch tuna without killing one dolphin. We are continuing to study this issue. We encircle the dolphins.

I say to my colleagues, Now imagine a boat with a circle around the back of that boat, and you have encircled the tuna fish that are swimming underneath these dolphins. The boat stops with a licensed observer on board, and then the back of the net drops down. Into that circle, into that net, go members of that tuna boat to chase the dolphins and the other marine mammals out of that net, and the net drops down below the surface of the water. And until all the dolphins are out of the net, that net does not get pulled and the tuna do not get processed on board ship.

This is not a perfect solution. There is no utopia on planet Earth. We must manage our limited resources with the technology that is available to us at this moment, and in my judgment the technology to reduce dolphin deaths, the technology to ensure the honesty of labeling dolphin safe tuna is this legislation.

So I will encourage my colleagues, as painful as it is to the gentleman from Massachusetts and the gentleman from California, and I very rarely vote against these two gentlemen when it comes to environmental issues, but I would encourage my colleagues to vote against the Miller-Studds amendment and vote for this legislation.

Mr. MILLER of California. Mr. Chairman, I yield 3 minutes to the gentleman from American Samoa [Mr. FALEOMAVAEGA].

Mr. FALEOMAVAEGA. Mr. Chairman, at some point in time in this debate the gentleman from Massachusetts, I know, will be offering an amendment to the pending legislation, and for that reason I rise in support of the amendment of the gentleman from Massachusetts [Mr. STUDDS] which will continue the meaningful standard of current Federal law on the use of the dolphin safe label.

Mr. Chairman, it was through a public outcry beginning over a decade ago that Congress responded in 1990 with the dolphin safe label we see on all tuna sold in the United States. American consumers wanted to purchase canned tuna, but they were not willing to do so if it meant killing over 100,000 dolphins per year. It was through a grass roots belief that dolphins should be protected that the dolphin safe label was born.

□ 1830

Throughout this period, Mr. Chairman, Mexican fishermen have wanted to catch tuna by encircling dolphins and selling it to consumers in the United States. The Gilchrest bill would give foreign interests greater access to our markets and remove the incentives to the tuna industry to stay in the United States. That is not good policy for anyone but the foreign fishing fleets and foreign canners.

Mr. Chairman, today, in a misplaced effort to comply with the foreign trade agreement, supporters of this bill propose changing the definition of dolphin-safe so dolphins can be chased and encircled in the catching of tuna, and the tuna can still be sold in the United States under the dolphin-safe label.

Mr. Chairman, I am opposed to this legislation and, quite frankly, even with the Studds amendment, but I do not believe that the bill adequately protects the dolphin stocks. Without the Studds amendment, Mr. Chairman, the consumers will not have that choice because they will not be able to tell dolphin-safe tuna from dolphin-unsafe tuna.

H.R. 2823 is not the solution, Mr. Chairman, to the dolphin issue I would choose, but the Studds amendment is the tolerable option. I urge my colleagues to vote for the Studds amendment when it is brought before the floor for consideration.

Mr. SAXTON. Mr. Chairman, I yield 3 minutes to the gentleman from New York [Mr. BOEHLERT].

(Mr. BOEHLERT asked and was given permission to revise and extend his remarks.)

Mr. BOEHLERT. Mr. Chairman, I rise in strong support of this bill. I wish to congratulate the gentleman from Maryland [Mr. GILCHREST] for all his hard work on it, for the thoroughness with which he took this challenging assignment on, for the openness of the process, for the methodical manner in which this final product was developed. WAYNE GILCHREST is a class act.

The choice we face in this debate is between ideological purity and practical impact. The purists want to push an approach to fishing in which no dolphins will ever become entangled in tuna nets. That sounds good, and we would all feel good voting for it, having demonstrated our purity. There is only one problem: that is, the practical impact that vote would have.

If we vote down this bill or amend it, we walk away from an international agreement that has been enormously successful in saving dolphins. Dolphin deaths have dropped from over 400,000 in the 1970's to less than 4,000 last year. The agreement will continue to move

us toward reducing mortality to zero. The agreement would fall apart. Other countries would go back to their old means of fishing, and dolphin mortality would increase again if we voted other than for the Gilchrest bill.

Not only that, bycatch of other species such as sea turtles would increase. So our choice is to vote for this bill and accept a small and declining level of dolphin mortality, or to pretend to purity and cause the death of dolphins and other sea creatures.

The gentleman from Maryland [Mr. GILCHREST], as one would expect, has taken the moderate approach. It has won the support of even such immoderate groups as Greenpeace.

Some of my friends are for this bill. People ask me, what about your friends? I point out some of my friends are for this bill, and some of my friends are not so enthusiastic. But let me tell the Members about my friends that are for this bill: The National Wildlife Federation, the Environmental Defense Fund, Greenpeace, World Wildlife Fund, Center for Marine Conservation, our good friends in the maritime trades department of the AFL–CIO, the American Sport Fishing Association, the American Tuna Boat Owners. The Washington Post twice has editorialized in support of this Gilchrest bill, and so has the New York Times and the Houston Chronicle.

Seasoned observers who care deeply about this process have all examined very carefully the Gilchrest proposal, and they have urged us, the Representatives of the American people, to vote for it. I proudly identify with my colleague, the gentleman from Maryland [Mr. GILCHREST], and I enthusiastically support this bill and urge my colleagues to do likewise.

Mr. MILLER of California. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I would like to respond to a couple of things that have been said here. The suggestion is that somehow, if we engage the legislation as it is currently written, that somehow that will lead to a reduction in the dolphin death rate from what we have today. The fact of the matter is the legislation allows for almost a 30 percent increase in dolphin deaths under this bill.

It also does not address and in fact would allow for the first time, under the guise of being dolphin-safe, the harassment, the hunting, capture, and killing, the attempt to harass, hunt, capture, or kill, marine mammals. We would not allow this, and this is not allowed for any other mammal, any other kind of fisheries under the law. But the fact of the matter is that is what happens.

What we do know, and one of the reasons that we have this legislation, is because the encirclement, the harassing, and the stress on the dolphins has taken a toll on them. Yet somehow we condone that, and we suggest that that is in fact dolphin-safe, when in fact all the scientists agreed when we wrote this law that that was not dolphin-safe. In fact, Greenpeace, which is supporting the Gilchrest approach here, I believe has never changed their position, that there should be an end to the encirclement of dolphins. But in fact, that is sanctioned under this legislation.

My colleagues keep referring to their friends who are supporting this legislation. I would like to point out that the Sierra Club, the American Society for the Prevention of Cruelty to Animals, the Earth Island Institute, the Humane Society of the United States, Friends of the Earth, the International Brotherhood of Teamsters, the American Humane Association, those organizations that have dedicated their entire existence to the humane treatment of animals, to ending the slaughter of animals, mammals and wildlife, oppose this legislation.

Again, by denigrating the label, by suggesting that these activities will be allowed, that the increased killing of dolphins will be allowed, and somehow trying to present to the same American consumer that has now been making a decision for many, many years that when they buy a can of tuna that is sold in the United States, that in fact the label of dolphin-safe means dolphin-safe, now we are going to pull a trick on them. We are going to pull a trick. We are going to tell them that dolphin-safe means dolphin-safe, but it does not. It means we can encircle, and we can harass, and we can maim, and we can injure, and we can in fact increase the number of dolphins that are killed.

The current system, with all of these bandits out there fishing the way they want, the current system has dramatically reduced the measured kill in dolphins some 95, 97 percent. Yet we are told now under the new regime what we have to do is allow these people to kill more dolphins.

Then we are going to kid the schoolchildren that led the crusade in this country for dolphin-safe tuna, for the consumers, for the packaging companies that complied with this and made a decision, made an investment, we are going to con all of them that now somehow this legislation is really dolphin-safe and better for the dolphins, in spite of the language in the legislation that allows the dolphins to be put under much more stress, to be injured, and to be maimed, in direct contradiction of the Marine Mammal Protection Act.

These are exactly the acts that are prohibited and for which these mammals are protected, but in the case of the dolphin, they will no longer have that protection. I am sure my colleagues on the other side, the colleagues supporting this legislation, would not suggest that we do away with that protection for marine mammals. But somehow, because of the insistence of Mexico that they need to do this, and I do not see Mexico volunteering not to take juvenile tuna in their coastal waters. They did not put that in this agreement. The only thing we put in this agreement is changing how American consumers are going to be able to depend upon a label and what this label means.

My colleagues say we have to change the method in which we fish for dolphins because it has an impact on juvenile tuna. But most of the juvenile tuna is taken within the coastal waters of Mexico, and it is exempt from this agreement.

Our trade negotiators, our State Department, constantly continue to sell the American market cheap. In one agreement after another, we constantly give away the integrity of the market, and, in this case, the integrity of our consumer protection, the integrity of our environmental laws, the integrity of our workplace, the integrity of the jobs for our workers.

Somehow we do not appreciate the real value of this market. The reason they are banging on the door for this agreement, and this is not a treaty, as people on the other side have suggested. This is about an agreement to go forward to negotiations for an agreement. But what we have is America unilaterally agreeing to change its basic consumer protection laws.

Mexico, however, is free to continue to take all the juvenile tuna they want, probably far in excess of anything that will be dealt with by the current system. So I would just hope that our colleagues would understand that there are a lot of suggestions about what this bill will do, but the language of the bill itself simply is contradictory to those representations.

Mr. Chairman, I reserve the balance of my time.

Mr. SAXTON. Mr. Chairman, I yield 2 minutes to the gentleman from Florida [Mr. GIBBONS].

Mr. GIBBONS. Mr. Chairman, I love the dolphin. I am privileged to, when I go home in Florida, wake up every morning and watch the dolphin frolic in my front yard. Fortunately, commercial fishing in my area of the world does not include the capture or the harassment of dolphin, so maybe I should stay out of this fight.

But I do love the species, and I think it is important that we begin to get an international agreement on the preservation of that species. I wish there were a perfect way to solve this problem, but there is not. I think the Gilchrest bill is a realistic bill and does the proper type of conservation of this particular species.

There is, as I say, with the technology that we have now and the knowledge that we have now, and the fact that we do not have an international agreement on the preservation of the dolphin, it leads me to believe that the Gilchrest bill goes in the right direction. Quite often we strike out in our attempts to do good by taking unilateral action. I believe we can do even better if we take international

action, because these are international waters we are dealing with. This is a migratory species that moves about quite rapidly.

I think, attacking this conservation matter, and the fact that such people as Greenpeace, whose credentials are beyond dispute as far as the species is concerned, are endorsing it, I think it is the wisest action to take. I say that, having great respect for the gentleman from Massachusetts [Mr. STUDDS] and the gentleman from California [Mr. MILLER] and their position. But I find that it is best in my judgment to go for the Gilchrest proposal.

Mr. SAXTON. Mr. Chairman, I yield 4 minutes to the gentleman from California [Mr. CUNNINGHAM].

Mr. CUNNINGHAM. Mr. Chairman, why support this bill? First of all, the United States has fallen under an encumbrance of having to have observers on a boat. This is in light of they have actually reduced the number of thousands of dolphins killed down to 4,000. My colleague, the gentleman from California, says first of all the number increased 20 percent. Then just a minute ago he said it increased 30 percent, which we need to know what it is. I can tell the Members what it is. It goes from 4,000 to 5,000. Let me tell the Members why.

Currently, currently the other nations that are involved or have the restrictions on them can go out and kill thousands of dolphin at will. But because of this agreement, the Panama Agreement, they fall under the same umbrella that we do. Fishermen have gone down to 4,000. Dolphin-safe does not have to be dolphin-safe under this current law.

Under this bill, we will know that 100 percent of the tuna under as dolphin-safe label will be dolphin-safe, because every single boat will have an observer, not just U.S. boats, but all 12 of the other nations. Why would my friends oppose that? The gentleman from New York, Mr. SHERRY BOEHLERT, called it ''ideological purity.'' We have some of those on our side. I recognize that. I think both groups need to moderate their positions.

□ 1845

I think that has been done by the gentleman from Maryland [Mr. GILCHREST], the gentleman from New Jersey [Mr. SAXTON], the gentleman from New York [Mr. BOEHLERT], people that are known for their environmental record, and on your side as well, I would say to the gentleman from California [Mr. MILLER].

I do not apply any motive to this. I think the gentleman has a purely intensive feeling about his support of his own amendment.

Let us take a look at the groups that support this. Earth Island. They have made millions of dollars managing the dolphin-safe label, managing the dolphin-safe label from Starkist.

Fact. Earth Island, who makes millions of dollars from this, is generating fundraising dollars for their efforts. It is an economical issue for them. But yet on the other side we have the Vice President of the United States; AL GORE, who is your champion for the environment. If we have any radical group on our side, it is the AFL–CIO. They endorse this. But on the other side we have the gentleman from New York [Mr. BOEHLERT], the gentleman from Maryland [Mr. GILCHREST], the gentleman from New Jersey [Mr. SAXTON], and many others who normally vote with a green vote. Because they feel that this is an honest effort to protect a resource that under the current conditions, you catch turtles because you fish for immature tuna, and you catch swordfish and the rest of it, and all that bycatch is wasted; killed. This method prevents that. It also saves the resource for future generations. That is why the President and AL GORE and many Members on your side of the aisle support this bill, as well as on our side.

I would ask the gentleman in good faith, and I think he knows I am sincere in this. I truly believe that this will save dolphins. I think it will help our fishermen. I think it will move Mexico in not just this but in other ways. Already Mexico has worked very closely with us on our sports fishermen's rights and moved in that generation. Unless we adopt international agreements and enforce them, and I will work with the gentleman to make sure that these are enforced, then I think that we have slipped backwards.

Mr. MILLER of California. Mr. Chairman, I yield myself 1 minute, just to say that the AFL–CIO does not support this legislation. We just spoke to them.

We have member unions of the AFL–CIO that support this legislation and we in fact have members of the AFL–CIO that support our version, the Studds amendment, of that same legislation. We just got off the phone to their representative. We both have constituents, just as you have environmental organizations on both sides.

The point is that these same nations that are now making this threat in fact today are not going out and killing tens of thousands, hundreds of thousands of dolphins, but they are threatening to. They are threatening to go out and act in a completely irresponsible fashion unless the U.S. Congress goes along with this attempt to get us to dupe the American consumers about the nature of the dolphin-safe label and the tuna which they buy.

Mr. Chairman, I reserve the balance of my time.

Mr. SAXTON. Mr. Chairman, I yield 2 minutes to the gentleman from Colorado [Mr. SKAGGS].

Mr. SKAGGS. Mr. Chairman, I support this bill. I believe its enactment is necessary if we are going to continue to make progress in reducing dolphin mortality associated with fishing for tuna.

I, like many of my colleagues, always have cause to pause for a moment before challenging the position of my friends and colleagues from Massachusetts and California on an issue like this. Certainly it is disconcerting to have words like ''conned'' and ''duped'' thrown into the debate. I think everybody here is in agreement about our basic objective, which is reducing dolphin mortality. It is evident that opinions are divided about how to pursue that objective, and so there is a division of opinion about this bill.

I respect those that question the bill's approach, because I know that what they are primarily seeking here is what I am seeking, and that is reducing to the minimum, as efficiently as we can, the deaths of dolphins. We all remember the horrifying pictures of dolphins dying in fishermen's nets. That brought the public clamor that got us the very major progress that we have made to date in this issue.

The improvement that has been made is largely the result of the La Jolla Agreement. That agreement has brought much reduction in dolphin mortality. But last year, as has been discussed, a dozen tuna fishing nations, including the United States, met to try to build on that agreement and put together a binding international agreement to replace the strictly voluntary La Jolla Agreement.

The result of those talks was the framework agreement known as the Panama Declaration. It is the purpose of this bill to implement that agreement in order to strengthen international conservation programs and set the stage for a further reduction in dolphin mortality. We need to support this legislation in order to be able to keep that international cohesion together in support of a goal that I think all Members share.

Mr. Chairman, I support this bill. I believe that its enactment is necessary if we are to continue to make progress in reducing dolphin mortality associated with fishing for tuna.

I think everyone here agrees that further reducing dolphin mortality should be the goal. But it's evident that opinions are divided about how we should pursue that objective—and as a result there are divisions of opinion about this bill. I respect those who have questions about this bill's approach, because I think that what's primarily involved here is an honest difference of opinion over the specific legislation, not a fundamental difference over its objectives.

We all remember the horrifying images of dolphins dying in fishermen's nets. Those scenes rightly brought a public clamor for urgent action. And, since then we've made real progress. In fact, dolphin mortality in the eastern tropical Pacific has been cut by better than 90 percent.

This improvement is to a large extent the result of an informal, voluntary agreement—known as the La Jolla Agreement—among countries whose nationals fish in the eastern Pacific.

However, while this agreement has brought much improvement, more attention has gone to the U.S. law setting criteria for labeling tuna as ''dolphin safe''—criteria based on fishing practices rather than on dolphin mortality.

Last year, a dozen tuna-fishing nations—including the United States—met in Panama to develop a binding international agreement to replace the strictly voluntary La Jolla Agreement. The result of those talks is a new framework agreement, known as the Panama Declaration. The purpose of this bill is to implement that declaration, in order to strengthen international conservation programs and to set the stage for further reducing dolphin mortality.

As we consider this legislation, we should keep in mind what the Panama Declaration provides, because it goes beyond previous agreements in several important ways.

Under the Panama Declaration, there would for the first time be a firm, binding international commitment to the goal of completely eliminating dolphin loss resulting from tuna fishing in the eastern Pacific Ocean. In addition, the declaration would provide new, effective protection for individual dolphin species—biologically-based mortality caps that will provide important new safeguards for the most depleted dolphin populations. And the Panama declaration provides for the world's strongest dolphin monitoring program, with independent observers on every fishing boat.

Implementation of the Panama Declaration depends upon the changes in U.S. law that would be made by this bill. Among other things, these changes will lift restrictions on access to our markets for tuna caught in compliance with the new agreement, including revision of the standard for use of the ''dolphin safe'' label. That change in the ''dolphin safe'' label seems to be the most controversial part of the bill, but it is an essential part and should be approved.

Remember, under the current law that a ''dolphin safe'' label on a can of tuna doesn't necessarily mean that no dolphins died in connection with the catch of the fish. Instead, it simply means that the fishermen did not use a school of dolphins as their guide for setting their nets. If that condition is met, the ''dolphin safe'' label can be applied even if dolphin mortality in fact has occurred. By contrast, under the Panama Declaration—as implemented by H.R. 2823—the term ''dolphin safe'' may not be used for any tuna caught in the eastern Pacific Ocean by a purse seine vessel in a set in which a dolphin mortality occurred—as documented by impartial, independent observers.

In other words, it's not true that this bill would destroy the meaning of the ''dolphin safe'' label—it would make its meaning more specific and more accurate, by imposing a no-mortality standard, while providing for further study of the effects of dolphin-encirclement and a mechanism to again stop that fishing technique if it's determined to have an adverse impact on dolphins. I think this is a desirable change in the law.

Furthermore, fishing can't be truly ''dolphin safe'' unless it's safe for the ecosystem. Because it focuses on fishing methods, not dolphin mortality, the current labeling law has had serious unintended consequences. Some of the ''dolphin safe'' methods tend to result in a catch of primarily juvenile tuna—harmful to the viability of the fishery—or result in numerous catches of other species such as endangered sea turtles or billfish.

In fact, it well may be better for the ocean ecosystem for tuna fishermen to set their nets on dolphins and then to release the dolphins safely when the tuna are harvested—something that is strongly discouraged by the current labelling standard.

So, Mr. Chairman, this is a good bill, one that represents a win-win situation for all. It's supported by the administration and the U.S. fishing industry as well as by environmental and conservation groups, including the National Wildlife Federation, the World Wildlife Fund, the Environmental Defense Fund, the Center for Marine Conservation, and Greenpeace. It deserves the support of the House.

Mr. TORKILDSEN. Mr. Chairman, I rise in strong support of H.R. 2823, the International Dolphin Conservation Program Act, sponsored by Mr. GILCHREST. This bill is vital to the protection of dolphins, sharks, endangered sea turtles, and other creatures of our marine ecosystem.

This bill is supported by such well-known environmental advocates as Greenpeace, World Wildlife Fund, the Center for Marine Conservation, and the Environmental Defense Fund.

H.R. 2823 is better for dolphins because it locks into place binding international legal protections for dolphins in the eastern tropical Pacific [ETP]. Currently, dolphin protection in the ETP is voluntary. Many nations seek to protect dolphins in order to sell tuna in the U.S. market.

The nations that fish for tuna in the eastern tropical Pacific have developed new fishing methods to reduce dolphin mortality. As a result of these efforts, dolphin mortality has dropped from 125,000 in 1991 to 3,300 last year, just 0.2 percent of the population. This is a level more than four times lower than that recommended by the National Research Council to allow recovery of dolphins. This bill sets aggressive mortality limits, with the goal of reducing dolphin mortality to zero.

Under the Gilchrest bill the ''dolphin safe'' definition is based on actual dolphin mortality. If a dolphin dies as a result of harvesting tuna, then that tuna will not be permitted into the United States and onto our shelves. Currently, despite the label on cans of tuna that it is dolphin safe, there has been shown to be some dolphin mortality in even log and school sets of tuna harvests. H.R. 2823 assures consumers that no dolphins died in the catch of labeled tuna.

Despite the current embargo, existing law has been ineffective in changing fishing practices of foreign fleets in the ETP; in fact, approximately 50 percent of sets by the foreign fleet are on dolphin schools despite the embargo.

H.R. 2823 implements the Panama Declaration, and international agreement to reduce dolphin mortality in the eastern tropical Pacific Ocean and to be bound by the conservation and management measures enacted by the Inter-American Tropical Tuna Commission [IATTC]. Without the Gilchrest bill the signers to the Panama Declaration will walk away from the agreement and we will risk all protections of dolphin throughout the region.

A vote for this bill is a vote for the marine environment. The Gilchrest bill contains tough provisions that require tuna fishermen to protect dolphins, sea turtles, sharks, and bill fish. Under current methods of fishing, hundreds of endangered sea turtles and thousands of sharks die every year. The Gilchrest bill provides for protections of these species while simultaneously strengthening international dolphin protections.

This bill is supported by the administration, Greenpeace, World Wildlife Fund, the Center for Marine Conservation, and the Environmental Defense Fund. While important environmental advocates like the Sierra Club and the Humane Society oppose this legislation, I feel this bill is a good compromise in protecting dolphins, sea turtles, and sharks throughout the eastern tropical Pacific Ocean.

I urge my colleagues to support H.R. 2823 and vote to protect dolphins in the ETP. I yield back the balance of my time.

Mr. MCDERMOTT. Mr. Chairman, last year the United Nations adopted a new treaty to assure the conservation of fish caught in international waters, known as the Agreement on the Conservation and Management of Straddling Fish Stocks and Highly Migratory Fish Stocks.

This new treaty, which was recently ratified by Congress with bipartisan support, seeks to reverse the depletion of fish and other marine life that has resulted from unsustainable fishing practices and the lack of effective international management.

The need for this new treaty is painfully obvious. Many of our most important fisheries have been depleted, undermining the economic well-being of coastal communities worldwide. Similarly, the wasteful bycatch of marine life in many fisheries poses a major threat to biodiversity.

The legislation we are debating today, H.R. 2823, the International Dolphin Conservation Program Act, and the Panama Agreement upon which it is premised, represents the most far-reaching attempt to date to implement the conservation mandates of the new treaty. If enacted by Congress, it will create a model for the management of high seas fisheries around the world.

H.R. 2823 advances several of the new, important conservation objectives of the U.N. treaty. For example, like the U.N. treaty, it prevents overfishing by requiring the establishment of catch limits based on a precautionary approach. Like the U.N. treaty, it also requires steps to minimize the wasteful by catch of all forms of marine wildlife. Like the U.N. treaty, it assures transparency in the management of fisheries in the eastern Pacific, so that all interested stakeholders can effectively participate in the management process; and like the U.N. treaty, it secures international cooperation in the conservation of marine resources.

H.R. 2823 recognizes that unilateral measures alone cannot succeed in conserving fisheries that are prosecuted in international waters. It builds upon the recent, important work by the United Nations aimed at the sustainable management of world fisheries.

H.R. 2823 is our best hope of assuring healthy fisheries as well as dolphin protection in the eastern Pacific Ocean. I urge my colleagues to support this legislation.

Mr. CRANE. Mr. Chairman, I am pleased to rise today in support of H.R. 2823. This is a unique opportunity to approve legislation that would put us in compliance with our international obligations, use multilateral standards for the imposition of sanctions instead of unilateral standards that violate the GATT, and meet our environmental concerns over dolphin mortality.

This bill was referred to the Ways and Means Committee to address its trade aspects. We reported it out as approved by the Resources Committee, without further amendment.

I support the bill because it would replace the current use of United States unilateral

standards as a trigger for an import ban of tuna caught with purse seine nets with multilateral standards agreed to as part of the Panama Declaration. If countries are in compliance with the multilateral standard for the fishing of yellowfin tuna, then the import ban would not apply.

Any use of unilateral standards for the imposition of sanctions is troubling. In fact, a GATT panel has found our current law to violate our international obligations. Instead, enforcement actions are most effective when they are based on international consensus, as this bill would establish. Such consensus is more constructive to effective management of the ETP tuna fishery by all countries concerned. I believe that these standards will serve as a positive incentive to reduce dolphin mortality, while, at the same time, putting the United States in compliance with international agreements.

The Studds amendment, however, would put the Panama Declaration at risk and would threaten all we have achieved. Adoption of this language would invite a serious challenge under the WTO and would discourage our trading partners from adopting more environmentally sound fishing methods. Far from achieving increased protection for dolphins, the amendment would undo the progress we have already made.

Proof of the benefits of H.R. 2823, without the Studds amendment, is the fact that this legislation is supported by the administration and key environmental groups such as the National Wildlife Federation, the Center for Marine Conservation, the Environmental Defense Fund, Greenpeace, and the World Wildlife Fund. In addition, our tuna fishing industry supports the bill, and our trading partners have indicated that they believe implementation of the bill would put us in compliance with our international obligations. With such a strong and diverse coalition behind this bill, we should strongly support this bill.

Mr. OXLEY. Mr. Chairman, I rise today in strong support of H.R. 2823, the International Dolphin Conservation Program Act. Among other things, this legislation implements the Declaration of Panama, agreed to by a dozen different nations, including the United States. As a strong proponent of free and fair trade, I think this represents a good example of how we can work together with out trading partners to achieve our shared goal of preserving the Earth's precious resources.

H.R. 2823 includes several provisions within the jurisdiction of the Committee on Commerce. H.R. 2823 provides for implementation of the declaration in an effort to increase international participation in activities to reduce the number of dolphins and other marine mammals that die each year as a result of tuna fishing techniques. This bill would also modify the definition of ''dolphin safe'' for the purpose of labeling tuna products sold in the United States, and alter current regulations on the importation of tuna products. Also, the bill would make misuse of the ''dolphin safe'' label an unfair and deceptive trade practice under section 5 of the Federal Trade Commission Act.

In short, this legislation will help the United States achieve its environmental goals by implementing a reasonable agreement reached by the United States and its trading partners. It is supported by Republicans and Democrats alike, some environmental groups, and the Clinton administration. I would also like to take this opportunity to thank the gentleman from Alaska [Mr. YOUNG] for his support and willingness to work with the Commerce Committee to expedite consideration of this legislation. I urge all of my colleagues to support this legislation.

Mr. BILBRAY. Mr. Chairman, we are here today to make a decision on an issue of great importance first and foremost to our marine environment, but also to the process by which we will craft the environmental and public health policies of the future. We have a choice between the status quo, which would focus solely on one issue at the expense of others which are equally important, and a comprehensive, forward-looking agreement which will carry strong dolphin and marine protection policies well into the next century. If we are truly interested in progressive, outcome-based environmental policy, then H.R. 2823 must serve as a cornerstone of that policy foundation.

Over the last decade, great strides have been made in reducing dolphin mortality rates in the eastern tropical Pacific [ETP], as a result of improved and innovative tuna fishing methods pioneered by the U.S. tuna fleet, and stepped-up levels of on-vessel observer monitoring. These improvements were reflected in the landmark La Jolla Agreement of 1992, a voluntary resolution entered into by a number of tuna fishing nations, including the United States, Mexico, and several Latin American countries. This agreement established strict and declining levels of annual dolphin mortality rates, requiring that an annual overall rate of less than 5,000 be achieved by 1999, which is less than 0.1 percent of the estimated total dolphin population. This program has been so effective that it has already achieved a rate of below 4,000 annually, which is considered by scientists to be below levels of biological significance. I have an article that elaborates further on this point, Mr. Chairman, which I would ask to be entered into the RECORD along with my statement, but I would like to read one passage from it at this point. These remarks come from Dr. James Joseph, who is the director of the Inter-American Tropical Tuna Commission [IATTC]:

> Joseph said the dolphin mortality rate is now so low that it cannot affect the survival of any of the dolphin species ''The dolphins increase at a rate of from 2.5% to 3.5% per year. The mortality for every (dolphin) stock is less than one-tenth of 1 percent,'' he said. In other words, a great many more young dolphins are born and survive each year than die in tuna nets. There are about 9.5 million dolphins in Eastern Pacific populations in all, and none of their several species—including common, spinner, and spotted—is endangered. ''We continue to take the approach that we can bring it (dolphin mortality) lower, and we continue to work in that direction. It is essential that we keep all of the countries involved in the fishery cooperating in our program,'' Joseph said.

The La Jolla Agreement also required that observers be posted on each licensed vessel, which were each assigned strict dolphin mortality limits [DML]. To date, the signatories have continued to operate in good faith to protect dolphin in the course of harvesting tuna under this nonbinding agreement; however, some nations had openly considered dropping out of the La Jolla Agreement and the Inter-American Tropical Tuna Commission, its umbrella organization, because despite the advances made in reducing dolphin mortality rates, U.S. law had not been changed to lift the existing embargoes on tuna imported into the United States. However, H.R. 2823, if enacted, would provide the incentives for these other fishing nations to want to remain involved in the IATTC and continue to fish for tuna in a dolphin-sensitive fashion, rather than ''leaving the table'' and reverting to older and more dolphin-unsafe fishing methods.

In addition to this threat of retreat from vastly improved dolphin protection practices, biological problems of significant dimensions have arisen as a result of alternative ''nondolphin'' fishing methods now in use due to the existing restrictions to setting tuna nets ''on dolphin''. Such methods include setting nets around tuna attracted to floating objects—log fishing—or around free-swimming schools of fish—school fishing. While these methods do reduce direct contact with dolphin, they create other problems. Studies indicate that up to 25 percent of volume of these harvest methods is ''bycatch'' of other species, including high volumes of sharks, billfish, and other pelagics, endangered sea turtles, and immature tuna. These young tuna are not market-ready, and are largely dead by the time they are returned to the sea. This wasteful depletion of juvenile tuna poses a serious threat to maintaining healthy, long-term populations of yellowfin tuna, in addition to stressing the populations of these other sensitive species.

Conversely, setting tuna nets ''on dolphin'' creates little bycatch other than the dolphin themselves. While this was problematic—and lethal—for dolphin in past years, recent improvements in tuna harvest methods, such as the ''backing down'' procedure, in which the edge of the nets are allowed to swim below the surface, affording dolphins the opportunity to leave the net, have served to greatly minimize the threat to dolphin. In addition, small boats and a number of divers are often deployed within the net to assist dolphin out of danger.

However, the problem of bycatch underscores a policy dilemma, as to how best to manage our marine resources on an ''ecosystem'' basis, rather than channeling all our energy and resources into ''single population'' strategies. While it is clearly essential that we continue to work to reduce dolphin mortality rates toward zero, this cannot and should not occur at the expense of other parts of our ocean biosystem, Fortunately, in H.R. 2823, we have a long-term solution before us today which will resolve the challenges, both environmental and economic, which we now face.

In October 1995, 12 nations, including the United States, met in Panama to craft a binding international agreement to protect dolphin and other species in the eastern tropical Pacific. Five major environmental organizations were instrumental in developing this agreement, which been dubbed the Panama Declaration. The declaration will establish a permanent mortality limit, with the goal of zero dolphin mortality in that fishery. It will set mortality caps for individual species of dolphin, and provide for individual vessel accountability by establishing strict per vessel mortality caps. Just as important, the Panama Declaration provides greater study of and protection for other now at risk from ''bycatch'', and increase internationally enforceable monitoring systems to ensure compliance by participating nations who wish to fish in the ETP.

The Panama Declaration, which will be codified into law by enactment of H.R. 2823, creates a binding and enforceable process to ensure continued declining rates of dolphin mortality, while for the first time adopting an ''ecosystem-based'' approach to ocean resource management. While there is absolutely no question that dolphin populations must and will continue to be protected and strengthened under the progressive strategies of this legislation, we can no longer ignore the potentially harmful problems which have been inadvertently created by our existing ''dolphin-safe'' policies. The Panama Declaration, in the form of H.R. 2823, should be codified into law, in order to ensure that we manage our marine resources to protect all species, in a sound and science-based manner. We must reject efforts, however well-intended, to reinforce the status quo, and move swiftly to enact the provisions of this legislation. H.R. 2823, which I have cosponsored along with a great number of my colleagues from both sides of the aisle, is the vehicle to achieve this, and I would urge all my colleagues to lend their support to this progressive measure.

This is more than sound ocean resources management. It is a blueprint for how we should proceed on future environmental strategy matters. This is an opportunity for us to move beyond the outdated ''single species'' approach of years past, and embrace more comprehensive, inclusive, and effective multispecies conservation management style. We have to be able to see the whole picture, and assemble our strategies accordingly. The increased loss of other marine life and sensitive species to ''bycatch'' under existing law has to date been largely overlooked, and is a looming biological threat which certainly merits the same levels of concern and proper scientific attention as has our dolphin population.

These unintended consequences are indeed troubling, and will be comprehensively addressed by the Panama Declaration and H.R. 2823. We have created the technology and the incentives to keep dolphin mortality at insignificant and declining levels, which will be reinforced and locked in by H.R. 2823. However, protection for the dolphin is not the ''end of the story'' for conserving our ocean environment. It is also not the end of our responsibilities. As we have done with other strategies, we must take a comprehensive approach to marine conservation as well, in order to identify and understand these threats, and take action on them before they reach a crisis point.

If we are truly interested in progressive, outcome-based environmental policy, guided by science, then we should embrace this bipartisan proposal, which is supported by the U.S. tuna fleet, the Clinton administration, and a number of major environmental groups. As we move into the next century, we should lead with an environmental strategy which reflects the level of scientific knowledge we have now, not what we knew 15 or 20 years ago. This bill keeps dolphins safe, and will help us avoid future problems with marine conservation. I urge all my colleagues to support H.R. 2823, the International Dolphin Conservation Act of 1996.

[From the San Diego Union Tribune, June 7, 1996]

SCIENTIST HAILED FOR SAVING DOLPHINS

(By Steve La Rue)

Dolphin deaths in tuna fishing nets have declined by about 98 percent since 1986 in the Eastern Pacific Ocean, and a San Diego marine scientist will get a large share of the credit tonight when he receives San Diego Oceans Foundation's highest award.

The annual Roger Revelle Perpetual Award will be presented to James Joseph, director of the La Jolla-based Inter-American Tropical Tuna Commission since 1969.

With Joseph at the helm, the eight-nation commission has mounted a sustained effort to reduce drowning deaths of dolphins in tuna fishing nets. Its success could help unlock a decades-old environmental dispute and end a U.S. embargo on tuna caught by boats from Mexico and other countries that look for the popular fish under dolphin schools.

Large tuna often swim under schools of dolphins in the Eastern Pacific Ocean for reasons that are not entirely understood. Fishing boats historically have encircled these surface-swimming schools with their nets, cinched the nets shut at the bottom, then reeled in their catch.

Air-breathing dolphins drowned in vast numbers, because they were snared in the nets and dragged under water. An estimated 133,174 dolphins died this way in 1986, but the total fell to an estimated 3,274 last year, according to the commission.

The decline has come through a variety of measures, including placement of observers on every tuna boat in the Eastern Pacific, newer equipment for some boats, better training of tuna crews and captains, special attention to individual boats with high-dolphin kills and other measures.

Joseph said the dolphin mortality level is now so low that it cannot affect the survival of any of the dolphin species.

The dolphins increase at a rate of from 2.5 to 3.5 percent per year. The mortality for every (dolphin) stock as a percentage of every stock is less than one-tenth of 1 percent,'' he said.

In other words, a great deal more young dolphins are born and survive each year than die in tuna nets. There are about 9.5 million dolphins in Eastern Pacific populations in all, and none of their several species—including common, spinner and spotted dolphins—is endangered.

''We continue to take the approach that we can bring it lower, and we continue to work in that direction. It is essential that we keep all of the countries involved in this fishery cooperating in our program,'' Joseph said.

Commission members include Costa Rica, France, Nicaragua, Panama, the United States; the Pacific island-nation of Vanuatu and Venezuela.

Frank Powell, executive director of Hubbs-Sea World Research Institute and last year's award winner, praised Joseph in a prepared statement as ''A first-class biologist who has devoted his entire career to the ocean. He has been instrumental in reducing the number of dolphin fatalities related to tuna fishing.''

The award—a wood sculpture of a garibaldi fish that remains in Scripps Bank's La Jolla office—will be present tonight at the San Diego Oceans Foundation benefit dinner.

The foundation is a volunteer organization committed to preserving San Diego's bays and ocean waters. The Roger Revelle Perpetual Award is named for the late scientist who was founder of UCSD and director of the Scripps Institution of Oceanography.

Lowering the dolphin kill also was a prelude to the introduction of proposed federal legislation to allow tuna caught by setting nets around dolphin schools to be sold in the United States as ''dolphin-safe''—but only if the commission's on-board observers certify that no dolphins were killed.

Under current law, no tuna can be sold as ''dolphin-safe'' is this country if they are caught by setting nets around dolphin schools.

The issue also has split environmental groups. Greenpeace, the Center for Marine Conservation, the Environmental Defense Fund, and the National Wildlife Federation support the proposed law. The Earth Island Institute, the Sierra Club, the Human Society of the United States, and the American Society for the Prevention of Cruelty to Animals oppose it.

Because of the current law and other factors, the U.S. tuna fishing fleet, which once numbered 110 vessels and was prominent in San Diego, has shrunk to 40 vessels operating in the Western Pacific and 10 in the Eastern Pacific.

The Earth Island Institute said in a statement that the legislation would allow ''Foreign tuna stained by the blood of dolphins to be sold on U.S. supermarket shelves'' and allow ''chasing, harassing, injuring, and encircling dolphins as long as no dolphins were 'observed' being killed outright.''

Mr. MILLER of California. Mr. Chairman, I have no further requests for time, and I yield back the balance of my time.

Mr. SAXTON. Mr. Chairman, I have no further requests for time, and I yield back the balance of my time.

The CHAIRMAN. All time for general debate has expired.

Pursuant to the rule, the amendment in the nature of a substitute printed in the CONGRESSIONAL RECORD as No. 1 is considered as an original bill for the purpose of amendment and is considered read.

The text of the amendment in the nature of a substitute is as follows:

H.R. 2823

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCES.

(a) SHORT TITLE.—This Act may be cited as the ''International Dolphin Conservation Program Act''.

(b) REFERENCES TO MARINE MAMMAL PROTECTION ACT.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Marine Mammal Protection Act of 1972 (16 U.S.C. 1361 et seq.).

SEC. 2. PURPOSE AND FINDINGS.

(a) PURPOSE.—The purposes of this Act are—

(1) to give effect to the Declaration of Panama, signed October 4, 1995, by the Governments of Belize, Colombia, Costa Rica, Ecuador, France, Honduras, Mexico, Panama, Spain, the United States of America, Vanuatu, and Venezuela, including the establishment of the International Dolphin Conservation Program, relating to the protection of dolphins and other species, and the conservation and management of tuna in the eastern tropical Pacific Ocean;

(2) to recognize that nations fishing for tuna in the eastern tropical Pacific Ocean have achieved significant reductions in dolphin mortality associated with that fishery; and

(3) to eliminate the ban on imports of tuna from those nations that are in compliance with the International Dolphin Conservation Program.

(b) FINDINGS.—The Congress finds the following:

(1) The nations that fish for tuna in the eastern tropical Pacific Ocean have achieved

significant reductions in dolphin mortalities associated with the purse seine fishery from hundreds of thousands annually to fewer than 5,000 annually.

(2) The provisions of the Marine Mammal Protection Act of 1972 that impose a ban on imports from nations that fish for tuna in the eastern tropical Pacific Ocean have served as an incentive to reduce dolphin mortalities.

(3) Tuna canners and processors of the United States have led the canning and processing industry in promoting a dolphin-safe tuna market.

(4) 12 signatory nations to the Declaration of Panama, including the United States, agreed under that Declaration to require that the total annual dolphin mortality in the purse seine fishery for yellowfin tuna in the eastern tropical Pacific Ocean not exceed 5,000, with a commitment and objective to progressively reduce dolphin mortality to a level approaching zero through the setting of annual limits.

SEC. 3. DEFINITIONS.

Section 3 (16 U.S.C. 1362) is amended by adding at the end the following new paragraphs:

''(28) The term 'International Dolphin Conservation Program' means the international program established by the agreement signed in La Jolla, California, in June 1992, as formalized, modified, and enhanced in accordance with the Declaration of Panama, that requires—

''(A) that the total annual dolphin mortality in the purse seine fishery for yellowfin tuna in the eastern tropical Pacific Ocean not exceed 5,000, with the commitment and objective to progressively reduce dolphin mortality to levels approaching zero through the setting of annual limits;

''(B) the establishment of a per-stock per-year mortality limit for dolphins, for each year through the year 2000, of between 0.2 percent and 0.1 percent of the minimum population estimate;

''(C) beginning with the year 2001, that the per-stock per-year mortality of dolphin not exceed 0.1 percent of the minimum population estimate;

''(D) that if the mortality limit set forth in subparagraph (A) is exceeded, all sets on dolphins shall cease for the fishing year concerned;

''(E) that if the mortality limit set forth in subparagraph (B) or (C) is exceeded sets on such stock and any mixed schools containing members of such stock shall cease for that fishing year;

''(F) in the case of subparagraph (B), to conduct a scientific review and assessment in 1998 of progress toward the year 2000 objective and consider recommendations as appropriate; and

''(G) in the case of subparagraph (C), to conduct a scientific review and assessment regarding that stock or those stocks and consider further recommendations;

''(H) the establishment of a per-vessel maximum annual dolphin mortality limit consistent with the established per-year mortality caps; and

''(I) the provision of a system of incentives to vessel captains to continue to reduce dolphin mortality, with the goal of eliminating dolphin mortality.

''(29) The term 'Declaration of Panama' means the declaration signed in Panama City, Republic of Panama, on October 4, 1995.''.

SEC. 4. AMENDMENTS TO TITLE I.

(a) AUTHORIZATION FOR INCIDENTAL TAKING.—Section 101(a)(2) (16 U.S.C. 1371(a)(2)) is amended as follows:

(1) By inserting after the first sentence ''Such authorizations may also be granted under title III with respect to the yellowfin tuna fishery of the eastern tropical Pacific Ocean, subject to regulations prescribed under that title by the Secretary without regard to section 103.''.

(2) By striking the semicolon in the second sentence and all that follows through ''practicable''.

(b) DOCUMENTARY EVIDENCE.—Section 101(a) (16 U.S.C. 1371(a)) is amended by striking so much of paragraph (2) as follows subparagraph (A) and as precedes subparagraph (C) and inserting:

''(B) in the case of yellowfin tuna harvested with purse seine nets in the eastern tropical Pacific Ocean, and products therefrom, to be exported to the United States, shall require that the government of the exporting nation provide documentary evidence that—

''(i) the tuna or products therefrom were not banned from importation under this paragraph before the effective date of the International Dolphin Conservation Program Act;

''(ii) the tuna or products therefrom were harvested after the effective date of the International Dolphin Conservation Program Act by vessels of a nation which participates in the International Dolphin Conservation Program, such harvesting nation is either a member of the Inter-American Tropical Tuna Commission or has initiated (and within 6 months thereafter completed) all steps (in accordance with article V, paragraph 3 of the Convention establishing the Inter-American Tropical Tuna Commission) necessary to become a member of that organization;

''(iii) such nation is meeting the obligations of the International Dolphin Conservation Program and the obligations of membership in the Inter-American Tropical Tuna Commission, including all financial obligations;

''(iv) the total dolphin mortality permitted under the International Dolphin Conservation Program will not exceed 5,000 in 1996, or in any year thereafter, consistent with the commitment and objective of progressively reducing dolphin mortality to levels approaching zero through the setting of annual limits and the goal of eliminating dolphin mortality; and

''(v) the tuna or products therefrom were harvested after the effective date of the International Dolphin Conservation Program Act by vessels of a nation which participates in the International Dolphin Conservation Program, and such harvesting nation has not vetoed the participation by any other nation in such Program.''.

(c) ACCEPTANCE OF EVIDENCE COVERAGE.—Section 101 (16 U.S.C. 1371) is amended by adding at the end the following new subsections:

''(d) ACCEPTANCE OF DOCUMENTARY EVIDENCE.—The Secretary shall not accept documentary evidence referred to in section 101(a)(2)(B) as satisfactory proof for purposes of section 101(a)(2) if—

''(1) the government of the harvesting nation does not provide directly or authorize the Inter-American Tropical Tuna Commission to release complete and accurate information to the Secretary to allow a determination of compliance with the International Dolphin Conservation Program;

''(2) the government of the harvesting nation does not provide directly or authorize the Inter-American Tropical Tuna Commission to release complete and accurate information to the Secretary in a timely manner for the purposes of tracking and verifying compliance with the minimum requirements established by the Secretary in regulations promulgated under subsection (f) of the Dolphin Protection Consumer Information Act (16 U.S.C. 1385(f)); or

''(3) after taking into consideration this information, findings of the Inter-American Tropical Tuna Commission, and any other relevant information, including information that a nation is consistently failing to take enforcement actions on violations which diminish the effectiveness of the International Dolphin Conservation Program, the Secretary, in consultation with the Secretary of State, finds that the harvesting nation is not in compliance with the International Dolphin Conservation Program.

''(e) EXEMPTION.—The provisions of this Act shall not apply to a citizen of the United States who incidentally takes any marine mammal during fishing operations outside the United States exclusive economic zone (as defined in section 3(6) of the Magnuson Fishery Conservation and Management Act (16 U.S.C. 1802(6))) when employed on a foreign fishing vessel of a harvesting nation which is in compliance with the International Dolphin Conservation Program.''.

(d) ANNUAL PERMITS.—Section 104(h) is amended to read as follows:

''(h) ANNUAL PERMITS.—(1) Consistent with the regulations prescribed pursuant to section 103 and the requirements of section 101, the Secretary may issue an annual permit to a United States vessel for the taking of such marine mammals, and shall issue regulations to cover the use of any such annual permits.

''(2) Annual permits described in paragraph (1) for the incidental taking of marine mammals in the course of commercial purse seine fishing for yellowfin tuna in the eastern tropical Pacific Ocean shall be governed by section 304, subject to the regulations issued pursuant to section 302.''.

(e) REVISIONS AND FUNDING SOURCES.—Section 108(a)(2) (16 U.S.C. 1378(a)(2)) is amended as follows:

(1) By striking ''and'' at the end of subparagraph (A).

(2) By adding at the end the following:

''(C) discussions to expeditiously negotiate revisions to the Convention for the Establishment of an Inter-American Tropical Tuna Commission (1 UST 230, TIAS 2044) which will incorporate conservation and management provisions agreed to by the nations which have signed the Declaration of Panama;

''(D) a revised schedule of annual contributions to the expenses of the Inter-American Tropical Tuna Commission that is equitable to participating nations; and

''(E) discussions with those countries participating or likely to participate in the International Dolphin Conservation Program, to identify alternative sources of funds to ensure that needed research and other measures benefiting effective protection of dolphins, other marine species, and the marine ecosystem;''.

(f) REPEAL OF NAS REVIEW.—Section 110 (16 U.S.C. 1380) is amended as follows:

(1) By redesignating subsection (a)(1) as subsection (a).

(2) By striking subsection (a)(2).

(g) LABELING OF TUNA PRODUCTS.—Paragraph (1) of section 901(d) of the Dolphin Protection Consumer Information Act (16 U.S.C. 1385(d)(1)) is amended to read as follows:

''(1) It is a violation of section 5 of the Federal Trade Commission Act for any producer, importer, exporter, distributor, or seller of any tuna product that is exported from or offered for sale in the United States to include on the label of that product the term 'Dolphin Safe' or any other term or symbol that falsely claims or suggests that the tuna contained in the product was harvested using a method of fishing that is not harmful to dolphins if the product contains any of the following:

''(A) Tuna harvested on the high seas by a vessel engaged in driftnet fishing.

''(B) Tuna harvested in the eastern tropical Pacific Ocean by a vessel using purse seine nets unless the tuna is considered dolphin safe under paragraph (2).

''(C) Tuna harvested outside the eastern tropical Pacific Ocean by a vessel using purse seine nets unless the tuna is considered dolphin safe under paragraph (3).

''(D) Tuna harvested by a vessel engaged in any fishery identified by the Secretary pursuant to paragraph (4) as having a regular and significant incidental mortality of marine mammals.''.

(h) DOLPHIN SAFE TUNA.—(1) Paragraph (2) of section 901(d) of the Dolphin Protection Consumer Information Act (16 U.S.C. 1385(d)(2)) is amended to read as follows:

''(2)(A) For purposes of paragraph (1)(B), a tuna product that contains tuna harvested in the eastern tropical Pacific Ocean by a vessel using purse seine nets is dolphin safe if the vessel is of a type and size that the Secretary has determined, consistent with the International Dolphin Conservation Program, is not capable of deploying its purse seine nets on or to encircle dolphins, or if the product meets the requirements of subparagraph (B).

''(B) For purposes of paragraph (1)(B), a tuna product that contains tuna harvested in the eastern tropical Pacific Ocean by a vessel using purse seine nets is dolphin safe if the product is accompanied by a written statement executed by the captain of the vessel which harvested the tuna certifying that no dolphins were killed during the sets in which the tuna were caught and the product is accompanied by a written statement executed by—

''(i) the Secretary or the Secretary's designee;

''(ii) a representative of the Inter-American Tropical Tuna Commission; or

''(iii) an authorized representative of a participating nation whose national program meets the requirements of the International Dolphin Conservation Program,

which states that there was an observer approved by the International Dolphin Conservation Program on board the vessel during the entire trip and documents that no dolphins were killed during the sets in which the tuna concerned were caught.

''(C) The statements referred to in clauses (i), (ii), and (iii) of subparagraph (B) shall be valid only if they are endorsed in writing by each exporter, importer, and processor of the product, and if such statements and endorsements comply with regulations promulgated by the Secretary which would provide for the verification of tuna products as dolphin safe.''.

(2) Subsection (d) of section 901 of the Dolphin Protection Consumer Information Act (16 U.S.C. 1385(d)) is amended by adding the following new paragraphs at the end thereof:

''(3) For purposes of paragraph (1)(C), tuna or a tuna product that contains tuna harvested outside the eastern tropical Pacific Ocean by a vessel using purse seine nets is dolphin safe if—

''(A) it is accompanied by a written statement executed by the captain of the vessel certifying that no purse seine net was intentionally deployed on or to encircle dolphins during the particular voyage on which the tuna was harvested; or

''(B) in any fishery in which the Secretary has determined that a regular and significant association occurs between marine mammals and tuna, it is accompanied by a written statement executed by the captain of the vessel and an observer, certifying that no purse seine net was intentionally deployed on or to encircle marine mammals during the particular voyage on which the tuna was harvested.

''(4) For purposes of paragraph (1)(D), tuna or a tuna product that contains tuna harvested in a fishery identified by the Secretary as having a regular and significant incidental mortality or serious injury of marine mammals is dolphin safe if it is accompanied by a written statement executed by the captain of the vessel and, where determined to be practicable by the Secretary, an observer participating in a national or international program acceptable to the Secretary certifying that no marine mammals were killed in the course of the fishing operation or operations in which the tuna were caught.

''(5) No tuna product may be labeled with any reference to dolphins, porpoises, or marine mammals, unless such product is labeled as dolphin safe in accordance with this subsection.''.

(i) TRACKING AND VERIFICATION.—Subsection (f) of section 901 of the Dolphin Protection Consumer Information Act (16 U.S.C. 1385(f)) is amended to read as follows:

''(f) TRACKING AND VERIFICATION.—The Secretary, in consultation with the Secretary of the Treasury, shall issue regulations to implement subsection (d) not later than 3 months after the date of enactment of the International Dolphin Conservation Program Act. In the development of these regulations, the Secretary shall establish appropriate procedures for ensuring the confidentiality of proprietary information the submission of which is voluntary or mandatory. Such regulations shall, consistent with international efforts and in coordination with the Inter-American Tropical Tuna Commission, establish a domestic and international tracking and verification program that provides for the effective tracking of tuna labeled under subsection (d), including but not limited to each of the following:

''(1) Specific regulations and provisions addressing the use of weight calculation for purposes of tracking tuna caught, landed, processed, and exported.

''(2) Additional measures to enhance observer coverage if necessary.

''(3) Well location and procedures for monitoring, certifying, and sealing holds above and below deck or other equally effective methods of tracking and verifying tuna labeled under subsection (d).

''(4) Reporting receipt of and database storage of radio and facsimile transmittals from fishing vessels containing information related to the tracking and verification of tuna, and the definition of sets.

''(5) Shore-based verification and tracking throughout the transshipment and canning process by means of Inter-American Tropical Tuna Commission trip records or otherwise.

''(6) Provisions for annual audits and spot checks for caught, landed, and processed tuna products labeled in accordance with subsection (d).

''(7) The provision of timely access to data required under this subsection by the Secretary from harvesting nations to undertake the actions required in paragraph (6) of this subsection.

The Secretary may make such adjustments as may be appropriate to the regulations promulgated under this subsection to implement an international tracking and verification program that meets or exceeds the minimum requirements established by the Secretary under this subsection.''.

SEC. 5. AMENDMENTS TO TITLE III.

(a) HEADING.—The heading of title III is amended to read as follows:

''TITLE III—INTERNATIONAL DOLPHIN CONSERVATION PROGRAM''.

(b) FINDINGS.—Section 301 (16 U.S.C. 1411) is amended as follows:

(1) In subsection (a), by amending paragraph (4) to read as follows:

''(4) Nations harvesting yellowfin tuna in the eastern tropical Pacific Ocean have demonstrated their willingness to participate in appropriate multilateral agreements to reduce, with the goal of eliminating, dolphin mortality in that fishery. Recognition of the International Dolphin Conservation Program will assure that the existing trend of reduced dolphin mortality continues; that individual stocks of dolphins are adequately protected; and that the goal of eliminating all dolphin mortality continues to be a priority.''.

(2) In subsection (b), by amending paragraphs (2) and (3) to read as follows:

''(2) support the International Dolphin Conservation Program and efforts within the Program to reduce, with the goal of eliminating, the mortality referred to in paragraph (1);

''(3) ensure that the market of the United States does not act as an incentive to the harvest of tuna caught with driftnets or caught by purse seine vessels in the eastern tropical Pacific Ocean that are not operating in compliance with the International Dolphin Conservation Program;''.

(c) INTERNATIONAL DOLPHIN CONSERVATION PROGRAM.—Section 302 (16 U.S.C. 1412) is amended to read as follows:

''SEC. 302. AUTHORITY OF THE SECRETARY.

''(a) REGULATIONS TO IMPLEMENT PROGRAM REGULATIONS.—(1) The Secretary shall issue regulations to implement the International Dolphin Conservation Program.

''(2)(A) Not later than 3 months after the date of enactment of this section, the Secretary shall issue regulations to authorize and govern the incidental taking of marine mammals in the eastern tropical Pacific Ocean, including any species of marine mammal designated as depleted under this Act but not listed as endangered or threatened under the Endangered Species Act of 1973 (16 U.S.C. 1531 et seq.), by vessels of the United States participating in the International Dolphin Conservation Program.

''(B) Regulations issued under this section shall include provisions—

''(i) requiring observers on each vessel;

''(ii) requiring use of the backdown procedure or other procedures equally or more effective in avoiding mortality of marine mammals in fishing operations;

''(iii) prohibiting intentional deployment of nets on, or encirclement of, dolphins in violation of the International Dolphin Conservation Program;

''(iv) requiring the use of special equipment, including dolphin safety panels in nets, monitoring devices as identified by the International Dolphin Conservation Program, as practicable, to detect unsafe fishing conditions before nets are deployed by a tuna vessel, operable rafts, speedboats with towing bridles, floodlights in operable condition, and diving masks and snorkels;

''(v) ensuring that the backdown procedure during the deployment of nets on, or encirclement of, dolphins is completed and rolling of the net to sack up has begun no later than 30 minutes after sundown;

''(vi) banning the use of explosive devices in all purse seine operations;

''(vii) establishing per vessel maximum annual dolphin mortality limits, total dolphin mortality limits and per-stock per-year mortality limits, in accordance with the International Dolphin Conservation Program;

''(viii) preventing the intentional deployment of nets on, or encirclement of, dolphins after reaching either the vessel maximum annual dolphin mortality limits, total dolphin mortality limits, or per-stock per-year mortality limits;

''(ix) preventing the fishing on dolphins by a vessel without an assigned vessel dolphin mortality limit;

''(x) allowing for the authorization and conduct of experimental fishing operations, under such terms and conditions as the Secretary may prescribe, for the purpose of testing proposed improvements in fishing techniques and equipment (including new technology for detecting unsafe fishing conditions before nets are deployed by a tuna vessel) that may reduce or eliminate dolphin mortality or do not require the encirclement of dolphins in the course of commercial yellowfin tuna fishing;

''(xi) authorizing fishing within the area covered by the International Dolphin Conservation Program by vessels of the United States without the use of special equipment or nets if the vessel takes an observer and does not intentionally deploy nets on, or encircle, dolphins, under such terms and conditions as the Secretary may prescribe; and

''(xii) containing such other restrictions and requirements as the Secretary determines are necessary to implement the International Dolphin Conservation Program with respect to vessels of the United States.

''(C) The Secretary may make such adjustments as may be appropriate to the requirements of subparagraph (B) that pertain to fishing gear, vessel equipment, and fishing practices to the extent the adjustments are consistent with the International Dolphin Conservation Program.

''(b) CONSULTATION.—In developing regulations under this section, the Secretary shall consult with the Secretary of State, the Marine Mammal Commission and the United States Commissioners to the Inter-American Tropical Tuna Commission appointed under section 3 of the Tuna Conventions Act of 1950 (16 U.S.C. 952).

''(c) EMERGENCY REGULATIONS.—(1) If the Secretary determines, on the basis of the best scientific information available (including that obtained under the International Dolphin Conservation Program) that the incidental mortality and serious injury of marine mammals authorized under this title is having, or is likely to have, a significant adverse effect on a marine mammal stock or species, the Secretary shall take actions as follows—

''(A) notify the Inter-American Tropical Tuna Commission of the Secretary's findings, along with recommendations to the Commission as to actions necessary to reduce incidental mortality and serious injury and mitigate such adverse impact; and

''(B) prescribe emergency regulations to reduce incidental mortality and serious injury and mitigate such adverse impact.

''(2) Prior to taking action under paragraph (1) (A) or (B), the Secretary shall consult with the Secretary of State, the Marine Mammal Commission, and the United States Commissioners to the Inter-American Tropical Tuna Commission.

''(3) Emergency regulations prescribed under this subsection—

''(A) shall be published in the Federal Register, together with an explanation thereof; and

''(B) shall remain in effect for the duration of the applicable fishing year; and

The Secretary may terminate such emergency regulations at a date earlier than that required by subparagraph (B) by publication in the Federal Register of a notice of termination, if the Secretary determines that the reasons for the emergency action no longer exist.

''(4) If the Secretary finds that the incidental mortality and serious injury of marine mammals in the yellowfin tuna fishery in the eastern tropical Pacific Ocean is continuing to have a significant adverse impact on a stock or species, the Secretary may extend the emergency regulations for such additional periods as may be necessary.

''(d) RESEARCH.—The Secretary shall, in cooperation with the nations participating in the International Dolphin Conservation Program and with the Inter-American Tropical Tuna Commission, undertake or support appropriate scientific research to further the goals of the International Dolphin Conservation Program. Such research may include but shall not be limited to any of the following:

''(1) Devising cost-effective fishing methods and gear so as to reduce, with the goal of eliminating, the incidental mortality and serious injury of marine mammals in connection with commercial purse seine fishing in the eastern tropical Pacific Ocean.

''(2) Developing cost-effective methods of fishing for mature yellowfin tuna without deployment of nets on, or encirclement of, dolphins or other marine mammals.

''(3) Carrying out stock assessments for those marine mammal species and marine mammal stocks taken in the purse seine fishery for yellowfin tuna in the eastern tropical Pacific Ocean, including species or stocks not within waters under the jurisdiction of the United States.

''(4) Studying the effects of chase and encirclement on the health and biology of dolphin and individual dolphin populations incidentally taken in the course of purse seine fishing for yellowfin tuna in the eastern tropical Pacific Ocean. There are authorized to be appropriated to the Department of Commerce $1,000,000 to be used by the Secretary, acting through the National Marine Fisheries Service, to carry out this paragraph. Upon completion of the study, the Secretary shall submit a report containing the results of the study, together with recommendations, to the Congress and to the Inter-American Tropical Tuna Commission.

''(5) Determining the extent to which the incidental take of nontarget species, including juvenile tuna, occurs in the course of purse seine fishing for yellowfin tuna in the eastern tropical Pacific Ocean, the geographic location of the incidental take, and the impact of that incidental take on tuna stocks, and nontarget species.

The Secretary shall include a description of the annual results of research carried out under this subsection in the report required under section 303.''.

(d) REPORTS.—Section 303 (16 U.S.C. 1414) is amended to read as follows:

''SEC. 303. REPORTS BY THE SECRETARY.

''Notwithstanding section 103(f), the Secretary shall submit an annual report to the Congress which includes each of the following:

''(1) The results of research conducted pursuant to section 302.

''(2) A description of the status and trends of stocks of tuna.

''(3) A description of the efforts to assess, avoid, reduce, and minimize the bycatch of juvenile yellowfin tuna and other nontarget species.

''(4) A description of the activities of the International Dolphin Conservation Program and of the efforts of the United States in support of the Program's goals and objectives, including the protection of dolphin populations in the eastern tropical Pacific Ocean, and an assessment of the effectiveness of the Program.

''(5) Actions taken by the Secretary under subsections (a)(2)(B) and (d) of section 101.

''(6) Copies of any relevant resolutions and decisions of the Inter-American Tropical Tuna Commission, and any regulations promulgated by the Secretary under this title.

''(7) Any other information deemed relevant by the Secretary.''.

(e) PERMITS.—Section 304 (16 U.S.C. 1416) is amended to read as follows:

''SEC. 304. PERMITS.

''(a) IN GENERAL.—(1) Consistent with section 302, the Secretary is authorized to issue a permit to a vessel of the United States authorizing participation in the International Dolphin Conservation Program and may require a permit for the person actually in charge of and controlling the fishing operation of the vessel. The Secretary shall prescribe such procedures as are necessary to carry out this subsection, including, but not limited to, requiring the submission of—

''(A) the name and official number or other identification of each fishing vessel for which a permit is sought, together with the name and address of the owner thereof; and

''(B) the tonnage, hold capacity, speed, processing equipment, and type and quantity of gear, including an inventory of special equipment required under section 302, with respect to each vessel.

''(2) The Secretary is authorized to charge a fee for issuing a permit under this section. The level of fees charged under this paragraph may not exceed the administrative cost incurred in granting an authorization and issuing a permit. Fees collected under this paragraph shall be available, subject to appropriations, to the Under Secretary of Commerce for Oceans and Atmosphere for expenses incurred in issuing permits under this section.

''(3) After the effective date of the International Dolphin Conservation Program Act, no vessel of the United States shall operate in the yellowfin tuna fishery in the eastern tropical Pacific Ocean without a valid permit issued under this section.

''(b) PERMIT SANCTIONS.—(1) In any case in which—

''(A) a vessel for which a permit has been issued under this section has been used in the commission of an act prohibited under section 305;

''(B) the owner or operator of any such vessel or any other person who has applied for or been issued a permit under this section has acted in violation of section 305; or

''(C) any civil penalty or criminal fine imposed on a vessel, owner or operator of a vessel, or other person who has applied for or been issued a permit under this section has not been paid or is overdue, the Secretary may—

''(i) revoke any permit with respect to such vessel, with or without prejudice to the issuance of subsequent permits;

''(ii) suspend such permit for a period of time considered by the Secretary to be appropriate;

''(iii) deny such permit; or

''(iv) impose additional conditions or restrictions on any permit issued to, or applied for by, any such vessel or person under this section.

''(2) In imposing a sanction under this subsection, the Secretary shall take into account—

''(A) the nature, circumstances, extent, and gravity of the prohibited acts for which the sanction is imposed; and

''(B) with respect to the violator, the degree of culpability, any history of prior offenses, and other such matters as justice requires.

''(3) Transfer of ownership of a vessel, by sale or otherwise, shall not extinguish any permit sanction that is in effect or is pending at the time of transfer of ownership. Before executing the transfer of ownership of a vessel, by sale or otherwise, the owner shall disclose in writing to the prospective transferee the existence of any permit sanction that will be in effect or pending with respect to the vessel at the time of transfer.

''(4) In the case of any permit that is suspended for the failure to pay a civil penalty

or criminal fine, the Secretary shall reinstate the permit upon payment of the penalty or fine and interest thereon at the prevailing rate.

''(5) No sanctions shall be imposed under this section unless there has been a prior opportunity for a hearing on the facts underlying the violation for which the sanction is imposed, either in conjunction with a civil penalty proceeding under this title or otherwise.''.

(f) PROHIBITIONS.—Section 305 is repealed and section 307 (16 U.S.C. 1417) is redesignated as section 305, and amended as follows:

(1) In subsection (a):

(A) By amending paragraph (1) to read as follows:

''(1) for any person to sell, purchase, offer for sale, transport, or ship, in the United States, any tuna or tuna product unless the tuna or tuna product is either dolphin safe or has been harvested in compliance with the International Dolphin Conservation Program by a country that is a member of the Inter-American Tropical Tuna Commission or has initiated steps, in accordance with Article V, paragraph 3 of the Convention establishing the Inter-American Tropical Tuna Commission, to become a member of that organization;''.

(B) By amending paragraph (2) to read as follows:

''(2) except in accordance with this title and regulations issued pursuant to this title as provided for in subsection 101(e), for any person or vessel subject to the jurisdiction of the United States intentionally to set a purse seine net on or to encircle any marine mammal in the course of tuna fishing operations in the eastern tropical Pacific Ocean; or''.

(C) By amending paragraph (3) to read as follows:

''(3) for any person to import any yellowfin tuna or yellowfin tuna product or any other fish or fish product in violation of a ban on importation imposed under section 101(a)(2);''.

(2) In subsection (b)(2), by inserting ''(a)(5) and'' before ''(a)(6)''.

(3) By striking subsection (d).

(g) REPEAL.—Section 306 is repealed and section 308 (16 U.S.C. 1418) is redesignated as section 306, and amended by striking ''303'' and inserting in lieu thereof ''302(d)''.

(h) CLERICAL AMENDMENTS.—The table of contents in the first section of the Marine Mammal Protection Act of 1972 is amended by striking the items relating to title III and inserting in lieu thereof the following:

''TITLE III—INTERNATIONAL DOLPHIN CONSERVATION PROGRAM

''Sec. 301. Findings and policy.
''Sec. 302. Authority of the Secretary.
''Sec. 303. Reports by the Secretary.
''Sec. 304. Permits.
''Sec. 305. Prohibitions.
''Sec. 306. Authorization of appropriations.''.

SEC. 6. AMENDMENTS TO THE TUNA CONVENTIONS ACT.

(a) MEMBERSHIP.—Section 3(c) of the Tuna Conventions Act of 1950 (16 U.S.C. 952(c)) is amended to read as follows:

''(c) at least one shall be either the Director, or an appropriate regional director, of the National Marine Fisheries Service; and''.

(b) ADVISORY COMMITTEE AND SCIENTIFIC ADVISORY SUBCOMMITTEE.—Section 4 of the Tuna Conventions Act of 1950 (16 U.S.C. 953) is amended to read as follows:

''SEC. 4. GENERAL ADVISORY COMMITTEE AND SCIENTIFIC ADVISORY SUBCOMMITTEE.

''The Secretary, in consultation with the United States Commissioners, shall:

''(1) Appoint a General Advisory Committee which shall be composed of not less than 5 nor more than 15 persons with balanced representation from the various groups participating in the fisheries included under the conventions, and from nongovernmental conservation organizations. The General Advisory Committee shall be invited to have representatives attend all nonexecutive meetings of the United States sections and shall be given full opportunity to examine and to be heard on all proposed programs of investigations, reports, recommendations, and regulations of the commission. The General Advisory Committee may attend all meetings of the international commissions to which they are invited by such commissions.

''(2) Appoint a Scientific Advisory Subcommittee which shall be composed of not less than 5 nor more than 15 qualified scientists with balanced representation from the public and private sectors, including nongovernmental conservation organizations. The Scientific Advisory Subcommittee shall advise the General Advisory Committee and the Commissioners on matters including the conservation of ecosystems; the sustainable uses of living marine resources related to the tuna fishery in the eastern Pacific Ocean; and the long-term conservation and management of stocks of living marine resources in the eastern tropical Pacific Ocean. In addition, the Scientific Advisory Subcommittee shall, as requested by the General Advisory Committee, the United States Commissioners or the Secretary, perform functions and provide assistance required by formal agreements entered into by the United States for this fishery, including the International Dolphin Conservation Program. These functions may include each of the following:

''(A) The review of data from the Program, including data received from the Inter-American Tropical Tuna Commission.

''(B) Recommendations on research needs, including ecosystems, fishing practices, and gear technology research, including the development and use of selective, environmentally safe and cost-effective fishing gear, and on the coordination and facilitation of such research.

''(C) Recommendations concerning scientific reviews and assessments required under the Program and engaging, as appropriate, in such reviews and assessments.

''(D) Consulting with other experts as needed.

''(E) Recommending measures to assure the regular and timely full exchange of data among the parties to the Program and each nation's National Scientific Advisory Committee (or equivalent).

''(3) Establish procedures to provide for appropriate public participation and public meetings and to provide for the confidentiality of confidential business data. The Scientific Advisory Subcommittee shall be invited to have representatives attend all nonexecutive meetings of the United States sections and the General Advisory Subcommittee and shall be given full opportunity to examine and to be heard on all proposed programs of scientific investigation, scientific reports, and scientific recommendations of the commission. Representatives of the Scientific Advisory Subcommittee may attend meetings of the Inter-American Tropical Tuna Commission in accordance with the rules of such Commission.

''(4) Fix the terms of office of the members of the General Advisory Committee and Scientific Advisory Subcommittee, who shall receive no compensation for their services as such members.''.

SEC. 7. EQUITABLE FINANCIAL CONTRIBUTIONS.

It is the sense of the Congress that each nation participating in the International Dolphin Conservation Program should contribute an equitable amount to the expenses of the Inter-American Tropical Tuna Commission. Such contributions shall take into account the number of vessels from that nation fishing for tuna in the eastern tropical Pacific Ocean, the consumption of tuna and tuna products from the eastern tropical Pacific Ocean and other relevant factors as determined by the Secretary.

SEC. 8. EFFECTIVE DATE.

This Act and the amendments made by this Act shall take effect upon certification by the Secretary of State to the Congress that a binding resolution of the Inter-American Tropical Tuna Commission, or another legally binding instrument, establishing the International Dolphin Conservation Program has been adopted and is in effect.

The CHAIRMAN. No other amendment shall be in order except a further amendment printed in House Report 104–708, which may be offered only by the gentleman from California [Mr. MILLER] or his designee, shall be considered read, shall be debatable for 1 hour, equally divided and controlled by the proponent and an opponent, and shall not be subject to amendment.

AMENDMENT OFFERED BY MR. STUDDS

Mr. STUDDS. Mr. Chairman, I offer an amendment made in order under the rule.

The CHAIRMAN. The Clerk will designate the amendment.

The text of the amendment is as follows:

Amendment offered by Mr. STUDDS: In section 901(d)(2)(B) of the Dolphin Protection Consumer Information Act (as proposed to be amended by section 4(h)(1) of the amendment in the nature of a substitute made in order as original text), insert '', chased, harassed, injured, or encircled with nets'' after ''killed'' in each of the places it appears.

The CHAIRMAN. Pursuant to House Resolution 489, the gentleman from Massachusetts [Mr. STUDDS] and a Member opposed each will control 30 minutes.

The Chair recognizes the gentleman from Massachusetts [Mr. STUDDS].

Mr. STUDDS. Mr. Chairman, I yield myself such time as I may consume.

(Mr. STUDDS asked and was given permission to revise and extend his remarks.)

Mr. STUDDS. Mr. Chairman, let me begin by stating most emphatically that I would very much prefer not to be standing here debating this issue or offering this amendment. I have very little doubt that by now every Member in this Chamber, and there must be at least six of them, and those who are watching, are thoroughly confused about how best to save dolphins. Apparently, so are the environmental groups, and, quite frankly, so am I.

Nonetheless, I offer this amendment because the one portion of this debate that should not be confusing is the definition of the word ''safe,'' notwithstanding the fact that people in this city have been always able to take short English words and euphemize the meaning out of them. When I grew up, safe meant secure from danger, harm or evil. That is what the dictionary says it means.

Under this bill, safe would permit doing all kinds of things to dolphins,

including seriously injuring them, and as long as no one actually noticed it happening, they might even be able to kill them. This legislation would define as safe a process that stops dolphins from feeding, separates mothers from their calves, injures animals, and allows them to be chased for hours until they are unable to swim any longer. We can only hope that the Committee on the Judiciary does not get a hold of this reasoning the next time it takes up reform of the criminal code.

For three of the four debates during which we have had strong bipartisan support for legislation protecting dolphins from the extraordinary slaughter that occurred in this fishery, I had the honor of chairing the subcommittee of jurisdiction. We passed the law requiring truth in tuna labeling because American consumers, American voters, and American schoolchildren demanded it. They made it clear that they did not want to endorse the selling of a product whose harvesting caused any harm to dolphins. Since its enactment in 1972, the Marine Mammal Protection Act has prohibited any, quote, attempt to harass, hunt, capture or kill any marine mammal, unquote.

Again, it is illegal under current law to harass, hunt, capture or kill any marine mammal. That language is in the law because we know that these activities are not safe from marine mammals.

Those who support the labeling change in this bill, I am sure, would not allow whale-watching vessels in my district to harass whales and separate mothers from nursing calves and then market those cruises as safe for whales. I suspect they would not allow Mr. YOUNG's oil companies to conduct exploratory drilling that disrupts the feeding behavior of whales and then call the oil whale-safe.

Two years ago, some of the environmental groups that are supporting this bill blocked regulations allowing dolphin-feeding cruises in Florida and in Texas because they were convinced that the harassment of dolphins was not safe.

The double standard in this bill, put there for Mexico's sake, violates in my judgment the integrity of everything we on both sides of this aisle have worked to achieve over the last 20 years.

The amendment is simple. It did not get read but it would have taken less time to read it than to designate it. It simply adds after the word ''killed,'' and I quote, ''chased, harassed, injured or encircled with nets.'' You cannot do any of those things under our amendment and call it dolphin safe.

The amendment leaves intact the provisions of the bill that lift the embargoes on tuna. It leaves intact the remainder of the international agreement. But it retains honest information for American consumers, and that is all it does.

Not long ago we held a debate on this floor about truth in nutrition labeling. Right now there is a bipartisan effort under way in both Chambers to establish simple labels on clothing and sporting goods that would inform consumers if those products were made by child labor. Labeling means something to consumers. It means trust.

The American people know what the word ''safe'' means. If we cannot be honest about the meaning, then we should probably get rid of the label. Perhaps we could call it ''good for Mexico,'' or ''NAFTA-consistent,'' or ''caught under international guidelines,'' but we should not call it safe for dolphins, because by any standard, semantic or otherwise, it is not.

Let me once again remind my colleagues that the amendment does not address the international agreement. it does not address the embargo. It simply says that we retain the sanctity and the meaning of the label ''dolphin-safe'' which has been so successful as it is now in current law, which says that if they want to use that label on imported tuna, they not only have to demonstrate that that tuna was caught in a way that did not kill dolphins but did not involve chasing, harassing, injuring, or encircling with nets the aforementioned dolphins.

Like the gentleman from Florida [Mr. GIBBONS], I too have communed with my own dolphins on this matter and, as I have in the past, I can assure my colleagues that in unequivocally dolphin ways they have made it very clear to me that they support this amendment. That is pretty tough. I know the gentleman from Alaska is going to suggest that these may be a regional dialect in question here, and that dolphins in other parts of the country may be saying something different, but I rather doubt that.

I am also prepared to stipulate, as suggested by the gentleman from New York, that the gentleman from Maryland is a class act. I think I made that observation myself even before the gentleman from New York [Mr. BOEHLERT] did. I have no doubt whatsoever about that. I wish there were more like him in this Chamber.

□ 1900

Mr. Chairman, I reserve the balance of my time.

Mr. SAXTON. Mr. Chairman, I rise in opposition to the amendment.

The CHAIRMAN. The gentleman from New Jersey [Mr. SAXTON] will control 30 minutes.

The Chair recognizes the gentleman from New Jersey [Mr. SAXTON].

Mr. SAXTON. Mr. Chairman, I yield such time as he may consume to the gentleman from Alaska [Mr. YOUNG].

Mr. YOUNG of Alaska. Mr. Chairman, I thank the gentleman for yielding me this time.

Mr. Chairman, I usually agree with my esteemed colleague from Massachusetts on fishery issues. He and I have worked together for 24 years and rarely do we disagree on the issues of fisheries. I must oppose his amendment, though, because the Gilchrest bill implements the Panama Declaration, as discussed in general debate, which locks into place binding conservation management measures for dolphin and other marine life.

This bill is supported, as has been said before, by five environmental organizations, the American Tunaboat Owners, the National Fisheries Institute, the Seafarers' International Union, the California Federation of Labor, the United Industrial Workers, the American Sportfishing Association, and the Clinton administration, although that gives me some reservation.

Mr. Chairman, H.R. 2823 recognizes the international voluntary compliance with the Inter-American Tropical Tuna Commission's dolphin conservation program, which has been in place for the past 4 years. This bill incorporates provisions into U.S. law to continue the international cooperation and compliance.

Over the last couple of months, Mr. GILCHREST has worked to address the concerns of the opponents to H.R. 2823. However, the definition of dolphin-safe has kept the two sides from reaching an agreement.

The amendment being offered by Mr. STUDDS was offered at subcommittee markup by Congressman FARR and was defeated. The Studds-Miller amendment will keep the current dolphin-safe definition which will continue to outlaw the use of fishing practices with the lowest bycatch, despite technological breakthroughs which have reduced dolphin mortality by 97 percent.

The proponents of this amendment will tell you that by keeping the current dolphin-safe definition, it will protect dolphins. However, the Studds-Miller amendment will not end the encirclement of dolphins by foreign fishermen in the eastern tropical Pacific Ocean. Since the adoption of the embargo in 1992, the number of dolphin sets has not decreased. Approximately 50 percent of sets by foreign fleets are on dolphin schools despite the embargo. The Studds-Miller amendment also promotes fishing practices which have a high bycatch of juvenile tuna, billfish, sea turtles and sharks.

Mr. Chairman, H.R. 2823 promotes conservation and management measures based on science. It does not promote the protection of one species over the needs of other marine species. This legislation protects dolphins and other marine life.

The Studds-Miller amendment, on the other hand, will jeopardize the progress made in reducing dolphin mortalities in the eastern tropical Pacific Ocean and do nothing to protect other marine life. Finally, the amendment will negate all of the international cooperation and compliance envisioned in the Panama Declaration.

Therefore, I ask my colleagues to vote against the Studds-Miller amendment. I think it will actually cut this bill.

Mr. STUDDS. Mr. Chairman, I find it difficult to believe the gentleman from

Alaska has been here for 24 years given his appearance, but we will have to take his word for it.

Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from Oregon [Ms. FURSE].

Ms. FURSE. Mr. Chairman, I rise in strong support of the Studds amendment. This amendment does one thing, it protects the integrity of the ''dolphin safe'' label.

Now, it is really very simple. The rest of the world would like to get into our market, they would like to sell their product under the label ''dolphin safe,'' but without this amendment and under this bill, tuna fisheries could chase, harass, injure dolphins and still get the benefit of the ''dolphin safe'' label.

Now, maybe in this bill we should have a ''dolphin less-safe'' label or a ''dolphin almost-safe'' label, but if we want the consumers to rely on the ''dolphin safe'' label, we must pass the Studds amendment because we simply do not know what the effects are of chasing and harassing these mammals. However, marine mammal biologists believe that the trauma that dolphins endure under this type of encirclement does lead to the diminishment of the dolphin populations.

I would remind my colleagues that our first obligation is to the U.S. consumer, not, not to the Mexican Government. We cannot allow our domestic consumer protection laws and environmental laws to be held hostage.

Please join me and the millions of Americans who want the opportunity to choose the type of tuna they are buying. They want to know that ''dolphin safe'' means ''dolphin safe.'' Support the Studds amendment. Make this bill significantly better.

Mr. SAXTON. Mr. Chairman, I yield 2 minutes to the gentleman from Maryland [Mr. CARDIN].

Mr. CARDIN. Mr. Chairman, first let me thank my colleague from New Jersey for yielding me this time and thank him for his leadership on this issue.

Mr. Chairman, I rise in support of H.R. 2823 and against the Miller-Studds amendment. I first want to compliment my colleague from Maryland, Mr. GILCHREST, for his leadership on this legislation. He has done a great job in bringing this issue forward, which would implement the Panama Declaration by opening up the U.S. market to tuna caught in compliance with the Tuna Commission Program, which would reduce dolphin mortality, lessen the bycatch of other forms of marine life and sustain dolphin and fish populations for the future.

Mr. Chairman, people are most concerned with the practice of dolphin encirclement by fishing vessels. The rate of dolphin mortality under the Panama Declaration has dramatically declined because of the declaration's goals to strictly limit any deaths, provide tunaboat crew training, and require internationally trained observers on all tuna vessels. This bill requires that the annual mortality rate be further reduced to less than a fraction of 1 percent of the dolphin population, leading to the elimination of dolphin mortalities altogether. The ''dolphin-safe'' label is preserved because certified inspectors aboard ship guarantee that no dolphins were killed.

We should not forget that other methods of catching tuna kill other sea life. Tuna have been known to swim near logs and debris close to shorelines. Fishermen who cast their nets to catch these tuna don't kill dolphins, but they do kill a huge bycatch of sharks, endangered sea turtles, and juvenile tuna whose survival is crucial to tuna prosperity years from now.

Because of the progress made through an international effort led by the United States, we have negotiated an agreement among all the countries that have fishing vessels in the eastern Pacific. Dolphin conservation gains have come as a result of more careful fishing and international cooperation, and we must continue with this progress by passing H.R. 2823.

Mr. Chairman, I urge my colleagues to defeat this amendment that would compromise this bill. Let us pass H.R. 2823. It is in the interest of the environment, and I urge my colleagues to support the legislation.

Mr. STUDDS. Mr. Chairman, I yield 2 minutes to the gentleman from California [Mr. FARR].

Mr. FARR of California. Mr. Chairman, I thank the gentleman from Massachusetts for yielding me this time.

Mr. Chairman, I rise in support of the Studds amendment and let me tell my colleagues why. There is a problem that I think the author, the gentleman from Maryland [Mr. GILCHREST], is trying to address. We all want to address that problem, and that is the problem of bycatch. But the bill, as written, really does not do that without harming dolphins, and that is why the Studds amendment makes the bill a better bill.

It is very simple. In America we have what we call truth in labeling. For 6 years U.S. consumers have been buying tuna in the stores that say that it is dolphin safe. We all know what the word ''safe'' means, our constituents know what it means, school kids know what it means. They are confident that tuna labeled as ''dolphin safe'' has not been caught in a way that harms dolphins.

The amendment that the gentleman from Massachusetts [Mr. STUDDS] is offering only puts 6 words into law. If the bill goes through right now, however, dolphins that are chased and die can be labeled ''dolphin safe.'' Dolphins that are harassed and die can be labeled ''dolphin safe.'' Dolphins that are injured or encircled with nets and die can be labeled as ''dolphin safe.''

That is not truth in labeling, and that is the problem here. We need to have truth in labeling.

I urge my colleagues, add these 6 words to this bill to make it a good bill, to make it a better bill, to make it a bill we can all vote for and support, because that is what the American people want. They do not want us in Congress to play tricks with labels on cans in order to enhance an industry that fishes way offshore from here.

Changing the definition of ''dolphin safe'' now without a sound scientific basis for that decision not only risks undercutting the progress we have made in the last decade to protect dolphins, but it also misleads the Amercan consumers.

Vote ''yes'' on this simple amendment. Restore order to this bill.

Mr. SAXTON. Mr. Chairman, I yield 8 minutes to the gentleman from Maryland [Mr. GILCHREST] who was the first to point out to me that this bill not only protects dolphins, but it also protects sea turtles, sharks, and billfish.

Mr. GILCHREST. Mr. Chairman, I thank the gentleman from New Jersey for yielding me this time, and I thank the gentleman from Massachusetts for his applause.

Mr. Chairman, if we could just look at this photograph over here for a second, what I want to try to display to my colleagues is the present condition of the marine ecosystem under the present law.

When we talk about bycatch, that means discarded fish, that means discarded marine mammals, that means discarded reptiles, that means discarded turtles, sea turtles, many of which are endangered.

If we look at this picture, up in the right-hand corner we will see sharks that are discarded in the present process of fishing techniques.

If we look at this photograph here, we will see in this trough immature tuna that will not be able to spawn, that will not sustain the population.

The basic point I want to get across here is that we need to find new methods of fishing, new techniques. Unless we change what we are doing at the present time, and unless we have an agreement with other countries to try to preserve and sustain the resources of our coastal oceans, we cannot do it alone.

Mr. SAXTON. Mr. Chairman, will the gentleman yield?

Mr. GILCHREST. I yield to the gentleman from New Jersey.

Mr. SAXTON. Mr. Chairman, I just want the gentleman to explain perhaps to Members who are not on the committee why it is that fishing on log sets and why it is that fishing on schools of tuna produces a larger bycatch than the proposed method of fishing on dolphins.

Mr. GILCHREST. Mr. Chairman, reclaiming my time, I will try to in 60 seconds educate people on encirclement, log sets, and tuna sets, if I can.

Basically, encirclement the way we did it in the past was bad. We had an embargo, we ended it, we reduced the dolphin kills from 100,000 a year down to under 4,000 a year. That is what we are trying to do here.

Log sets. Tuna, for some strange reason, will swim under something. If they do not swim under dolphins like mature tuna fish do, they will swim under logs. Now, we have a lot of immature tuna that swim under logs. We do not have any dolphins there, but when they encircle the tuna and catch them in these big nets, not only do they catch tuna fish, but what we see in these pictures here is they catch many more marine species.

These species are under stress because they are being discarded. They are not being used.

Mr. SAXTON. Mr. Chairman, if the gentleman would continue to yield. This is an important point.

If we prohibit fishing on dolphins, which we now believe we can do much safer than we used to, then we not only permit fishing on log sets and permit fishing on schools, but we encourage those fishermen who would normally be fishing in a safer way on dolphins to go fish on log sets and on schools where we get this higher bycatch.

Mr. GILCHREST. The whole reason for this particular legislation is threefold: to reduce the number of dolphins killed, to reduce the number of marine species that are killed in the process of catching tuna, and to set up an agreement that we are sponsoring to ensure the sustainability of the marine ecosystem. We can then open the door to a number of other environmental agreements, including global warming.

What I want to do is to talk briefly on some of the charges that the other side has made.

Last year there were 3,300 dolphins killed in the eastern tropical Pacific. That is down 99 percent from what it was. That is using this particular technique.

Why do we have in our bill a maximum, maximum, of 5,000 dolphins killed? That is because there will be more fishers in the fishery, so we need to have some reasonable number. Five thousand dolphins killed is biologically insignificant as assessed by some of the best scientists in the world. One of them is from the National Oceanic and Atmospheric Administration, a woman named Elizabeth Edwards, who says that is biologically insignificant.

We understand that. We do not accept the 5,000 number. We will continue to work toward zero.

Here is what Dr. Edwards says about the study, that the process that we are trying to get into law stresses dolphins to the degree that it harms them. She says, ''In particular the 5 reviewers were unanimous in their opinion that the study failed to confirm the stated conclusion that dolphins were experiencing acute continuous stress.''

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So I wanted to dismiss that accusation that the encirclement, where you allow the dolphins to get out, which is what we are doing, causes stress that harms the dolphin. There is no evidence to that effect. The Center for Marine Conservation, one of our more sophisticated, respected environmental groups around the country, says arguably stress is not found to lead to species decline, the stress that they experience in this encirclement. And understand, we do not want to encircle dolphins. This is not the last step in this process. This international agreement does not end the way we catch tuna fish.

This international agreement by the United States, by the environmental groups such as Greenpeace, Center for Marine Conservation, we want to continue to use the expertise of the United States to find ways to ensure the sustainability of the marine ecosystem and reduce dolphin kills to zero and some day hopefully end encirclement entirely. But we cannot do it alone. We need this international agreement. I want to point out one other thing. IATTC is showing an increase in dolphin population.

Now, the comment that we are importing tuna fish for the purpose of doing something for the benefit of Mexico or Mexican fishermen, and we are not concerned about the death of dolphins. Well, I want to say something. In our bill, on every single boat there will be, there must be, observers in order to sell that tuna fish into the United States. So we will know, however unfortunate it might be, every single dolphin death. And we will know that because we have observers on board those boats. Since we have observers on those boats, we recognize in the past year there has been 3,300 dolphin deaths, but we know that, and we are trying to reduce that.

Now, the present regime, before this legislation goes into effect, we are getting much of our tuna fish, if not most of our tuna fish, from the western tropical Pacific, where there are no observers on those boats, and it is fundamentally understood. It is fundamentally understood that from 10,000 to 40,000 dolphins are killed a year. We have no control over that. Do we want to have dolphin kills without anybody to observe those dolphin deaths and then quite likely import that tuna, can it in the United States, and then label it dolphin safe? I would much rather have an understanding as to the number of dolphin deaths and a continuous effort to reduce those dolphin deaths.

Mr. Chairman, I urge my colleagues to oppose the Miller-Studds amendment and to support the legislation. It is an international agreement of very positive proportions so that we can continue down the road as a planet, as a world population that is continuing to increase to have some sense of understanding together as a global community to sustain the limited resources that are essential for the food of this planet.

Mr. STUDDS. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I want to correct one thing. The gentleman from Maryland may be right or he may be wrong, but he is simply asserting something without documentation. There has only been one study to date that we know on the effect of encirclement of dolphins, and I am holding it in my hand. It is from the Journal of Pathophysiology, and it has the imposing title of ''Adrenocortical Color Darkness and Correlates as Indicators of Continuous Acute Premortem Stress in Chased and Purse-seine Captured Male Dolphins.'' So there. I want the record to reflect that, done by the National Marine Fisheries Service, the only study we have suggests, does not assert, suggests to the contrary.

Now, the dolphins as usual speak for themselves. There are two species that have been consistently, over time, chased and netted in this fishery: The eastern spinner dolphin and the northern offshore spotted dolphin. I do not know which one the gentleman is communing with. According to the National Marine Fisheries Service, these two populations are at less than 20 percent of their original size. This is an indisputable fact due to the 8 million deaths that have taken place over the last 20 years.

Now, we have been enormously successful in reducing those deaths, as most people have mentioned speaking on both sides of this issue, but, and this is a large ''but,'' in spite of the much observed lower level of dolphin deaths these two dolphin populations are now growing. The fact is worth repeating. Although dolphin deaths have dropped from approximately 100,000 annually to about 3,600, we see no increase in these populations.

Many biologists believe that the constant injury and harassment of these animals is preventing the recovery of the populations. I do not pretend to assert that as fact. I have been quite open from the beginning that I do not know. But I suggest that no one else here knows either. Insofar as we have any study to suggest that the contrary may be true, to assert something on the floor of this hallowed institution does not make it so, and in this case it might be that a little bit of humility and caution might be in order.

Mr. Chairman, I yield 2 minutes to the gentleman from New Jersey [Mr. PALLONE].

Mr. PALLONE. Mr. Chairman, I urge my colleagues to support the amendment offered by the gentleman from Massachusetts [Mr. STUDDS]. Consumers have a right to know that ''dolphin safe'' means that dolphins were not harassed or killed. That is what the label has meant for the last 6 years.

Under the Studds amendment, tuna can be sold in the United States regardless of whether it was caught using safe techniques, but it could not be labeled ''dolphin safe'' unless it meets the standard that every American consumer has relied upon and should be able to continue to rely upon.

It is hard to believe that chasing dolphins by speedboats and helicopters until they are too exhausted to escape

and then encircled in a purse-seine net can be considered safe. At worst, the netted dolphins face the risk of crushed bones, loss of fins, or suffocation in the nylon nets. At the very least, mortal injuries may ensue from separation of mothers from their calves or the severe stress caused by this harassment which may have detrimental effects.

One study suggests that there may be immediate effects of stress on these animals or long-term effects on the population as a whole, as indicated by the reduced pregnancy rates from heavily fished areas. There are signs that netting dolphins may have adverse effects, with the stress being one possible cause.

All of which may not necessarily go observed as the dolphins also sink or survive the experience only to die later. Meaning that the change to the ''dolphin safe'' label would render it worthless as now observed, and I quote, ''observed,'' mortalities occurred during the netting.

The bottom line is that the only true safe method to fish for tuna is to remove dolphins from the equation. The public knows this and so do over 80 environmental groups that support this amendment. That is why I voted for the current definition of dolphin safe in 1990 under the Dolphin Protection Consumer Information Act.

At Mexico's request in 1991, a GATT panel found that trade embargoes on tuna imports under the authority of the Marine Mammal Protection Act did not meet with trade obligations. But the dolphin-safe label was not an issue before the GATT dispute panel; only the embargo itself. There is no legitimate trade conflict with the dolphin-safe label. The Studds amendment will continue to preserve the dolphin-safe label, which is an integral part of dolphin protection.

Mr. Chairman, I include the following ''Dear Colleague'' letter for the RECORD.

SAVE THE ''DOLPHIN SAFE'' LABEL

DEAR COLLEAGUE: H.R. 2823, ''The International Dolphin Conservation Program Act'' will change U.S. law and allow tuna caught by methods that injure and terrorize dolphins to be labeled ''Dolphin Safe.'' The bill's proponents admit that under H.R. 2823, the number of dolphins that will be killed could rise. In fact, H.R. 2823 specifically permits a 25% increase in the number of dead dolphins.

This legislation would perpetuate a fraud on American consumers.

Consumers have a right to know that ''Dolphin Safe'' means that dolphins were not harassed or killed. That is what the label has meant for the past 6 years.

Under the Studds amendment, tuna can be sold in the United States regardless of whether it was caught using safe techniques. But it could not be labelled ''Dolphin Safe'' unless it meets the standard that every American consumer has relied upon and should be able to continue to rely on.

WHAT THE ''DOLPHIN SAFE'' LABEL MEANS

H.R. 2823 (Gilchrest)	Studds Amendment
Dolphins can be encircled, harassed, injured and tuna can still be called Dolphin Safe); 25% increase in dolphin mortality allowed.	Current law: no harassing techniques, no dolphin injuries, no dolphin deaths; non-safe tuna may be sold without the label.

If we can't save dolphins, at least we can save the label.

Support the ''Dolphin Safe'' Label: Support the Studds Truth in Labelling Amendment.

Sincerely,

SAM FARR.

FRANK PALLONE, Jr.

Mr. SAXTON. Mr. Chairman, I yield 1 minute to the gentleman from Maryland [Mr. GILCHREST] for purposes of responding to the author of the amendment.

Mr. GILCHREST. Mr. Chairman, in response to the assertion of the gentleman from Massachusetts, let me respond to the study that was done on stress by Dr. Elizabeth Edwards of the National Oceanic and Atmospheric Administration. This is what she said about the study concerning stress in dolphins:

''While all five reviewers felt that post-mortem examination of one or more physiological or histological samples taken from dolphins killed during purse-seining might well provide some indication of types and amounts of stress the animals may have experienced prior to death, none of the reviewers,'' talking about the study that was done, ''none of the reviewers felt that the body of work described in this paper presented any convincing evidence. In particular, the reviewers'' of the study ''were unanimous in their opinion that the study failed to confirm the stated conclusion * * *''

Mr. SAXTON. Mr. Chairman, I yield 2 minutes to the gentleman from San Diego, CA [Mr. BILBRAY].

Mr. BILBRAY. Mr. Chairman, I regretfully have to oppose the Studds amendment, and I would like to clarify that. I oppose the amendment because it locks us into the old concepts of species management that might have served us well in the seventies and the eighties, but is totally deficient for the latter part of the nineties and going into the next century.

Mr. Chairman, one of the great accomplishments that we are seeing this decade is the movement from single-species management to multispecies management when it comes to environmental protection. This amendment would lead us back into single-species management.

Mr. Chairman, I do not think anyone who originally supported this legislation meant to endanger sensitive marine species or to encourage, if not mandate, fishing practices that would directly and negatively impact different species, including endangered species. The loss of endangered sea turtles as a result of the present alternative to this legislation, H.R. 2823, the main bill, was, I think, totally unforeseen back in the 1970's and the 1980's, and new science says that we need to address this.

Now, Mr. Chairman, I do not want to make this a battle between Flipper and the Ninja Turtles; that we are going to have to choose between porpoises and billfish, or dolphins and endangered turtles. I think there is a proper way to do this, and one of the ways is to direct our fishing practices in a manner that would facilitate protection of multiple species, as H.R. 2823 would do. This amendment would strike that concept and move us back to the era of the 1970's and 1980's; the old concept that we will only look at one species rather than the entire environment.

Mr. Chairman, I ask that my colleagues consider the fact that both Vice President GORE and Greenpeace, among others, recognize that it is time to move forward and be more progressive and more global in our approach to ocean species management. America must lead, but we cannot do this alone, and species management cannot be done appropriately when focused only on one species or subspecies. This amendment would move us back to that position, that would hamstring us in addressing these protection issues in a comprehensive manner.

So I would ask the supporters of the motion to recognize its unintentional but negative impact to endangered marine species, and to reflect on the facts which are that this Studds amendment does not address the concerns that we need to address to definitely protect dolphins and other ocean animals.

Mr. SAXTON. Mr. Chairman, I yield 3 minutes to the gentleman from Arizona [Mr. KOLBE].

Mr. KOLBE. Mr. Chairman, I thank the gentleman for yielding.

Mr. Chairman, I rise in support of this bill H.R. 2823, the International Dolphin Conservation Program Act and in opposition to the amendment offered by the gentleman from California [Mr. MILLER] and the gentleman from Massachusetts [Mr. STUDDS].

I think this is an exceptional bill providing an international solution to an international problem, and that is the regulation of tuna fishing in the open seas. It is a good bill and reflects a good compromise among a lot of competing interests. But, I think we need to start by putting it in historical perspective.

In the mid-1970's, dolphin mortality rates were clearly at unacceptable levels. Over 500,000 dolphins were being killed each year in pursuit of tuna stocks. So in response to this unacceptable loss of life among the dolphin population, 5 years ago the United States placed an embargo on the importation of tuna caught using primitive encirclement measures.

But as has been pointed out in this debate, in recent years tuna fishermen have developed new and innovative methods which enable them to capture tuna without ensnaring dolphins at the same time. We have tough new monitoring procedures that have been instituted and international oversight responsibility has been strengthened.

Over time, these procedures have become increasingly internationalized, first through voluntary compliance with the La Jolla Agreement, then through permanent binding procedures set forth in the Panama Declaration.

By implementing the Panama Declaration, H.R. 2823 brings us along in the next step as the gentleman from Maryland has suggested, the next step in this evolutionary process. It locks in the reforms of the Panama Declaration and strengthens compliance procedures. The bill also provides incentives needed for other nations to remain in compliance by providing those nations who abide by the agreement with access to their most important tuna market, the United States.

It was this issue with Mexico and my work with the United States-Mexico Interparliamentary Conference that brought me first to this issue.

□ 1930

Make no mistake about it, these market incentives are absolutely critical to the continued success of the program. The procedures required under the Panama Declaration are costly: onboard observers on all tuna boats, individual boat licensing, and use of nets and divers to ensure the safety of the dolphin population.

But let us be blunt. Without the U.S. market as an incentive, these nations are certain to revert to destructive fishing practices of the past and just export to the markets that they can, and we will end up with dolphin kill ratios as high as we had in the 1970's and 1980's. If we do not act today and enact this legislation without amendment, what we have left is a dolphin-safe label but no dolphins.

As has been pointed out, this bill does more than protect dolphins. It provides an effective method to conserve total marine ecosystem in the eastern Pacific. The fishing practices encouraged by proposed alternative legislation result in an unreasonably excessive bycatch of a number of different species, including endangered sea turtles, sharks, billfish, and large numbers of tuna and other fish species. In fact, the fishing procedures advocated by the opponents to this bill are likely to endanger the long-term health of tuna stocks themselves.

We need this bill. We can do it. We can have tuna fishing, and we can protect dolphins. We have the technology to preserve the marine ecosystem and protect the dolphin. Let us do it. Let us implement the legislation of the Panama Declaration. Keep the dolphin and the marine ecosystem safe. I urge support for the bill and opposition to the Studds amendment.

Mr. STUDDS. Mr. Chairman, now that English is about to become the official language and we have La Jolla and Saint Diego, I guess I should yield to the gentlewoman from Saint Frank or Saint Francis, whatever that will become once we become English speaking.

Mr. Chairman, I yield 3 minutes to the distinguished gentlewoman from California [Ms. PELOSI].

Ms. PELOSI. Mr. Chairman, I thank the gentleman for yielding and rise in support of his amendment.

It is a wonderful thing in the House of Representatives that we are expressing all of this concern for the dolphin. Hopefully, this will carry over to the human species as well.

Mr. Speaker, as I said, I rise in opposition to the legislation as it is and in the hopes that our colleagues will vote in support of the Studds amendment. As has been said, in 1990, environmental, animal and consumer activists won a victory with the advent of the dolphin-safe label for commercially sold tuna. No product can be labeled dolphin-safe if the tuna is caught by chasing, harassing or netting dolphins. The issue before the house tonight is about what can be labeled dolphin-safe.

The dolphin-safe label has worked to preserve dolphin populations. After Congress adopted its ban of imported tuna caught using enclosure nets in 1992, the dolphin mortality rate dropped from 100,000 per year to less than 3,000, as has been indicated.

The bill before us would change the meaning of dolphin-safe to allow activities that would include highspeed chases with boats and helicopters, the separation of mothers from their calves, the withholding of food from trapped schools and the deliberate injury of dolphins to prevent the school from escape.

I call to the attention of my colleagues this chart which compares what the dolphin-safe label means.

Under the bill, it means this. Under the public view, dolphin-safe means this. We have got to keep faith with the public in our truth-in-labeling.

In fact almost any fishing activity would be termed dolphin-safe provided that no dolphins were observed to die during the catch. Dolphin populations have been depleted by as much as 80 percent. The dolphin-safe label stopped this trend and has proved one of the most successful consumer initiatives in U.S. history. Americans care about what is left of our natural resources and the threatened creatures who inhabit them.

The Studds amendment maintains the integrity of the dolphin-safe sticker to the definition of the label. Dolphin-safe must mean that dolphins are safe and not injured or killed in the hunt for tuna.

H.R. 2823 allows an increase in the dolphin deaths and unlimited injury and harassment of dolphin. That is by no means dolphin-safe.

Mr. Chairman, I urge our colleagues to support the Studds amendment which would enable us to keep the promise made to the American people. The trade agreements would not result in the weakening of U.S. environmental laws. At the same time, it would help us live up to those trade obligations and protect dolphins. I urge an ''aye'' vote on the Studds amendment.

Mr. SAXTON. Mr. Chairman, I yield 1 minute to the gentleman from Maryland [Mr. GILCHREST] who is busy reerecting some visual aids.

Mr. GILCHREST. Mr. Chairman, I thank the gentleman for yielding the time.

If I may, the gentleman from California asked me to get my own chart so I will not use the chart that the gentlewoman from California [Ms. PELOSI] used just a second ago. What I would like to do, when we looked at the chart from Ms. PELOSI, the fine gentlewoman from California, she showed us a dolphin sort of beat up and said that that is what is going to happen under our bill, and then a dolphin that looked really healthy and find and not beat up. That is what would happen with their bill and their dolphin-safe bill.

What I want to explain though, just another point, existing law, 10,000–40,000 dolphins are killed that are not observed. Many likely are killed in the process of catching tuna fish that are sold in the United States because we do not observe those deaths as dolphin-safe with the label.

What we want to do is put an observer on every single boat, every single time they fish for dolphins, every single time they fish for tuna, and they cannot sell that tuna in the United States unless they have a licensed observer on board. We want to protect the system, protect the truth in labeling. Vote against the Studds amendment.

Mr. STUDDS. Mr. Chairman, I yield 2 minutes to the gentleman from California [Mr. MILLER] so that he may politely but devastatingly respond to the gentleman from Maryland.

Mr. MILLER of California. Mr. Chairman, the chart is terribly graphic and makes the point. We will have observers on the boat. What observers can observe is dolphins being, for example, encircled, harassed, hunted down, maimed, and injured. Under that bill that is what is allowed.

Under current law, that is not allowed, that is not allowed. And to be sold on supermarket shelves, the tuna that results cannot be sold as dolphin-safe. What we are saying is, you can have your ocean management techniques, you can try your bycatch, you can do all of those things. But when it results in a dolphin being maimed, being harassed and being chased and being stressed and being exhausted, do not try to tell the American consumer that that is dolphin-safe.

What the Studds amendment says is let the consumer choose. Let the consumer choose. They can choose the existing can of tuna with the existing label under the Studds amendment that they know is dolphin-safe. Or they can choose some pale imitation that lets you kill an increased number of dolphins, lets you harass, lets you encircle, lets you stress, lets you harm, lets you maim, all with observers.

The American people do not want observers to this activity. They want an end to this activity. That is what the Studds amendment allows to happen.

Mr. STUDDS. Mr. Chairman, I yield myself 30 seconds.

I observe no further requests for time on this side. If the gentleman has the right to close and intends to use it, I trust he will do it with humane brevity. I challenge the gentleman to prove to a certainty that anything that can be said has not already been said.

With that in mind and secure in the feeling that what has been said on behalf of the amendment far outweighs in subtlety and in strength and in humor and goodwill that which has been said in opposition to the amendment, I confidently, quietly, and quickly yield back the balance of my time.

Mr. SAXTON. Mr. Chairman, I yield myself such time as I may consume for purposes of closing debate.

Mr. Chairman, I think the gentleman is right. Much of what has been said has been said. It is pretty obvious to me that the weight of the arguments in opposition to the gentleman's amendment are strong and heavy and that we should move to a vote, hopefully directly to final passage.

Just let me close by summarizing. A vote in favor of final passage and previously to that, I suppose, against the Studds amendment enables the United States to join with 11 other countries to put in place fishing methods agreed to by those 12 countries that will protect dolphins, protect sea turtles, protect sharks, protect billfish, and protect juvenile tuna. That is what the gentleman from California [Mr. BILBRAY] was referring to when he talked about multispecies management.

It is true, I suspect, that if we were to reject this bill and in so doing enact the Studds amendment, I suppose that unilaterally we could protect dolphins in 1 country out of the 12. My understanding is that that includes presently something in the neighborhood of six to eight fishing boats on the west coast of the United States. That is what we would be regulating, six to eight boats in one country as opposed to many boats in a dozen countries.

In addition to that, Mr. Chairman, I would just like to point out, once again, that it would be unusual for the major environmental groups, including the National Wildlife Federation, the Environmental Defense Fund, Greenpeace, the World Wildlife Fund, the Center for Marine Conservation, and others to join with this chairman of the Subcommittee on Fisheries, Wildlife and Oceans and the Clinton administration and variety of labor groups in supporting final passage of this bill, if it were subject to all of the charges that have been made by some of the opponents.

Obviously, we hope that this bill passes. As one who has been a supporter of marine wildlife and aqua wildlife all of my career, along with many other Members, such as Mr. GILCHREST and others from both sides, we believe on a bipartisan basis that this bill deserves to be passed, should be passed, and will implement a very important international agreement.

Mr. Chairman, I ask Members on both sides of the aisle for strong bipartisan support and encourage a ''no'' vote on the Studds amendment and obviously a ''yes'' vote on final passage.

Mr. OLVER. Mr. Chairman, this amendment offers American consumers exactly what we know they want. It took American citizens more than two decades to get the Congress to end the slaughter of dolphins and adopt dolphin-safe labeling of tuna.

The terrible pictures of herds of dead dolphins in a sea of red are practically gone from memory. It's been great environmental success.

Without the Studds amendment the underlying bill moves us backward. No, it doesn't mean that we'll return to the days of mass dolphin slaughter, but it does mean that dolphins will be chased, harassed, and encircled.

Perhaps there is no mammal more symbolic of American's love and concern for animals—than the dolphin.

As this Congress desperately attempts to recast itself in the wake of its poor environmental record—no vote is easier and will please such a broad spectrum of the American public than the Studds amendment.

Recently, this Congress has voted for consumer-friendly right-to-know provisions in several bills.

Yet today, this bill aims to confuse the dolphin-safe label and deceive the American public.

Americans want to know which tuna has been caught without risks to dolphins.

The dolphin-safe label ought to mean what it says.

Finally, I believe it's fair to say that no one in recent memory in this body has done so much to protect so many of one individual species than my colleague from Massachusetts.

We should honor his 20 years of work and expertise by supporting the Studds amendment.

If Studds does not pass—we could be faced with another tuna boycott until the American public can be sure that dolphin-safe labels are telling the truth.

Ms. ESHOO. Mr. Chairman, I rise in support of this important and necessary amendment, and I thank Representatives STUDDS and MILLER for all of their efforts to protect our planet's ocean life and our Nation's consumers.

Mr. Chairman, this amendment is simple: It protects dolphins from being chased, harassed, injured, or encircled with nets by tuna fishermen.

It's necessary because the underlying legislation would allow unlimited harassment and injuring of dolphins, so long as no more than 5,000 are actually killed in the eastern tropical Pacific each year. Despite increased deaths and injury to dolphins, tuna caught under the provisions of the underlying legislation could still be labeled in the United States as dolphin-safe. That's not acceptable. In my view, there should be zero dolphin deaths associated with our dolphin-safe label.

Seven years ago, 100,000 dolphins were slaughtered each year. As a result of the U.S. tuna industry's voluntary policy of refusing to purchase tuna caught while harming or killing dolphins, that number has dropped to approximately 3,200—an impressive 97 percent.

The Studds amendment retains the integrity of the dolphin safe label by ensuring that dolphins are not harassed while fishing for tuna. Although H.R. 2823, even if improved by the Studds/Miller amendment, would condone more dolphin deaths than are associated with the current U.S. dolphin safe label, it would actually result in fewer dolphin deaths worldwide. This is because only 5,000 deaths total would be permitted, and only those foreign fishermen that fish in compliance with the 5,000 limit would be able to sell their tuna to the U.S. market.

Consumers need to know that dolphin safe means what it says. The Studds amendment although imperfect, helps move us in that direction.

Mr. Chairman, I urge my colleagues to support the Studds amendment, support the wishes of the American consumer, and support the dolphins.

Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. The question is on the amendment offered by the gentleman from Massachusetts [Mr. STUDDS].

The question was taken; and the Chairman announced that the noes appeared to have it.

RECORDED VOTE

Mr. STUDDS. Mr. Chairman, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 161, noes 260, not voting 12, as follows:

[Roll No. 384]

AYES—161

Abercrombie	Farr	Lipinski
Andrews	Fattah	Lofgren
Baldacci	Fazio	Lowey
Barcia	Fields (LA)	Maloney
Barrett (WI)	Filner	Manton
Becerra	Flanagan	Markey
Berman	Foglietta	Martini
Bilirakis	Foley	Mascara
Blumenauer	Forbes	McDermott
Blute	Frank (MA)	McHale
Bonior	Franks (NJ)	McKinney
Borski	Frost	McNulty
Brown (CA)	Furse	Meehan
Brown (FL)	Gejdenson	Meek
Brown (OH)	Gephardt	Menendez
Bryant (TN)	Goodling	Meyers
Bunn	Gordon	Millender-McDonald
Campbell	Green (TX)	Miller (CA)
Chabot	Gutierrez	Mink
Clay	Hall (OH)	Moakley
Clayton	Harman	Mollohan
Clyburn	Hastings (FL)	Moran
Coleman	Hilliard	Murtha
Collins (IL)	Hinchey	Nadler
Collins (MI)	Holden	Neal
Conyers	Jackson (IL)	Ney
Costello	Jackson-Lee (TX)	Oberstar
Coyne	Jacobs	Obey
Cummings	Jefferson	Olver
de la Garza	Johnson (SD)	Owens
DeFazio	Johnson, E. B.	Pallone
DeLauro	Jones	Payne (NJ)
Dellums	Kanjorski	Pelosi
Deutsch	Kaptur	Poshard
Dixon	Kennedy (MA)	Rahall
Doggett	Kennedy (RI)	Rangel
Dornan	Kildee	Reed
Doyle	Kleczka	Rivers
Durbin	Klink	Rose
Engel	LaHood	Roybal-Allard
Ensign	Lantos	Rush
Eshoo	Lewis (GA)	Sabo
Evans		

Sanders
Sanford
Schiff
Schroeder
Schumer
Scott
Shays
Slaughter
Smith (NJ)
Spratt
Stark
Stokes
Studds
Stupak
Taylor (MS)
Thornton
Torres
Torricelli
Velazquez
Vento
Visclosky
Volkmer
Wamp
Ward
Waters
Watt (NC)
Waxman
Weller
Wilson
Wise
Woolsey
Wynn
Yates
Zimmer

NOES—260

Ackerman
Allard
Archer
Armey
Baesler
Baker (CA)
Baker (LA)
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Beilenson
Bentsen
Bereuter
Bevill
Bilbray
Bishop
Bliley
Boehlert
Boehner
Bonilla
Bono
Boucher
Brewster
Browder
Bryant (TX)
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Cardin
Castle
Chambliss
Chapman
Chenoweth
Christensen
Chrysler
Clement
Clinger
Coble
Coburn
Collins (GA)
Combest
Condit
Cooley
Cox
Cramer
Crane
Crapo
Cremeans
Cubin
Cunningham
Danner
Davis
Deal
DeLay
Diaz-Balart
Dickey
Dicks
Dingell
Dooley
Doolittle
Dreier
Duncan
Dunn
Edwards
Ehlers
Ehrlich
English
Everett
Ewing
Fawell
Fields (TX)
Fowler
Fox
Franks (CT)
Frelinghuysen
Frisa
Funderburk
Gallegly
Ganske
Gekas
Geren
Gibbons
Gilchrest
Gillmor
Gilman
Gonzalez
Goodlatte
Goss
Graham
Greene (UT)
Greenwood
Gunderson
Gutknecht
Hall (TX)
Hamilton
Hancock
Hansen
Hastings (WA)
Hayes
Hayworth
Hefley
Hefner
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Horn
Hostettler
Houghton
Hoyer
Hunter
Hutchinson
Hyde
Inglis
Istook
Johnson (CT)
Johnson, Sam
Johnston
Kasich
Kelly
Kennelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
LaFalce
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Levin
Lewis (CA)
Lewis (KY)
Lightfoot
Lincoln
Linder
Livingston
LoBiondo
Longley
Lucas
Luther
Manzullo
Matsui
McCarthy
McCollum
McHugh
McInnis
McIntosh
McKeon
Metcalf
Mica
Miller (FL)
Minge
Molinari
Montgomery
Moorhead
Morella
Myers
Myrick
Nethercutt
Neumann
Norwood
Nussle
Ortiz
Orton
Oxley
Packard
Parker
Pastor
Paxon
Payne (VA)
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pombo
Pomeroy
Porter
Portman
Pryce
Quillen
Quinn
Radanovich
Ramstad
Regula
Richardson
Riggs
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Roukema
Royce
Salmon
Sawyer
Saxton
Scarborough
Schaefer
Seastrand
Sensenbrenner
Shadegg
Shaw
Shuster
Sisisky
Skaggs
Skeen
Skelton
Smith (MI)
Smith (TX)
Smith (WA)
Solomon
Souder
Spence
Stearns
Stenholm
Stockman
Stump
Talent
Tanner
Tate
Tauzin
Taylor (NC)
Tejeda
Thompson
Thornberry
Thurman
Tiahrt
Torkildsen
Traficant
Upton
Vucanovich
Walker
Walsh
Watts (OK)
Weldon (FL)
Weldon (PA)
White
Whitfield
Wicker
Williams
Wolf
Young (AK)
Zeliff

NOT VOTING—12

Bachus
Brownback
Flake
Ford
Hastert
Martinez
McCrery
McDade
Serrano
Thomas
Towns
Young (FL)

□ 2000

Mr. ARCHER changed his vote from ''aye'' to ''no.''

Ms. VELÁZQUEZ, Mr. RAHALL, and Mr. HOLDEN changed their vote from ''no'' to ''aye.''

So the amendment was rejected.

The result of the vote was announced as above recorded.

The CHAIRMAN. The question is on the amendment in the nature of a substitute.

The amendment in the nature of a substitute was agreed to.

The CHAIRMAN. Under the rule, the Committee rises.

Accordingly the Committee rose; and the Speaker pro tempore (Mr. FOX of Pennsylvania) having assumed the chair, Mr. COLLINS of Georgia, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, have had under consideration the bill (H.R. 2823) to amend the Marine Mammal Protection Act of 1972 to support the International Dolphin Conservation Program in the eastern tropical Pacific Ocean, and for other purposes, pursuant to House Resolution 489, he reported the bill back to the House with the amendment adopted by the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

The question is on the amendment in the nature of a substitute.

The amendment in the nature of a substitute was agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. SAXTON. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 316, noes 108, not voting 9, as follows:

[Roll No. 385]

AYES—316

Ackerman
Allard
Archer
Armey
Baesler
Baker (CA)
Baker (LA)
Ballenger
Barr
Barrett (NE)
Bartlett
Barton
Bass
Bateman
Becerra
Beilenson
Bentsen
Bereuter
Berman
Bevill
Bilbray
Bishop
Bliley
Blumenauer
Blute
Boehlert
Boehner
Bonilla
Bono
Borski
Boucher
Brewster
Browder
Brown (FL)
Bryant (TN)
Bryant (TX)
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Cardin
Castle
Chambliss
Chapman
Chenoweth
Christensen
Chrysler
Clement
Clinger
Clyburn
Coble
Coburn
Collins (GA)
Combest
Condit
Cooley
Cox
Cramer
Crane
Crapo
Cremeans
Cubin
Cummings
Cunningham
Danner
Davis
de la Garza
DeLay
Deutsch
Diaz-Balart
Dickey
Dicks
Dingell
Dixon
Doggett
Dooley
Doolittle
Dreier
Duncan
Dunn
Edwards
Ehlers
Ehrlich
English
Ensign
Everett
Ewing
Fawell
Fazio
Fields (LA)
Fields (TX)
Flanagan
Foley
Forbes
Fowler
Fox
Franks (CT)
Frelinghuysen
Frisa
Frost
Funderburk
Gallegly
Ganske
Gekas
Geren
Gibbons
Gilchrest
Gillmor
Gilman
Gonzalez
Goodlatte
Goodling
Gordon
Goss
Graham
Green (TX)
Greene (UT)
Greenwood
Gunderson
Gutknecht
Hall (OH)
Hall (TX)
Hamilton
Hancock
Hansen
Harman
Hastert
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hefner
Heineman
Herger
Hilleary
Hobson
Hoekstra
Hoke
Holden
Horn
Hostettler
Houghton
Hoyer
Hunter
Hutchinson
Hyde
Inglis
Istook
Jackson-Lee (TX)
Johnson (CT)
Johnson, Sam
Johnston
Jones
Kasich
Kelly
Kennelly
Kim
King
Kingston
Klug
Knollenberg
Kolbe
LaFalce
LaHood
Largent
Latham
LaTourette
Laughlin
Lazio
Leach
Levin
Lewis (CA)
Lewis (KY)
Lightfoot
Lincoln
Linder
Livingston
LoBiondo
Longley
Lucas
Luther
Manton
Manzullo
Martini
Mascara
Matsui
McCarthy
McCollum
McDermott
McHale
McHugh
McInnis
McIntosh
McKeon
Meek
Metcalf
Mica
Miller (FL)
Minge
Mink
Molinari
Mollohan
Montgomery
Moorhead
Moran
Morella
Myers
Myrick
Nethercutt
Ney
Norwood
Nussle
Ortiz
Orton
Oxley
Packard
Parker
Pastor
Paxon
Payne (VA)
Peterson (FL)
Peterson (MN)
Petri
Pickett
Pombo
Pomeroy
Porter
Portman
Pryce
Quillen
Quinn
Radanovich
Rahall
Ramstad
Rangel
Reed
Regula
Richardson
Riggs
Roberts
Roemer
Rogers
Rohrabacher
Ros-Lehtinen
Roth
Roukema
Roybal-Allard
Royce
Salmon
Sawyer
Saxton
Scarborough
Schaefer
Schiff
Scott
Seastrand
Sensenbrenner
Shadegg
Shaw
Shays
Shuster
Sisisky
Skaggs
Skeen
Skelton
Slaughter
Smith (MI)
Smith (TX)
Smith (WA)
Solomon
Souder
Spence
Stearns
Stenholm
Stockman
Stump
Stupak
Talent
Tanner
Tate
Tauzin
Taylor (NC)
Tejeda
Thomas
Thompson
Thornberry
Thornton
Torkildsen
Torres
Traficant
Upton
Visclosky
Vucanovich
Walker
Walsh
Wamp
Ward
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
White
Whitfield
Wicker
Williams
Wilson
Wise
Wolf
Yates
Young (AK)
Zeliff

NOES—108

Abercrombie
Andrews
Baldacci
Barcia
Barrett (WI)
Bilirakis
Bonior
Brown (CA)
Brown (OH)

Bunn	Jacobs	Owens
Campbell	Jefferson	Pallone
Chabot	Johnson (SD)	Payne (NJ)
Clay	Johnson, E. B.	Pelosi
Clayton	Kanjorski	Poshard
Coleman	Kaptur	Rivers
Collins (IL)	Kennedy (MA)	Rose
Collins (MI)	Kennedy (RI)	Rush
Conyers	Kildee	Sabo
Costello	Kleczka	Sanders
Coyne	Klink	Sanford
Deal	Lantos	Schroeder
DeFazio	Lewis (GA)	Schumer
DeLauro	Lipinski	Serrano
Dellums	Lofgren	Smith (NJ)
Dornan	Lowey	Spratt
Doyle	Maloney	Stark
Durbin	Markey	Stokes
Engel	McKinney	Studds
Eshoo	McNulty	Taylor (MS)
Evans	Meehan	Thurman
Farr	Menendez	Tiahrt
Fattah	Meyers	Torricelli
Filner	Millender-McDonald	Velazquez
Foglietta	Miller (CA)	Vento
Frank (MA)	Moakley	Volkmer
Franks (NJ)	Murtha	Waters
Furse	Nadler	Watt (NC)
Gejdenson	Neal	Waxman
Gephardt	Neumann	Woolsey
Gutierrez	Oberstar	Wynn
Hilliard	Obey	Zimmer
Hinchey	Olver	
Jackson (IL)		

NOT VOTING—9

Bachus	Ford	McDade
Brownback	Martinez	Towns
Flake	McCrery	Young (FL)

☐ 2020

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. GILCHREST. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on the bill just passed.

The SPEAKER pro tempore (Mr. FOX of Pennsylvania). Is there objection to the request of the gentleman from Maryland?

There was no objection.

TEAMWORK FOR EMPLOYEES AND MANAGERS ACT OF 1995—VETO MESSAGE FROM THE PRESIDENT OF THE UNITED STATES

The SPEAKER pro tempore. The unfinished business is the further consideration of the veto message of the President on the bill (H.R. 743) to amend the National Labor Relations Act to allow labor management cooperative efforts that improve economic competitiveness in the United States to continue to thrive, and for other purposes.

Mr. GOODLING. Mr. Speaker, I ask unanimous consent that the veto message of the President, together with the accompanying bill, H.R. 743, be referred to the Committee on Economic and Educational Opportunities.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Pennsylvania?

There was no objection.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 123, ENGLISH LANGUAGE EMPOWERMENT ACT OF 1996

Mr. GOSS, from the Committee on Rules, submitted a privileged report (Rept. 104–734) on the resolution (H. Res. 499) providing for consideration of the bill (H.R. 123) to amend title 4, United States Code, to declare English as the official language of the Government of the United States, which was referred to the House Calendar and ordered to be printed.

CONFERENCE REPORT ON H.R. 3754, LEGISLATIVE BRANCH APPROPRIATIONS ACT, 1997

Mr. PACKARD submitted the following conference report and statement on the bill (H.R. 3754) making appropriations for the legislative branch for the fiscal year ending September 30, 1997, and for other purposes:

CONFERENCE REPORT (H. REPT. 104–733)

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 3754) ''making appropriations for the Legislative Branch for the fiscal year ending September 30, 1997, and for other purposes,'' having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its amendments numbered 9, 20, 23, and 24.

That the House recede from its disagreements to the amendments of the Senate numbered 1, 2, 6, 10, 11, 12, 13, 14, 17, 18, and 19, and agree to the same.

Amendment Numbered 3:

That the House recede from its disagreement to the amendment of the Senate numbered 3, and agree to the same with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert: *$2,750,000*; and the Senate agree to the same.

Amendment Numbered 4:

That the House recede from its disagreement to the amendment of the Senate numbered 4, and agree to the same with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert: *$69,356,000*; and the Senate agree to the same.

Amendment Numbered 5:

That the House recede from its disagreement to the amendment of the Senate numbered 5, and agree to the same with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert: *$33,437,000*; and the Senate agree to the same.

Amendment Numbered 7:

That the House recede from its disagreement to the amendment of the Senate numbered 7, and agree to the same with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert: *$2,782,000*; and the Senate agree to the same.

Amendment Numbered 8:

That the House recede from its disagreement to the amendment of the Senate numbered 8, and agree to the same with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert: *$24,532,000*; and the Senate agree to the same.

Amendment Numbered 15:

That the House recede from its disagreement to the amendment of the Senate numbered 15, and agree to the same with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert: *$9,753,000*; and the Senate agree to the same.

Amendment Numbered 16:

That the House recede from its disagreement to the amendment of the Senate numbered 16, and agree to the same with an amendment, as follows:

In lieu of the sum proposed by said amendment, insert: *$1,310,000*; and the Senate agree to the same.

Amendment Numbered 21:

That the House recede from its disagreement to the amendment of the Senate numbered 21, and agree to the same with an amendment, as follows:

In lieu of the matter proposed by said amendment, insert:

SEC. 314. (A) Upon enactment into law of this Act, there shall be established a program for providing the widest possible exchange of information among legislative branch agencies with the long range goal of improving information technology planning and evaluation. The Committee on House Oversight of the House of Representatives and the Committee on Rules and Administration of the Senate are requested to determine the structure and operation of this program and to provide appropriate oversight. All of the appropriate offices and agencies of the legislative branch as defined below shall participate in this program for information exchange, and shall report annually on the extent and nature of their participation in their budget submissions to the Committee on Appropriations of the House of Representatives and the Committee on Appropriations of the Senate.

(B) As used in this section—

(1) the term ''offices and agencies of the legislative branch'' means the office of the Clerk of the House, the office of the Secretary of the Senate, the office of the Architect of the Capitol, the General Accounting Office, the Government Printing Office, the Library of Congress, the Congressional Research Service, the Congressional Budget Office, the Chief Administrative Officer of the House of Representatives, and the Sergeant at Arms of the Senate; and

(2) the term ''technology'' refers to any form of computer hardware and software; computer-based systems, services, and support for the creation, processing, exchange, and delivery of information; and telecommunications systems, and the associated hardware and software, that provide for voice, data, or image communication.

And the Senate agree to the same.

Amendment Numbered 22:

That the House recede from its disagreement to the amendment of the Senate numbered 22, and agree to the same with an amendment, as follows:

In lieu of the of the first section number named in said amendment, insert: *315;* and the Senate agree to the same.

Amendment Numbered 25:

That the House recede from its disagreement to the amendment of the Senate numbered 25, and agree to the same with an amendment, as follows:

In lieu of the of the first section number named in said amendment, insert: *316* and at the end of the matter proposed by said amendment, insert the following:

Sec. 317. For payment to Jo Ann Emerson, widow of Bill Emerson, late a Representative from the State of Missouri, $133,600.

And the Senate agree to the same.

RON PACKARD,
CHARLES H. TAYLOR,
DAN MILLER,
ROGER F. WICKER,
BOB LIVINGSTON,
RAY THORNTON,
JOSÉ SERRANO,
VIC FAZIO,
DAVID R. OBEY,
Managers on the Part of the House.

CONNIE MACK,
ROBERT F. BENNETT,
BEN NIGHTHORSE CAMPBELL,
MARK O. HATFIELD,
PATTY MURRAY,
BARBARA A. MIKULSKI,
ROBERT C. BYRD,
Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes on the two Houses on the amendments of the Senate to the bill (H.R. 3754) making appropriations for the Legislative Branch for the fiscal year ending September 30, 1997, and for other purposes, submit the following joint statement to the House and Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report.

TITLE I—CONGRESSIONAL OPERATIONS

SENATE

Amendment No. 1: Appropriates $441,208,000 for the operations of the Senate, and contains several administrative provisions. Inasmuch as the amendment relates solely to the Senate and in accord with long practice under which each body determines its own housekeeping requirements and the other concurs without intervention, the managers on the part of the House, at the request of the managers on the part of the Senate, have receded to the Senate amendment.

HOUSE OF REPRESENTATIVES

The managers on the part of the House, with the concurrence of the managers on the part of the Senate, support the policy of disposing of excess House computer equipment for the use of elementary and secondary schools, comparable to the program established by the Senate. The House managers note that, under current statute, the Committee on House Oversight has the authority to make such dispositions.

JOINT ITEMS

JOINT COMMITTEE ON INAUGURAL CEREMONIES OF 1997

Amendment No. 2: Deletes $950,000, and related provisions, appropriated for the Joint Committee on Inaugural Ceremonies of 1997 as proposed by the House and inserts $950,000, together with related provisions, appropriated for the Joint Committee on Inaugural Ceremonies of 1997 as proposed by the Senate. These funds are provided in accordance with Senate Concurrent Resolutions 47 and 48, 104th Congress, agreed to in the Senate on March 20, 1996.

JOINT ECONOMIC COMMITTEE

Amendment No. 3: Appropriates $2,750,000 for the Joint Economic Committee instead of $3,000,000 as proposed by the House and $750,000 as proposed by the Senate. The conferees agree that the long term need for this committee should be reviewed and expect the funding to be phased down to zero in the future.

CAPITOL POLICE BOARD

CAPITOL POLICE

SALARIES

Amendment No. 4: Appropriates $69,356,000 for the salaries and related personnel expenses of the Capitol Police instead of $68,392,000 as proposed by the House and $70,132,000 as proposed by the Senate. The conferees believe that the information and systems that support Capitol Police financial management processes are in need of improvement. To some extent, the transfer of payroll/personnel recordkeeping to the National Finance Center will lead to significant improvement in the reliability and accuracy of financial data, but other accounting and management information systems also require attention.

Amendment No. 5: Provides $33,437,000 to the Sergeant at Arms of the House of Representatives, to be disbursed by the Chief Administrative Officer of the House, for the Capitol Police assigned to the House rolls instead of $32,927,000 as proposed by the House and $34,213,000 as proposed by the Senate.

Amendment No. 6: Provides $35,919,000 to the Sergeant at Arms and Doorkeeper of the Senate, to be disbursed by the Secretary of the Senate, for the Capitol Police assigned to the Senate rolls as proposed by the Senate instead of $35,465,000 as proposed by the House.

GENERAL EXPENSES

Amendment No. 7: Appropriates $2,782,000 for general expenses of the Capitol Police instead of $2,685,000 as proposed by the House and $2,880,000 as proposed by the Senate. The additional funds provided above the House bill are provided for vehicle replacement.

CONGRESSIONAL BUDGET OFFICE

SALARIES AND EXPENSES

Amendment No. 8: Appropriates $24,532,000 for salaries and expenses, Congressional Budget Office, instead of $24,288,000 as proposed by the House and $24,775,000 as proposed by the Senate.

ARCHITECT OF THE CAPITOL

CAPITOL BUILDINGS AND GROUNDS

CAPITOL BUILDINGS

Amendment No. 9: Appropriates $23,255,000 for Capitol buildings, Architect of the Capitol as proposed by the House instead of $23,555,000 as proposed by the Senate.

The conferees note that the Capitol Police, due to legislation enacted in the District of Columbia Appropriations Act for Fiscal Year 1996, will inherit the D.C. canine facility located at Blue Plains at a site adjacent to the Botanic Garden plant nursery. In the meantime, through a reprogramming of funds made available by the Committees on Appropriations, the Capitol Police canine operation was relocated, on July 24, 1996, to a site adjacent to the buildings, training grounds, and kennels they will occupy when the D.C. canine operation vacates. This recent Capitol Police relocation was accomplished within a few months of learning of extremely hazardous conditions at the former location, and includes new kennels, training grounds, temporary office and classroom buildings, and other facilities necessary to continue this very important security program. The Committees on Appropriations have been advised that the space being developed for the D.C. canine operation will be completed by February 27, 1997. The conferees expect that the Architect of the Capitol and the Capitol Police will make the necessary arrangements to move into those quarters immediately upon their availability. In the meantime, the conferees believe that the Architect of the Capitol should survey the need for renovations at the D.C. canine facility. If it is determined that renovations are necessary, the Committees on Appropriations will entertain a request to reprogram funds based upon the receipt of adequate engineering estimates, plans, and design documentation.

HOUSE OFFICE BUILDINGS

The managers on the part of the House, with the concurrence of the managers on the part of the Senate, direct that all employees displaced by the custodial contract at the Ford House Office Building will be absorbed in available vacant positions and expect every effort to be made to place them in positions of equal or comparable pay.

SENATE OFFICE BUILDINGS

Amendment No. 10: Appropriates $39,640,000, of which $3,200,000 shall remain available until expended, for the operations of the Senate office buildings. Inasmuch as the amendment relates solely to the Senate and in accord with long practice under which each body determines its own housekeeping requirements and the other concurs without intervention, the managers on the part of the House, at the request of the managers on the part of the Senate, have receded to the Senate amendment.

TITLE II—OTHER AGENCIES

LIBRARY OF CONGRESS

SALARIES AND EXPENSES

Amendment No. 11: Provides $216,007,000 for salaries and expenses, Library of Congress as proposed by the Senate instead of $215,007,000 as proposed by the House. The conferees agree with the Senate report language regarding the deputy Librarian of Congress.

Amendment No. 12: Earmarks $928,800 for the operation of the American Folklife Center as proposed by the Senate.

ADMINISTRATIVE PROVISIONS

Amendment No. 13: Deletes a provision proposed by the House and stricken by the Senate authorizing account-to-account transfers, subject to approval, of funds appropriated in the bill to the Library of Congress.

Amendment No. 14: Provides a two-year authorization for the American Folklife Center as proposed by the Senate.

ARCHITECT OF THE CAPITOL

LIBRARY BUILDINGS AND GROUNDS

STRUCTURAL AND MECHANICAL CARE

Amendment No. 15: Appropriates $9,753,000 for structural and mechanical care, Library buildings and grounds, Architect of the Capitol instead of $9,003,000 as proposed by the House and $10,453,000 as proposed by the Senate. These funds include $750,000 above the House bill for an uninterruptible power supply. The conferees note that the additional amounts provided were not included in the budget request transmitted to the Congress.

Amendment No. 16: Provides that $1,310,000 shall remain available until expended for structural and mechanical care, Library buildings and grounds instead of $560,000 as proposed by the House and $1,910,000 as proposed by the Senate.

GENERAL ACCOUNTING OFFICE

SALARIES AND EXPENSES

The conferees agree that funding included for the General Accounting Office contract audit services is $8,000,000.

TITLE III—GENERAL PROVISIONS

Amendment No. 17: Deletes a provision proposed by the House and stricken by the Senate regarding dynamic macroeconomic scoring of certain spending and revenue legislation.

Amendment No. 18: Authorizes law enforcement personnel of the Capitol Police to elect to receive compensatory time off in lieu of overtime compensation in excess of the maximum for their work period as proposed by the Senate.

Amendment No. 19: Makes a date change in section 316 of Public Law 101–302 regarding Senate artwork as proposed by the Senate.

Amendment No. 20: Deletes a provision proposed by the Senate that the Government Printing Office shall be considered an agency and the Public Printer shall be considered the head of the agency for purposes of sections 801(b)(2)(B) and 801(b)(2)(C), respectively, of the National Energy Conservation Policy Act.

Amendment No. 21: Changes a section number and amends a provision inserted by

the Senate regarding technology planning, evaluation, development, and management in the legislative branch. The conference agreement requests the Senate Committee on Rules and the Committee on House Oversight to oversee a program for providing the widest possible exchange of information among legislative branch agencies with the long range goal of improving information technology planning and evaluation.

The conferees note that the Committee on House Oversight and the Senate Committee on Rules and Administration have begun a process to develop a common information system. The Clerk of the House and the Secretary of the Senate have been called upon to coordinate the project with the oversight of those Committees and to ultimately propose the standards for a legislative branch wide information system to the Committees for approval.

An open exchange of technology, projects, plans and developments is crucial to the success of a legislative branch wide information system. The conferees expect, therefore, that the following organizations will be relied upon to participate and assist in this effort: the Clerk of the House, the Chief Administrative Officer of the House, the office of the Secretary of the Senate, the Sergeant at Arms of the Senate, the Library of Congress, the Government Printing Office, House Information Resources, the Senate Computer Center, the General Accounting Office, the Congressional Budget Office, and the office of the Architect of the Capitol.

Section 209 of the Legislative Branch Appropriations Act, 1996, directed the Library of Congress to develop a plan and supporting analyses for this system. In so doing, the Library identified the major programs under development in various parts of the legislative branch as well as a significant amount of duplication. The process begun by the oversight committees will enable the strengths of each program to be recognized and integrated into a system that will benefit Congress as a whole.

Amendment No. 22: Retains a provision proposed by the Senate, amended to change a section number, that amends section 3303 of Title 5, United States Code, together with technical and conforming amendments, regarding recommendations made by Senators and Representatives for applicants to the competitive service.

Amendment No. 23: Deletes a provision proposed by the Senate regarding an electronic information system. The managers on the part of the House and Senate agree that the Congressional Research Service, upon the request of the Senate Committee on Rules and Administration, and in consultation with the Secretary of the Senate and the heads of the appropriate offices and agencies of the legislative branch, shall coordinate the development of an electronic congressional legislative information and document retrieval system to provide for the legislative information needs of the Senate through the exchange and retrieval of information and documents among legislative branch offices and agencies. The managers on the part of the House and the Senate also agree that the Library of Congress shall assist the Congressional Research Service in supporting the Senate in this effort, and shall provide technical staff and resources as may be necessary.

Amendment No. 24: Deletes a provision inserted by the Senate regarding employment limitations under section 207(e) of title 18, United States Code.

Amendment No. 25: Retains a provision proposed by the Senate, amended to change a section number, that amends Chapter 1 of title 17, United States Code, to exempt from infringement of copyright the reproduction or distribution of certain publications in specialized formats exclusively for use by blind or other persons with disabilities. In addition, the conferees, at the request of the managers on the part of the House, have inserted a provision that provides the traditional death gratuity for the widow of Bill Emerson, late a Representative from the State of Missouri.

CONFERENCE TOTAL—WITH COMPARISONS

The total new budget (obligational) authority for the fiscal year 1997 recommended by the Committee of Conference, with comparisons to the fiscal year 1996 amount, the 1997 budget estimates, and the House and Senate bills for 1997 follow:

New budget (obligational) authority, fiscal year 1996	$2,187,356,000
Budget estimates of new (obligational) authority, fiscal year 1997	2,339,421,000
House bill, fiscal year 1997	1,681,311,000
Senate bill, fiscal year 1997	2,165,081,000
Conference agreement, fiscal year 1997	2,165,097,600
Conference agreement compared with:	
New budget (obligational) authority, fiscal year 1996	−22,258,400
Budget estimates of new (obligational) authority, fiscal year 1997	−174,323,400
House bill, fiscal year 1997	+483,786,600
Senate bill, fiscal year 1997	+16,000

RON PACKARD,
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VIC FAZIO,
DAVID R. OBEY,
Managers on the Part of the House.

CONNIE MACK,
ROBERT F. BENNETT,
BEN NIGHTHORSE CAMPBELL,
MARK O. HATFIELD,
PATTY MURRAY,
BARBARA A. MIKULSKI,
ROBERT C. BYRD,
Managers of the Part of the Senate.

PROVIDING FOR DISPOSAL OF PUBLIC LANDS IN SUPPORT OF MANZANAR HISTORIC SITE

Mr. HANSEN. Mr. Speaker, I ask unanimous consent for the immediate consideration in the House of the bill (H.R. 3006) to provide for disposal of public lands in support of the Manzanar Historic Site in the State of California, and for other purposes.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Utah?

Mr. MILLER of California. Mr. Speaker, reserving the right to object, I yield to the gentleman from California [Mr. LEWIS] to explain the purpose of the bill.

(Mr. LEWIS of California asked and was given permission to revise and extend his remarks.)

Mr. LEWIS of California. I appreciate the gentleman yielding.

Mr. Speaker, responding to the gentleman from California, this bill is designed to add additional land to the Manzanar Historic Site. I think the House knows that that was a major location whereby Americans of Japanese descent were interned during World War II, and it is combined with a rather fantastic environmental project taking place between the country of Inyo and the Los Angeles Department of Water and Power.

Mr. MILLER of California. I thank the gentleman.

Mr. Speaker, further reserving the right to object, I yield to the gentleman from California [Mr. MATSUI].

(Mr. MATSUI asked and was given permission to revise and extend his remarks.)

Mr. MATSUI. I thank the gentleman from California for yielding.

Mr. Speaker, I thank the gentleman from California [Mr. LEWIS] for leading the way on this piece of legislation. We really appreciate all he has done as well as, of course, the gentleman from Utah [Mr. HANSEN], the gentleman from Alaska [Mr. YOUNG], the gentleman from California [Mr. MILLER], and the gentleman from New Mexico [Mr. RICHARDSON].

I just want to thank all the gentlemen for all the help on behalf of the Japanese-American community.

Mr. LEWIS of California. Mr. Speaker, if the gentleman will yield further under his reservation, I must say I very much appreciate the cooperation of my colleague from California as well, all of my colleagues from California. This is a very important measure.

Mr. MATSUI. Mr. Speaker, I am extremely pleased that we are moving forward tonight with this important legislation, H.R. 3006, the Owens River Valley Environmental Restoration and Manzanar Land Transfer Act of 1996. This bill will allow us to complete the process of creating a National Historic Site on the grounds of the former Manzanar Internment Camp.

During World War II, 11,000 Americans of Japanese ancestry were confined at the Manzanar Internment Camp. These individuals were some of the over 120,000 Japanese-Americans interned at 10 sites throughout the United States.

The National Park Service determined in the 1980's that of the 10 former internment camps, Manzanar was best suited to be preserved and to thus serve as a reminder to Americans of the glaring violation of civil rights that the internment represented. As a result, the 102d Congress passed Public Law 102–248 establishing a national historic site at Manzanar.

H.R. 3006 will finish this process by allowing the Federal Government to obtain the

Manzanar site through a land exchange with the Los Angeles Department of Water and Power [LADWP], which currently owns the property. The parties that would be involved in this land transfer—LADWP, the National Park Service, the Bureau of Land Management, and Inyo County—reached agreement in February on a land exchange that can occur rapidly once our legislation is passed. All of these parties strongly support this legislation.

When completed, the Manzanar National Historic Site will stand as powerful testimony to the tragedy of the internment. Through its ability to educate future generations of Americans, the site will make an important contribution to our efforts to prevent any group in the United States from ever suffering such a widespread abrogation of its constitutional liberties.

I want to express my deep gratitude to my colleague, JERRY LEWIS, for his hard work in introducing this legislation and moving it forward. In addition, I deeply appreciate the assistance of the Resources Committee, particularly Chairman DON YOUNG and the ranking minority member GEORGE MILLER, as well as JIM HANSEN and BILL RICHARDSON, chairman and ranking minority member of the National Parks, Forests and Lands Subcommittee respectively.

I also want to thank Sue Embrey and the other members of the Manzanar National Historic Site Advisory Commission. Their tireless commitment to the realization of the Manzanar NHS has been the critical force behind this effort. Finally, we could not have reached this stage without the help of Director of the National Park Service Roger Kennedy, the regional staff of the National Park Service and Bureau of Land Management, the Los Angeles Department of Water and Power [LADWP], and Inyo County.

I look forward to working with my colleagues in this body and in the Senate to achieve final passage of this important bill.

Mr. MILLER of California. Mr. Speaker, H.R. 3006 will facilitate the disposal of certain public lands for the benefit of the Manzanar National Historic Site by revoking some outdated public land withdrawals. It is our understanding that these lands, which the BLM has identified for disposal, will then be used in an exchange for lands owned by the city of Los Angeles which are inside the boundary of the Manzanar National Historic Site. In addition, the bill expands the Boundaries of the Manzanar National Historic Site to include an additional 300 acres of land that has been found to have important archaeological elements.

This is a good initiative that is supported by the administration, and on a bipartisan basis by Members of the California delegation. We support the bill and have no objection to its consideration today.

Mr. Speaker, I withdraw my reservation of objection.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Utah?

There was no objection.

The Clerk read the bill, as follows:

H.R. 3006

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. TERMINATION OF WITHDRAWALS.

(a) UNAVAILABILITY OF CERTAIN LANDS.—The Congress, by enacting the Act entitled ''An Act to establish the Manzanar National Historic Site in the State of California, and for other purposes'', approved March 3, 1992 (106 Stat. 40; Public Law 102–248), (1) provided for the protection and interpretation of the historical, cultural, and natural resources associated with the relocation of Japanese-Americans during World War II and established the Manzanar National Historic Site in the State of California, and (2) authorized the Secretary of the Interior to acquire lands or interests therein within the boundary of the Historic Site by donation, purchase with donated or appropriated funds, or by exchange. The public lands identified for disposal in the Bureau of Land Management's Bishop Resource Area Resource Management Plan that could be made available for exchange in support of acquiring lands within the boundary of the Historic Site are currently unavailable for this purpose because they are withdrawn by an Act of Congress.

(b) TERMINATION OF WITHDRAWAL.—To provide a land base with which to allow land exchanges in support of acquiring lands within the boundary of the Manzanar National Historic Site, the withdrawal of the following described lands is terminated and such lands shall not be subject to the Act of March 4, 1931 (chap. 517; 46 Stat. 1530):

MOUNT DIABLO MERIDIAN

Township 2 North, Range 26 East

Section 7:
North half south half of lot 1 of southwest quarter, north half south half of lot 2 of southwest quarter, north half south half southeast quarter,

Township 4 South, Range 33 East

Section 31:
Lot 1 of southwest quarter, northwest quarter northeast quarter, southeast quarter;
Section 32:
Southeast quarter northwest quarter, northeast quarter southwest quarter, southwest quarter southeast quarter,

Township 5 South, Range 33 East

Section 4:
West half of lot 1 of northwest quarter, west half of lot 2 of northwest quarter,
Section 5:
East half of lot 1 of northeast quarter, east half of lot 2 of northeast quarter,
Section 9:
Northwest quarter southwest quarter northeast quarter,
Section 17:
Southeast quarter northwest quarter, northwest quarter southeast quarter,
Section 22:
Lot 1 and 2,
Section 27:
Lot 2, west half northeast quarter, southeast quarter northwest quarter, northeast quarter southwest quarter, northwest quarter southeast quarter,
Section 34:
Northeast quarter, northwest quarter, southeast quarter,

Township 6 South, Range 31 East

Section 19:
East half northeast quarter southeast quarter.

Township 6 South, Range 33 East

Section 10:
East half southeast quarter;
Section 11:
Lot 1 and 2, west half northeast quarter, northwest quarter, west half southwest quarter, northeast quarter southwest quarter;
Section 14:
Lots 1 thru 4, west half northeast quarter, southeast quarter northwest quarter, northeast quarter southwest quarter, northwest quarter southeast quarter.

Township 7 South, Range 32 East

Section 23:
South half southwest quarter;
Section 25:
Lot 2, northeast quarter northwest quarter.

Township 7 South, Range 33 East

Section 30:
South half of lot 2 of northwest quarter, lot 1 and 2 of southwest quarter,
Section 31:
North half of lot 2 of northwest quarter, southeast quarter northeast quarter, northeast quarter southeast quarter.

Township 8 South, Range 33 East

Section 5:
Northwest quarter southwest quarter.

Township 13 South, Range 34 East

Section 1:
Lots 43, 46, and 49 thru 51.
Section 2:
North half northwest quarter southeast quarter southeast quarter.

Township 11 South, Range 35 East

Section 30:
Lots 1 and 2, east half northwest quarter, east half southwest quarter, and west half southwest quarter southeast quarter.
Section 31:
Lot 8, west half west half northeast quarter, east half northwest quarter, and west half southeast quarter.

Township 13, South, Range 35 East

Section 18:
South half of lot 2 of northwest quarter, lot 1 and 2 of southwest quarter, southwest quarter northeast quarter, northwest quarter southeast quarter;
Section 29:
Southeast quarter northeast quarter, northeast quarter southeast quarter.

Township 13 South, Range 36 East

Section 17:
Southwest quarter northwest quarter, southwest quarter;
Section 18:
South half of lot 1 of northwest quarter, lot 1 of southwest quarter, northeast quarter, southeast quarter;
Section 19:
North half of lot 1 of northwest quarter, east half northeast quarter, northwest quarter northeast quarter;
Section 20:
Southwest quarter northeast quarter, northwest quarter, northeast quarter southwest quarter, southeast quarter;
Section 28:
Southwest quarter southwest quarter;
Section 29:
East half northeast quarter;
Section 33:
Northwest quarter northwest quarter, southeast quarter northwest quarter.

Township 14 South, Range 36 East

Section 31:
Lot 1 and 2 of southwest quarter, southwest quarter southeast quarter.

aggregating 5,630 acres, more or less.

(c) AVAILABILITY OF LANDS.—Upon enactment of this Act, the lands specified in subsection (b) shall be open to operation of the public land laws, including the mining and mineral leasing laws, only after the Secretary of the Interior has published a notice in the Federal Register opening such lands.

COMMITTEE AMENDMENT

The SPEAKER pro tempore. The Clerk will report the committee amendment.

The Clerk read as follows:

Committee amendment: Page 8, after line 4, insert the following:

SEC. 2. ADDITIONAL AREA.

Section 101 of Public Law 102–248 is amended by inserting in subsection (b) after the second sentence ''The site shall also include an additional area of approximately 300 acres as demarcated as the new proposed boundaries in the map dated March 8, 1996, entitled 'Manzanar National Historic Site Archaeological Base Map'.''

The committee amendment was agreed to.

The bill was ordered to be engrossed and read a third time, was read the third time, and passed.

The title of the bill was amended so as to read: ''A bill to provide for disposal of public lands in support of the Manzanar National Historic Site in the State of California, and for other purposes.''

A motion to reconsider was laid on the table.

TRANSFERRING JURISDICTION OF FEDERAL PROPERTY LOCATED IN THE DISTRICT OF COLUMBIA

Mr. HANSEN. Mr. Speaker, I ask unanimous consent for the immediate consideration in the House of the bill (H.R. 2636) to transfer jurisdiction over certain parcels of Federal real property located in the District of Columbia, and for other purposes.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Utah?

Mr. MILLER of California. Mr. Speaker, reserving the right to object, and I shall not object, I yield to the gentleman from Utah [Mr. HANSEN].

(Mr. HANSEN asked and was given permission to revise and extend his remarks.)

Mr. HANSEN. Mr. Speaker, I rise in support of this piece of legislation.

Mr. MILLER of California. Mr. Speaker, further reserving the right to object, I just want to mention that this legislation was introduced by our colleague the gentleman from Minnesota [Mr. OBERSTAR]. I want to thank the gentleman from Utah for his cooperation.

Mr. Speaker, H.R. 2636, introduced by our colleague, Mr. OBERSTAR, authorizes a three-way transfer of jurisdiction over several parcels of land among the Architect of the Capitol, the Secretary of the Interior, and the District of Columbia. In addition to facilitating management of these parcels, this transfer is being done for the purpose of setting aside a parcel of land adjacent to the Capitol Grounds for the proposed Japanese-American Patriotism Memorial. The memorial will honor the patriotic efforts of Japanese-Americans in World War II.

It is our understanding that the parties involved support this transfer and we have no objection to the passage of the bill.

Mr. MATSUI. Mr. Speaker, I rise to express my strong support for this important legislation and my great pleasure that it is before us this evening. H.R. 2636 is needed to facilitate the construction of a Memorial honoring the patriotism of Japanese Americans during World War II here in our nation's Capital.

In 1992, Congress passed Public Law 102–502, authorizing the construction of this Memorial on federal property. Under the terms of the legislation, the Memorial will involve virtually no Federal costs. All construction and major maintenance costs will be paid by private funds. The National Japanese American Memorial Foundation, formerly the Go For Broke National Veterans Association, has already begun this fundraising effort.

Land currently owned by the Architect of the Capitol has been selected as a site for the Memorial. However, in order for the construction of the Memorial to proceed, the land must be transferred to the National Park Service. H.R. 2636 would direct such a transfer to occur. In exchange, the Architect of the Capitol would obtain a parcel of land adjacent to the Hart Senate Office Building that is more integral to the Capitol grounds.

It is critically important for the land exchange to occur this year. The 1992 authorizing legislation and other applicable law require that construction on the Memorial begin by 1999. Until the land is transferred, the approval process for the Memorial's design can not begin. Because of the many agencies involved, this approval process will almost definitely consume the next three years.

33,000 Americans of Japanese Ancestry served in the military during World War II. The all Japanese American 100th Infantry Battalion/442nd Regimental Combat Team was the most decorated unit in military history for its size and length of service—700 members of the unit gave their lives. When completed, this Memorial will pay tribute to the immeasurable sacrifice made by these individuals as well as the many other contributions that Japanese-Americans made to the war effort.

This effort would not have reached this stage without the hard work and assistance of several individuals. The leadership of my friend and former colleague Norm Mineta in achieving the passage of the original 1992 legislation as well as his important role in developing this legislation was absolutely essential. In addition, I am extremely grateful to the sponsor of H.R. 2636, JIM OBERSTAR and also to Chairman of the Transportation and Infrastructure Committee, BUD SHUSTER. I also deeply appreciate the assistance of the Resources Committee, particularly Chairman DON YOUNG and the Ranking Minority Member GEORGE MILLER, as well as JIM HANSEN and BILL RICHARDSON, chairman and ranking minority member of the National Parks, Forests and Lands Subcommittee respectively.

The Board and staff of the National Japanese American Memorial Foundation has also been critical to this effort. I would note particularly the Foundation's Chairman Emeritus William Marutani, its Chairman Mo Marumoto, Honorary Co-Chair Etsu Mineta Masaoka and Executive Director George Wakiji.

I look forward to working with my colleagues in this body and in the Senate to achieve final passage of this important bill.

Mr. MILLER of California. Mr. Speaker, I withdraw my reservation of objection.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Utah?

There was no objection.

The Clerk read the bill, as follows:

H.R. 2636

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. PURPOSE.

It is the purpose of this Act—

(1) to assist in the effort to timely establish within the District of Columbia a national memorial to Japanese American patriotism in World War II; and

(2) to improve management of certain parcels of Federal real property located within the District of Columbia, by transferring jurisdiction over such parcels to the Architect of the Capitol, the Secretary of the Interior, and the Government of the District of Columbia.

SAC. 2. TRANSFERS OF JURISDICTION.

(a) IN GENERAL.—Effective on the date of the enactment of this Act and notwithstanding any other provision of law, jurisdiction over the parcels of Federal real property described in subsection (b) is transferred without additional consideration as provided by subsection (b).

(b) SPECIFIC TRANSFERS.—

(1) TRANSFERS TO SECRETARY OF THE INTERIOR.—

(A) IN GENERAL.—Jurisdication over the following parcels is transferred to the Secretary of the Interior:

(i) That triangle of Federal land, including any contiguous sidewalks and tree space, that is part of the United States Capitol Grounds under the jurisdiction of the Architect of the Capitol bound by D Street, N.W., New Jersey Avenue, N.W., and Louisiana Avenue, N.W., in Square W632 in the District of Columbia, as shown on the Map Showing Properties Under Jurisdiction of the Architect of the Capitol, dated November 8, 1994.

(ii) That triangle of Federal land, including any contiguous sidewalks and tree space, that is part of the United States Capitol Grounds under the jurisdiction of the Architect of the Capitol bound by C Street, N.W., First Street, N.W., and Louisiana Avenue, N.W., in the District of Columbia, as shown on the Map Showing Properties Under Jurisdiction of the Architect of the Capitol, dated November 8, 1994.

(B) LIMITATION.—The parcels transferred by subparagraph (A) shall not include those contiguous sidewalks abutting Louisiana Avenue, N.W., which shall remain part of the United States Capitol Grounds under the jurisdiction of the Architect of the Capitol.

(C) CONSIDERATION AS MEMORIAL SITE.—The parcels transferred by clause (i) of subparagraph (A) may be considered as a site for a S6201 national memorial to Japanese American patriotism in World War II.

(2) TRANSFERS TO ARCHITECT OF THE CAPITOL.—Jurisdiction over the following parcels is transferred to the Architect of the Capitol:

(A) That portion of the triangle of Federal land in Reservation No. 204 in the District of Columbia under the jurisdiction of the Secretary of the Interior, including any contiguous sidewalks, bound by Constitution Avenue, N.E., on the north, the branch of Maryland Avenue, N.E. running in a northeast direction on the west, the major portion of Maryland avenue, N.E., on the south, and 2nd Street, N.E., on the east, including the contiguous sidewalks.

(B) That irregular area of Federal land in Reservation No. 204 in the District of Columbia under the jurisdiction of the Secretary of the Interior, including any contiguous sidewalks, northeast of the real property described in subparagraph (A) bound by Constitution Avenue, N.E., on the north, the branch of Maryland Avenue, N.E., running to the northeast on the south, and the private property on the west known as lot 7 in square 726.

(C) The two irregularly shaped medians lying north and east of the property described in subparagraph (A), located between

the north and south curbs of Constitution Avenue, N.E., west of its intersection with Second Street, N.E., all as shown in Land Record No. 268, dated November 22, 1957, in the Office of the Surveyor, District of Columbia, in Book 138, Page 58.

(D) All sidewalks under the jurisdiction of the District of Columbia abutting on and contiguous to the land described in subparagraphs (A), (B), and (C).

(3) TRANSFERS TO DISTRICT OF COLUMBIA.—Jurisdiction over the following parcels is transferred to the Government of the District of Columbia:

(A) That portion of New Jersey Avenue, N.W., between the northernmost point of the intersection of New Jersey Avenue, N.W., and D Street, N.W., and the northernmost point of the intersection of New Jersey Avenue, N.W., and Louisiana Avenue, N.W., between squares 631 and W632, which remains Federal property.

(B) That portion of D Street, N.W., between its intersection with New Jersey Avenue, N.W., and its intersection with Louisiana Avenue, N.W., between Squares 630 and W632, which remains Federal property.

SEC. 3. MISCELLANEOUS.

(A) COMPLIANCE WITH OTHER LAWS.—Compliance with this Act shall be deemed to satisfy the requirements of all laws otherwise applicable to transfers of jurisdiction over parcels of Federal real property.

(b) LAW ENFORCEMENT RESPONSIBILITY.—Law enforcement responsibility for the parcels of Federal real property for which jurisdiction is transferred by section 2 shall be assumed by the person acquiring such jurisdiction.

(c) UNITED STATES CAPITOL GROUNDS.—

(1) DEFINITION.—The first section of the Act entitled ''An Act to define the United States Capitol Grounds, to regulate the use thereof, and for other purposes'', approved July 31, 1946 (40 U.S.C. 193a), is amended to include within the definition of the United States Capitol Grounds the parcels of Federal real property described in section 2(b)(2).

(2) JURISDICTION OF CAPITOL POLICE.—The United States Capitol Police shall have jurisdiction over the parcels of Federal real property described in section 2(b)(2) in accordance with section 9 of such Act of July 31, 1946 (40 U.S.C. 212a).

(e) EFFECT OF TRANSFERS.—A person relinquishing jurisdiction over a parcel of Federal real property transferred by section 2 shall not retain any interest in the parcel except as specifically provided by this Act.

COMMITTEE AMENDMENT

The SPEAKER pro tempore. The Clerk will report the committee amendment.

The Clerk read as follows:

Committee amendment: Page 4, line 12, strike ''S6201''.

The committee amendment was agreed to.

The bill was ordered to be engrossed and read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. HANSEN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 3006 and H.R. 2636, the bills just passed.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Utah?

There was no objection.

□ 2030

SPECIAL ORDERS

The SPEAKER pro tempore (Mr. FOX of Pennsylvania). Under the Speaker's announced policy of May 12, 1995, and under a previous order of the House, the following Members will be recognized for 5 minutes each.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from New Jersey [Mr. SAXTON] is recognized for 5 minutes.

[Mr. SAXTON addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Illinois [Mrs. COLLINS] is recognized for 5 minutes.

[Mrs. COLLINS of Illinois addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Indiana [Mr. BURTON] is recognized for 5 minutes.

[Mr. BURTON of Indiana addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

SPECIAL CEREMONY FOR STEPHEN D. BAKRAN

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Michigan [Mr. STUPAK] is recognized for 5 minutes.

Mr. STUPAK. Mr. Speaker, I would like to call to your attention and that of the U.S. House of Representatives a special ceremony that will be held this Friday, August 2, in Wells, MI, in my congressional district.

On Friday, the family of Navy aviation Radioman Second Class Stephen D. Bakran will gather at the gardens of Rest Memorial Park in Wells, MI, as his remains are laid to rest.

It is the tradition of our Nation to honor our war dead. What makes the ceremony for Airman Bakran so special is the fact that this important closure for the family comes more than five decades after this young man was killed in action.

From Navy officials and other sources, we know that Stephen Bakran was part of a special bombing squadron on a unique mission assigned to the U.S.S. *Ranger*, CV–4, the first ship built from the keel up as an aircraft carrier.

Stephen Bakran came to be aboard the *Ranger* after enlisting in the Navy on June 27, 1941, only weeks after his graduation from high school.

The eldest son in a Catholic family of 11 children, Stephen is remembered by family, friends, teachers, and others as an honest, hard working, caring individual.

The son of Croatian immigrants, Stephen is recalled in his role as a money earner for the family on his paper route, a dutiful son working in the family garden or tending the farm animals, and a responsible sibling changing and washing diapers of his younger brothers and sisters.

Airman Bakran is part of the first U.S. carrier based mission launch against Nazi-held Norway. Code named Operation Leader, the planes of the mission sank Nazi shipping and caused other damage at the cost of two SBD–5 Dauntless scout bombers. One of these bombers that were downed claimed the lives of Stephen Bakran and his pilot, Lieutenant Clyde A. Tucker, Jr. of Alexandria, LA.

Reports say that Stephen Bakran was still firing his machine gun as his plane went down on October 4, 1943.

Although the Navy listed Stephen Bakran and Clyde Tucker as killed in action, it was not until 1990 that a Norwegian diving club and a Norwegian historical research vessel found the wreckage of the aircraft off the coast of Bodo, Norway, in 150 feet of water.

It was not until July of 1993 that divers were able to locate and recover the two aviators. The remains of Clyde Tucker were identified in 1994 and are buried in Arlington National Cemetery. However, DNA tests did not conclusively identify the remains of Stephen Bakran until this year.

I am pleased that I was able to assist the family by working with our military officials during the identification process, and now I am extremely grateful to everyone, including those who helped to find, identify and transport Steve Bakran back to his family where they will be able to find a final resting place for this fallen warrior.

Today as we watch other families struggle with the tragedies of the disappearance of loved ones in a dark watery grave, we find comfort in witnessing that the search for our military missing in action never ends and the door of hope, hope that they may be found, never closes.

Mr. Speaker, let us remember the Bakran family in our thoughts and prayers on Friday. I regret that I will not be able to attend the funeral, as I will be here attending to legislative business. The Bakran family, the Wells and Escanaba community will be at Steve's funeral, but my family will join the Bakran family in a final salute to our World War II Navy veteran who is laid to rest.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California [Mr. RIGGS] is recognized for 5 minutes.

[Mr. RIGGS addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California [Ms. MILLENDER-MCDONALD] is recognized for 5 minutes.

[Ms. MILLENDER-MCDONALD addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Washington [Mr. METCALF] is recognized for 5 minutes.

[Mr. METCALF addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

TRIBUTE TO JACK HENNING

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California [Mr. BROWN] is recognized for 5 minutes.

Mr. BROWN of California. Mr. Speaker, I rise today to pay tribute to the life and career of John F. ''Jack'' Henning.

On Tuesday, July 30, 1996, yesterday, the California labor movement bid a fond farewell to their top leader for the past 26 years. Mr. Henning, at the age of 80 years, retired as executive secretary-treasurer of the California Labor Federation, AFL–CIO.

Born in San Francisco, where he was raised in a blue collar family, Jack earned a college degree in English literature at St. Mary's College. Mr. Henning's rise in labor unions began in the 1940's, when he held jobs in a pipe and steel plant; and in 1949, he began working at the California Labor Federation, initially as a senior staffer. Mr. Henning has also served as Director of the California Department of Industrial Relations in the early 1960's, where I worked closely with him in my role as a member of the State Assembly Committee on Industrial Relations.

He also worked as Under Secretary of Labor in both the Kennedy and Johnson administrations, where again I worked closely with him as a Member of Congress and a member of the Committee on Education and Labor. In addition to his already distinguished career, Mr. Henning was also the Ambassador to New Zealand from 1967 to 1969, where again I visited with him on my first trip to Anarctica, and a Regent of the University of California from 1977 to 1989.

After Mr. Henning returned home from New Zealand, he took the helm of the California Labor Federation, and for the past 26 years never faced an opponent for the post.

Throughout his career in the labor union movement, which he began as a young man in 1938, he was heralded as a master orator, ''thundering from the political left against what he regards as the scourge of unbridled capitalism.'' Mr. Henning has been a champion of the working poor and underclass, fighting to increase their standard of living. Mr. Henning was instrumental in the passage of the California Agricultural Labor Relations Act of 1975, which gave farm workers the right to organize and bargain collectively, as he was in sponsoring an initiative in 1988 which regulated workplace health and safety for the state's workers.

During his farewell address, he called upon those to his political right to visit any major U.S. city and ''see what capital has done to the poor, see the centers of wealth and the mansions and the corporate wealth, and then see the impoverished . . . homeless, beggers at the table of wealth.'' One of his many accomplishments has been preventing restaurant owners from counting tips as part of the minimum wage.

Jack Henning has left behind a career in the labor union movement in which his contributions will not be forgotten. His tough negotiating skills along with his ability to sway people with his orations, have provided labor employees with better working conditions. He has truly been an inspiration to me and to others who are fighting to protect the jobs and lives of the citizens of California.

Mr. Speaker, I ask my colleagues to join me in commending Jack Henning on his dedicated service to the California Labor Federation and to the workers of the State of California.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Florida [Mr. FOLEY] is recognized for 5 minutes.

[Mr. FOLEY addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Texas [Ms. JACKSON-LEE] is recognized for 5 minutes.

[Ms. JACKSON-LEE of Texas addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California [Mr. MILLER] is recognized for 5 minutes.

[Mr. MILLER of California addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

ECONOMIC GROWTH UNDER CLINTON ADMINISTRATION HAS BEEN ANEMIC

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California [Mr. DREIER] is recognized for 5 minutes.

Mr. DREIER. Mr. Speaker, I rise this evening to comment on a statement that was made throughout the debate on this historic welfare reform measure that was passed. I am pleased to see that we did it in a bipartisan way, but both sides of the aisle, very appropriately, accurately stated that as we look at reducing welfare we are going to be faced with an economy that will not have enough jobs for those people out there who are going to be moving off of welfare.

That is a very legitimate concern because economic growth under this administration has been anemic. In fact, it has been lower than 21 of the last 30 years.

Now, I believe, Mr. Speaker, that it is very important for us to follow up the very historic welfare reform legislation which we passed today with an economic growth plan that increases savings and investment, which will lead to higher rates of productivity, increase worker wages and the creation of more private sector jobs.

The reason for the anemic growth that we have seen is that productivity growth is too low. Productivity is too low because we are not investing enough in both physical capital and human capital. Unfortunately, this administration is responsible for low productivity growth because the tax and regulatory burden has been way too great.

Every year since Bill Clinton took office, taxes have been higher and family income has been lower than when he got elected. In fact, as we all have come to find out, the average family has a tax burden which is in excess of 38 percent.

Under the Clinton administration the cost of complying with Federal regulations has also been very high. It averages $1,000 per household. Obviously, we all know that regulation increases the cost of employing workers, and thus acts as a tax on job creation and employment.

Now, this administration is responsible for low productivity growth because the President has fought our efforts to reform the education system that we have. Unfortunately, this administration, due to it, government spending on education, as we all know, has gone way up, while the performance, the school performance and student achievement have remained static and are leaving young Americans ill equipped to function in today's increasingly competitive global economy.

What Congress can do to increase productivity and long-term capital economic growth is very, very key, and there are more than a few items that we can do to address them. Obviously, the first that comes to mind for virtually everyone is balance the budget.

We have been very committed to a balance budget, and we know what that will create. It obviously increases domestic savings, it lowers interest rates, and increases overall investment, and we know that that would be a very, very key and beneficial item as we look towards addressing this concern of anemic economic growth and slow productivity.

Another one that is very key is to decrease the tax burden on investment.

Now, so often these things are mislabeled as a tax cut on the rich, but every shred of empirical evidence, Mr. Speaker, has demonstrated that it will in fact be beneficial in job creation and economic growth.

A capital gains tax cut will make more venture capital available for emerging technologies as we charge toward the millennium. We know how important that is. We know that job creation is emanating from the private sector and the small business sector of our economy.

□ 2045

We also need, in looking at the technological changes that are made, we need to make the research and development tax credit permanent so that this incentive that we need for encouraging innovation in new technologies is there.

We also need to do what we can to increase the skills of the workforce in this country, improving basic education through school choice, increasing local control and reducing the bureaucracy; creating tax deferred or tax-free education savings account similar to individual retirement accounts, something that this administration admittedly has talked about, but has not acted upon. And we have tried responsibly to move ahead with that and have not gotten much support from the administration. We have not cut spending on education, nor should we continue to throw money at what is a wasteful, broken system.

We need also to enact significant regulatory reform. The explosion of new regulation we have seen since 1988 has raised the cost of labor and capital, created barriers to the formation of new companies and jobs, and raised the cost of employing Americans.

The higher cost of employment, in turn, means that in a competitive economy the return to labor in the form of wages is greatly reduced. The regulatory burden needs to be rolled back, not only to allow wages to rise, but also to decrease the cost of hiring workers. And remember, again we are trying to address the concern that many have raised that will follow on with reforming the welfare structure.

We also need to have a modest increase in the long-term growth rate, which can have a dramatic impact on the standard of living here in the United States. A 1 percent increase in long-term economic growth would mean 6 million new jobs created over an 8-year-period, $700 billion more in tax revenue, enough to balance the budget by the year 2002 without any spending cuts, and also Social Security would remain solvent for 30 more years if we were to have just a 1 percent increase in long-term economic growth.

Also, 200,000 new small businesses would be created over a 4-year period.

With that, I am convinced, Mr. Speaker, that we could go a long way towards addressing the concerns that have been raised by Members on both sides of the aisle that will following the wake of reforming the welfare system, but it must be done, it must be done as expeditiously as possible. Unleash this economy and let us do it now.

PENSIONS MUST BE PROTECTED

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Massachusetts [Mr. TORKILDSEN] is recognized for 5 minutes.

Mr. TORKILDSEN. Mr. Speaker, I rise this evening to discuss an issue important to every American: protecting pensions.

Pensions represent security and independence for all working Americans. As Americans have come to rely on Social Security, they also have every right to expect their pensions will be there when they retire.

This Congress has made great strides in enacting a balanced budget. Finally, Republicans and most Democrats agree that the budget must be balanced in the next 6 years. How we actually get to a balanced budget is still being debated, but at least there is bipartisan agreement to balance the budget.

The issue of pensions became a part of last year's budget battle. While I supported the balanced budget, I voted for the motion to instruct conferees that would have ensured workers' pensions throughout America. The reason we needed to instruct conferees was that the act proposed allowing some businesses to tap into so-called excess pension funds. While under this proposal, these funds would need to be used in other employee benefit accounts, cutting pension accounts for any reason could place workers' retirements at risk. The investment market is simply too volatile.

In many cases these were not ''excess'' pension funds at all, but were simply the value that inflation had added to the pension funds. If anything, these excess funds should only be used for cost-of-living adjustments for retirees. That is why I voted to instruct conferees to protect workers' pensions.

A study done by the Pension Guaranty Corporation reported that plans with excess funding could become underfunded with an economic downturn, such as a drop in interest rates or market shifts. While businesses must make up any shortfalls, this weakens their overall financial health. This just is not worth the risk.

It is critical that Congress protect these pensions for workers as it did when the Tax Reform Act of 1986 was passed. Congress recognized that employers have an obligation to ensure their employees' pensions. This obligation is critical in the 1990's.

When the budget was signed into law by President Clinton, it contained no changes that would allow any corporate raid on pensions. I will continue my work to protect workers' pensions. These funds were earned by retirees and they must be there when they need them.

AMERICA IS IN NEED OF PRAYER

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California [Mr. DORNAN] is recognized for 5 minutes.

Mr. DORNAN. Mr. Speaker, I had the opportunity to put in that section of the RECORD we call the Extension of Remarks a beautiful, thoughtful, short exposition by the Reverend Joseph Wright. He is not from my State. It was given to me by one of the outside institutions around this place, the lovely Rita Warren of Massachusetts, who goes through all the hoops around here to get permission to have a Passion Play on the East Steps of our beautiful U.S. Capitol every Easter week; and I noticed she is starting to worry about what is happening to our country, vis-a-vis what Reverend Billy Graham or the Holy Father in Rome has said.

So I notice that she has her Passion Play out on the steps with a figure of Jesus and all of his beautiful sayings as the Prince of Peace that can save our world. But she asked me, since she had given me this recitation by Reverend Wright if I could not read it on the floor of the House, as well as put it in.

So for Rita Warren, I will do that, Mr. Speaker. The following is excerpted from a prayer in the Kansas house. This was delivered on the floor of the Kansas legislature, courageous Bob Dole's home State, on January 23 by Joe Wright of Central Christian Church, Wichita.

We have ridiculed the absolute truth of God's word and called it pluralism.

We have worshiped false gods and called it multiculturalism.

We have endorsed perversion and called it alternative lifestyle or diversity.

We have exploited the poor and called it the lottery.

We have neglected the needy and called it self-preservation.

We have rewarded laziness and called it welfare.

We have killed the pre-born and called it choice.

We have neglected to discipline our children and have called it building self-esteem.

We have abused power and called it political savvy.

We have coveted our neighbor's possessions and called it ambition.

We have polluted the airwaves with profanity and pornography and called it freedom of expression.

We have ridiculed the time-honored values of our forefathers and called it enlightenment.

We have indoctrinated our children and called it education.

We have censored God from our public life and called it religious freedom.

We have prevented our citizens from defending themselves and called it gun control.

We have allowed violent criminals to be released to prey on society and called it compassion or rehabilitation.

We have imprisoned the innocent and let the guilty go free and called it justice.

Indeed America is in much need of prayer.

And in my concluding minute, let me point out, Mr. Speaker, that the RU–486 pill, about to emerge on the American market, has been called by Thomas Grenchik, director of the archdiocesan Pro-Life Office as a child-pesticide. He says Clinton has another anticipated victory in his campaign to kill the pre-born.

''At the President's direction,'' Mr. Grenchik says, ''the Food and Drug Administration has strong-armed the use of RU–486 from its European owner and, as promised, will ramrod the approval of this child-pesticide at all costs.''

It goes on to describe this panel of experts on July 19, way out of town in Gaithersburg with a 6–0 vote, two abstaining, on unleashing this child-pesticide.

RU–486, also known by its generic name mifepristone, is taken first and causes the uterine lining to break down and slough off. Then misoprostol, a prostaglandin that stimulates uterine contractions, is taken 2 days later, a complicated procedure requiring several medical visits, precise drug doses, and monitoring.

In an editorial in ''L'Osservatore Romano,'' the Vatican newspaper, it was condemned as an abortion pill, ''the pill of Cain, the monster that cynically kills one's brother''; and in this editorial, a moral theologian writes that the pill's anticipated approval in the United States is an important victory for what it termed, and this is in Rome, the ''abortion party'' led by the Population Council and the International Planned Parenthood Federation.

So the battle goes on, Mr. Speaker, and let us hope that people go into this with their eyes open and that we do not have a delayed time bomb of the thalidomide problem here. Yes, as Reverend Joe Wright says, America is certainly a Nation in need of prayer.

As Billy Graham said in our beautiful Rotunda when he received, unanimously from both the Senate and the House, the Congressional Gold Medal, America is a Nation on the brink of self-destruction.

ACTIONS TO MARKET ABORTION PILL ARE DENOUNCED

The archdiocesan pro-life director denounced this week's government actions that would soon put the abortion-inducing pill RU–486 on the American market.

Thomas Grenchik, director of the archdiocesan Pro-Life Office, said that President Clinton ''has another anticipated victory in his campaign to kill'' the unborn. ''At the president's direction, the Food and Drug Administration has strong-armed the use of RU–486 from its European owner and, as promised, will ramrod the approval of this child-pesticide at all costs.''

A panel of scientific experts recommended July 19 that the FDA here in Washington allow the controversial abortion-inducing pill to be marketed in the United States.

Following a public hearing in Gaithersburg, the FDA's Reproductive Health Drugs Advisory Committee voted 6–0 that the benefits of the RU–486/misoprostol regimen for terminating early pregnancies outweigh its risks. Two members of the panel abstained.

RU–486, also known by its generic name mifepristone, is taken first and causes the uterine lining to break down and slough off. Misoprostol, a prostaglandin that stimulates uterine contractions, is taken two days later. The procedure requires several medical visits, precise drug dosage and monitoring.

An editorial in the July 22 issue of L'Osservatore Romano, the Vatican newspaper, condemned the abortion pill as ''the pill of Cain, the monster that cynically kills one's brother.''

The editorial, signed by Father Gino Concetti, a moral theologian, said the pill's anticipated approval in the United States was an important victory for what it termed the ''abortion party'' led by the Population Council and the International Planned Parenthood Federation.

At the hearing, the Population Council, a New-York based research organization that holds the U.S. patent rights to RU–486, presented clinical data from two French trials involving 2,480 women and preliminary safety data from U.S. trials involving 2,100 women.

More than 30 individuals also testified during the open portion of the meeting.

The French data showed the medical abortion procedure to be 95 percent effective. However, panelists also heard that women participating in the clinical trials experienced painful contractions of the uterus as well as nausea, vomiting, diarrhea, pelvic pain and spasm, and headache.

In some cases where the chemical combination failed to produce an abortion, women then had surgical abortions; others completed their pregnancies and delivered babies with deformities.

According to an FDA statement after the panel decision, ''a very small percentage of patients in the clinical trials required hospitalizations, surgical treatment or transfusions.''

Dr. Mark Louviere, a Waterloo, Iowa, emergency room physician who said he is a supporter of legalized abortion, told FDA panelists that he treated a participant in the Planned Parenthood of Iowa trial who lost more than half of her blood volume and nearly died.

''I am concerned that all of the true complications of RU–486 are not being reported to both the media and to the FDA,'' he said, adding that he also fears the use of RU–486 ''by physicians without appropriate follow-up.''

''The FDA approval process is moving at an unheard-of-pace to approve this deadly drug combination, leaving many concerns about safety unresolved,'' said Wanda Franz, a developmental psychologist at West Virginia University and president of the National Right to Life Committee, in a statement from the group's Washington office.

''Respect for human life and women's health, not developing human 'pesticides,' should be at the center of the FDA's concern when advancing new drugs,' said Judie Brown, president of the American Life League, in a statement from the organization's headquarters in Stafford, VA.

RU–486 was developed by the French company Roussel Uclaf, and has been taken by more than 200,000 European women since 1989. In 1994, Roussel Uclaf signed over U.S. rights to the Population Council, which filed the FDA application in March.

In deciding on drug applications, the federal agency usually has followed the recommendations of its advisory committees. If RU–486 is approved by the FDA, the drug would be sold by Advances in Health Technology, a company set up for that purpose last year, and could be available in the United States next year.

REPORT ON RESOLUTION WAIVING REQUIREMENT OF CLAUSE 4(b) OF RULE XI WITH RESPECT TO SAME DAY CONSIDERATION OF RESOLUTION REPORTED BY COMMITTEE ON RULES

Mr. GOSS (during the special order of the gentleman from Georgia [Mr. KINGSTON] from the Committee on Rules, submitted a privileged report (Rept. No. 104–735) on the resolution (H. Res. 500) waiving a requirement of clause 4(b) of rule XI with respect to consideration of a certain resolution reported from the Committee on Rules, which was referred to the House Calendar and ordered to be printed.

A DIFFERENT VISION OF AMERICA

The SPEAKER pro tempore. Under the Speaker's announced policy of May 12, 1995, the gentleman from Georgia [Mr. KINGSTON] is recognized for 60 minutes as the designee of the majority leader.

Mr. KINGSTON. Mr. Speaker, I wanted to talk tonight about a different vision of America, a vision that we are not really seeing from the Washington bureaucracy, but one that this Congress is trying to form and trying to achieve and move our Nation towards.

We have asked ourselves some fundamental questions: What kind of America do we want? Do we want an America where illegal drug use is up? Do we want an America where taxes are up and wages are down? Do we want an America where welfare traps families and despairs generation after generation? And do we want an America where illegal immigration is up? And do we want one where a White House has more scandals than Hollywood has disaster films?

Look at that vision of America. That is somehow what many of the Washington bureaucrats see and administer today.

Think about another kind of America. Would we like one that has stronger and safer families through a real fight against crime and illegal drugs? Do we want an America where there are more opportunities through lower taxes, higher wages, better jobs and more free time? Do we want an American where illegal immigration is down and English is truly our common and unifying language? Do we want an America where welfare is replaced by work? And do we want an America where the White House is the moral leader of the country, not just the political issues.

These are the things that we are going to talk about tonight, and I have

with me our esteemed colleague from Pennsylvania, Mr. CURT WELDON.

Mr. WELDON, if you have any comments, let me yield to you.

Mr. WELDON of Pennsylvania. Mr. Speaker, I thank the gentleman for yielding, and I am pleased to join with him this evening in a portion of his special order. As he knows, I will be taking a special order following this to discuss our defense bill that will be on the floor this week. But I thought it very important to highlight the key areas the gentleman has raised that are really, I think, going to frame the debate as we move into the final 3 months of the election cycle into September and October and talk about what is the status of this country today in five key areas and what is the vision for the future and which party and which candidate can offer the best vision for America.

I start out by saying to the gentleman and my friend, I ran for office and got involved in public life because of drug use in my hometown and my county. I come from a town that was one of our most distressed communities in Pennsylvania. I was born and raised, the youngest of nine children, there, was active in the community a number of ways, including the volunteer fire company and the Red Cross and the Boy Scout troop, and was upset because our town had become the national headquarters of one of the five largest motorcycle gangs in America.

That gang controlled all the drug trafficking along the east coast of this country. They had 65 members living there, and the national president lives there and because we were just a small town, we had no resources of coping with the problem of drug abuse.

We have continuously seen since that point in time, approximately 20 years ago, a declining use of drugs in America. During the era of Ronald Reagan and George Bush, we saw a marked decrease in the use of drugs in this country.

The gentleman has some factual information that he might want to insert in the RECORD. My understanding is that in the past 3 years the use of drugs in this country has in fact reversed, and we are now seeing an increase in the amount of drug use by 14-year-old's. Is that correct?

Mr. KINGSTON. You have made a very good point. For 11 straight years, until 1992, illegal drug use fell in all categories of drugs except, for some reason, heroin, but everything else had fallen.

□ 2100

Now, since 1992, when a lot of these drug education programs and a lot of the interdiction programs and enforcement programs were cut, under the Clinton administration drug use has gone back up to the extent now that, just to give some numbers, marijuana use among teenagers has dropped, excuse me, has since 1992 increased 137 percent amongst 12- and 13-year-olds. Now, for 14- to 15-year-olds there has been a 200 percent increase.

Of the graduating class of 1995, statistically half of the will have experienced some sort of illegal drug, and a drug like LSD which we really had not been talking about at all in recent years is now back strong on the streets and LSD use has increased 62 percent since 1992.

One of the things that we have been fighting is the fact that the President had slashed the funding for the Office of National Drug Control Policy by 80 percent. I am on the Treasury-Post Office Committee. We are doing everything we can to work with General McCaffrey, the new drug czar, to restore much of this funding and do everything we can, but along with government funding there are some other things that we can do to fight drugs.

And I do believe in these interdiction programs. I do believe in local policing in States like Georgia where, for example, the police opened up a satellite station in the middle of one of the biggest housing projects, where they had the high drug use and they had crime and teenage dropout and teenage pregnancy problems. As a result of them doing that, the children got to know the police officers. The families came out of the house and the streets got to be safe. And in Statesboro, GA, in that high crime area, drug use has dropped.

That is the sort of thing that we are trying to encourage with our budget is local policies to fight drugs.

Mr. WELDON of Pennsylvania. The gentleman makes an excellent point. Two key considerations here. First of all, while the administration puts out the rhetoric of being concerned about drug use and supposedly doing something about it, the facts and this is typically the case throughout this administration, just do not bear out the rhetoric.

As the gentleman and my friend pointed out, the office of Drug Enforcement Administration reporting to the White House has in fact been cut by, I think the figure used was 84 percent. In fact, it has been decimated. But this President, knowing that he can use perception as opposed to substance, in his last State of the Union Speech appointed one of this Nation's heroes, General Barry McCaffrey, to head up the drug effort because he wanted to give the people the perception that he in fact is really doing something substantive. So he appoints a genuine hero in this country, whom all of us have the highest respect for and whom all of us want to help, while at the same time he is decimating the funding to allow the programs under the control of that individual and that agency in fact to go forward.

Furthermore, perceptually, this administration has created a casual atmosphere about drug use. That casual atmosphere then gets translated to our teenagers across the country, and they then think maybe it is okay to do some drugs or limited use and we see the numbers start to go up, as our colleague has pointed out. We saw descending use of drugs in this country for the previous 12 years, and in the last 3 years we have seen an increase in drug use by the use of this country.

While we cannot blame any one person for that, we can look at the factors that may in fact be causing that increase and the fact that we have to be doing more substantively to deal with that increase. As the gentleman points out, that is one of the issues that we have been fighting to have as a top priority for the past 2 years since the Republican Party has controlled this institution.

Mr. KINGSTON. I want to conclude this section of our five-part discussion with this comment. Two other things we want to do with drugs is to have severe penalties, pressure; if you are pushing drugs to school kids on basketball courts or playgrounds, you go to jail. You stay in jail. We need to have that.

Then finally for the addicts, why not have a 24-hour a day hotline that says if a drug addict says I am ready to kill myself, I have hit bottom, I want to bounce back up, give a 24-hour hotline that we will get you help the next day, we will get you help on the spot, because once an individual has made up his or her mind to kick the habit, then they are the easiest to cure.

We are going to talk again about in a second on illegal immigration, but in the meantime let me yield to the distinguished chairman of the Committee on Rules, Mr. SOLOMON.

Mr. SOLOMON. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I just came from a Committee on Rules meeting and heard what my colleagues were doing on this proliferation of drug use in America. It is such a sad, sad thing. The gentleman over here from Pennsylvania [Mr. WELDON] mentioned casual attitude. Let me tell how bad that casual attitude is coming out of the White House and what is happening to our children and our grandchildren.

Seventy-five percent of all violent crime in America today that is committed against women and children, 75 percent that is committed against women and children are drug-related. What has this casual attitude done? It is the most pathetic thing. Today among 12- and 13-year olds, marijuana use is up 137 percent. And in the 14- and 15-year-old range, it is up 200 percent. Among young adults, it has doubled just in the last four years. The worst part of it is these kinds of drugs today, because of this casual attitude coming out of the White House and other places, means that drugs now are being used as weapons against women and children. A drug like Rohypnol, for instance, is used as a weapon where, after young women have been plied with marijuana or with alcohol, they have had a Rohypnol tablet slipped into their drink. It renders them unconscious, but awake, so that they cannot

defend themselves but they can see what is going on when the rape is taking place. This is a whole new generation that is now exposed to this.

When we compare this to Nancy Reagan's ''Just Say No'' and Ronald Reagan when he sponsored, when he approved my legislation which had random drug testing for our military, we had use of drugs in our military that was running at 25 percent back in the early 1980s, and once we implemented that random drug testing system, it dropped to 4.5 percent. Drug use all over America began to drop.

Now look what has happened. It has turned around and it is just ruining these kids. Is a terrible thing.

I thank the gentleman for bringing this to our attention and we need to focus on this all the way. There better be a change at the White House in this casual attitude.

Mr. KINGSTON. Mr. Speaker, I wanted to go on to the next topic that Mr. WELDON and I wanted to bring up, the subject of illegal immigration.

First, let me recognize Mr. BOB EHRLICH of Maryland, who is here with us tonight. Before I yield to the gentleman, let me throw out some statistics on how bad the illegal immigration problem is, because most Americans know that we have a lot of illegal aliens in America but they do not know how extensive the problem is.

There are an estimated 4.5 million illegal aliens in America now, that is about the size of the State of Indiana; 300,000 new illegal aliens come each year and so the problem is getting bigger and bigger. In many cases, they are using false documents to get American welfare benefits, American jobs and so forth, and it is displacing people and putting a further tax drain on us.

One of the huge tax drains is in the Federal penal system where right now approximately 22 percent of the prisoners in the Federal penitentiaries are illegal aliens, and about 80 percent of them are violent offenders which are the most expensive to incarcerate.

We have a lot of direct and indirect costs because of the strain of illegal aliens, but one of them is now that school systems must offer not just bilingual education but multi-lingual education. In Seattle, for example, there are 75 different languages spoken in the school system; in Los Angeles, 80; 100 in Chicago.

Now, we are all sons and daughters of immigrants, most of us sons and daughters of legal immigrants. But what they did when they came to America is they learned American culture and they learned English as our common language. They did not turn their back on the home country great traditions. Savannah, GA, where I live, has ethnic celebrations all through the year, because we have a strong ethnic heritage. We want to keep that in mind and celebrate it.

I know where I was raised, not in Savannah but in Athens, GA, a lot of Cuban families came after Castro took over and in most of their homes they spoke Spanish. But their children were raised in the school systems where they learned English. Now those children are in very good jobs because they were not trained to be special. They were trained—well, I take that back. They were trained to be special because all Americans are special. But now our school systems have all these ridiculous requirements. I have heard that the voting ballot in California is in seven different languages. Can you imagine voting but not knowing English?

I yield to the gentleman from Maryland [Mr. EHRLICH].

Mr. EHRLICH. Mr. Speaker, the gentleman said an awful lot of truth here. It really speaks to the fact that we are a multi-ethnic culture and we revel in that fact.

The gentleman just recited that fact, but we are one culture. And that one culture has a common language, which is English. Of course, the English bill will certainly dominate the debate on this floor over the next couple days. But I know the gentleman has put it very well. What better means to you achieve economic mobility in this country other than by a common language? Does it make any sense that any other options—look what is happening in Quebec right to the north?

Multi-ethnic but one single culture, that is the way to the American dream. That is the way to economic prosperity. That is certainly the message that should go out from this Congress.

Mr. KINGSTON. If you will remember the biblical story about the tower of Babel, the story is that the villagers decided to build a tower to heaven. And the Lord did not want that done and, as a preemptive measure, gave them all different languages. And then they could not work together, and they broke up and they started all the other nations.

I am not saying that we cannot work with each other when we speak different languages, but the fact is, it is interesting that thousands and thousands of years ago, in a Bible story we all learned as children, the way to break up a nation was to have different languages. I believe, to say it in a positive light, the way to unify America further is having one common language. Today there are 320 languages spoken in the United States of America.

Mr. WELDON of Pennsylvania. Mr. Speaker, on the issue of immigration, again, this administration wants to create the perception among the American people that Republicans do not care, that we are not sensitive, that we are not compassionate. And we have to rise up and we have to shout as loud as we can the facts, because that is not the case.

What we are trying to do is to stop the abuse. I think the best case that I can point to of what is going haywire in this country was brought to my attention by a good friend and colleague from California, ELTON GALLEGLY, who has been the leader in this Congress in terms of immigration. ELTON GALLEGLY showed me a brochure, I think it was the last session of Congress, printed in Spanish, paid for by the U.S. taxpayers.

This four-page brochure was being handed out in southern California to anyone who was Spanish speaking that needed health care. And what it said was that if you are pregnant, you can go to any hospital within the jurisdiction of the brochure being given out, I think it was Orange County, and you can get prenatal care, postnatal care, and have the cost of delivering your child borne by the taxpayers of this country.

If you are a young Mexican mother and you know in a brochure printed in your native language that you can come across the border to America, where health care is the best in the world, and you can go to any hospital and have your prenatal care provided, your baby delivered and your postnatal care provided, what are you going to do? You are going to do everything you can to come across that border.

Here is the real rub. The person also knows, the mother also knows when that child is born in America, guess what, that child is an American citizen. Even though that child is born to an illegal immigrant in this country, that child becomes a full U.S. citizen with the same rights as any other child born here.

But what really bothered me about this brochure, which should bother every Member of this institution, was a paragraph in the bottom of the third page that said, you cannot be turned into the immigration service even if you are here illegally.

☐ 2115

Now we wonder why we have an immigration problem. Here is a brochure printed by the taxpayers of this country in Spanish given to people all over the southern part of California and in Mexico, and we wonder why they are all coming across the border. We just cannot continue to be the health care resource center for the world. That is what we are talking about, immigration reform that stops that.

Mr. KINGSTON. Well, let me give some numbers on that:

1996 taxpayers will spend $26 billion to provide welfare benefits to noncitizens which includes 11 billion in Medicaid benefits, which is basically free insurance, health care, free health care; 4.4 billion in Supplemental Security Income, which is up, incidentally, 825 percent.

Now remember we are just talking about noncitizens.

There is 2.9 billion in food stamps; 2.3 billion in Aid to Families with Dependent Children; 3.89 billion in housing cash assistance and other subsidies. And that is from a Harvard University study; that is not exactly, you know, a conservative group up there. But this

is putting an additional tax strain on American middle class taxpayers.

I believe we need to strengthen our border patrols. We need to crack down on deportation of criminals aliens. We need to have sponsorship, legally binding; so if you want to bring your family member or whoever in, fine, but you need to be responsible for that person to make sure he or she is independent of government benefits.

We also need to protect American jobs. There are a lot of American jobs that have been displaced.

Then finally tomorrow this House will vote on English-first as a language. I believe we have enough votes to pass it. I think the President is probably going to veto it, but I am not discouraged because the liberal Governor of Georgia vetoed it two or three times himself. Finally this year, because of election year pressures, he signed it. As we saw today with welfare, our President is very sensitive to election year pressures, and maybe we can get his attention on it.

Mr. EHRLICH. If the gentleman will yield, I think the message is well taken.

I hear this term sensitivity used in this House so much. But I never hear that term used in the context of the American taxpayer.

The gentleman cited an interesting statistic early on; I think it bears repeating. The gentleman, I believe, said that 22 percent of the population in the Federal penal system in this country, is illegal aliens; is that correct?

Mr. KINGSTON. That is absolutely correct.

Mr. EHRLICH. This free ride on the American taxpayer has to end. That is the bottom line to illegal drugs. That is the bottom line to illegal immigration. That is the bottom line to reforming our legal immigration system. That is the bottom line to welfare reform as we have discussed. It is the bottom line to almost every issue in this town because, as the gentleman just said, working Americans are just tired of it. They are tired of the free ride.

We have a very hospitable people in this country. We are a Nation of immigrants, as the gentleman has said. We are sensitive to the concerns and the plights of people. But at some point this Congress has to say:

You know what, folks? You know what, world? There is a limit to what we can do, and we expect you to abide by our laws.

Mr. KINGSTON. Our compassion does not rule out common sense, and we have to just put a little bit more common sense in it. Just as we have said, we are going to address this illegal immigration, this English-first issue. This Congress is going to move in that direction.

The other thing that we all mention is $26 billion is the direct cost of illegal immigration. There are other indirect costs, but that tax strain is further adding to the third issue that we wanted to discuss. That is the fact that this Congress, this Republican agenda, wants to have for our middle class citizens lower taxes, higher wages and more free time.

I am going to show you some of the statistics on taxes, but right now we know that the average middle class family is paying 38 percent of the total household income in taxes, which basically means the second income earner is working for the government. That is just, you know, what is happening. Right now we all work until May 7 to have the tax-free independence. So from January 1 to May 7 every year, people are working just to pay the IRS and State and local taxes.

Now, if you add on the cost of government regulations and other taxes, you are going until July 3d for Independence Day.

Now people will say, well, what are you talking about? Let me show you this chart.

This is a gas pump. On $1.20 for a gallon of gas—fortunately I am paying a little bit less in Georgia, but I know the folks in Maryland, they all are paying more than $1.20. But on a $1.20 gallon of gas, 56 cents goes to taxes, and that includes—I am just going to read:

FICA tax, corporate income tax, individual tax, capital gains tax, customs, ad valorem taxes, State taxes, corporate income, unemployment taxes, motor fuel taxes, excise taxes, used oil disposal taxes, business property taxes, pipeline throughput taxes. It is ridiculous. When people buy 10 gallons worth of gas, they are paying $5.60. They do not even think about taxes on top of what has already been taken out of their paycheck.

Now let us talk about a bottle of beer, 43 cents on a dollar bottle—well a little over a dollar, but 43 cents on a bottle of beer goes to taxes, basically the same kind of thing.

On a loaf of bread there are 118 different taxes that you and I and our families pay when we go to the grocery store to buy a loaf of bread. Hidden in the cost of that bread are 118 different taxes. That is why the middle class families are working their tails off. The harder they work, the less time they have because the more taxes they have to pay, and we do not have that family fellowship that we so desperately need to impart values to our next generation.

Mr. EHRLICH. That is why the middle class in this country is nervous. When working folks get nervous, this place feels it. The gentleman has raised a very interesting point. The gentleman talked about, what was it, 120 different taxes on a loaf of bread?

Mr. KINGSTON. One hundred eighteen.

Mr. EHRLICH. One hundred eighteen. But when we go to the grocery store, what do we see? One price, one price. We never think about it.

And I love this term ''takehome pay.'' What does takehome pay mean to you, to the average person?

Well, after you work until what, July 3d this year, you get your takehome pay. You work the rest of the year for yourself; right?

Mr. KINGSTON. Well now, actually your direct tax burden—you work from January 1 to May 7, and then the indirect tax in regulatory burden, you go on to July 3d.

Mr. EHRLICH. But the rest of the year you are really not taking home the rest of your paycheck because, despite your takehome pay, you take your takehome pay, your cash, and you go out and you buy things which are taxes.

So I think we really need to understand the dramatic way in which taxes impact the average working person in this country.

Mr. KINGSTON. Now to give my colleagues an idea of the Federal Government Washington command control bureaucracy view on taxes versus drugs, when we talked about earlier 13- and 14-year-olds using marijuana higher than ever before, I think, in history, but it is up anywhere from 137 to 200 percent depending on what age group in that 12-to-14 range, here is what we have fighting drugs.

Now this chart, I hope you can see it.

The DEA has 6,700 employees, and that is to fight drugs. The Border Patrol, immigration folks, 5,800 employees. So that is what we have got. You know, we will just round this up and say about 13,000 employees for fighting drugs and illegal immigration.

For the IRS we have 111,000 employees. Now, of those 111,000 employees, for every 3,000 citizens of America there is one criminal investigator.

So what we are saying is, no, we cannot fight drugs, we cannot fight illegal immigration, but we can audit you, and we can make sure that you are paying your taxes, and people should pay their taxes, and IRS should be able to collect it.

But it shows a disproportionate value rendered when you have 110,000 IRS employees versus 13,000 Border Patrol and drug enforcement.

Mr. EHRLICH. If the gentleman will yield, it reflects the values that have held sway in this town for at least 30 to 40 years. That is exactly what it reflects.

I know the gentleman is very anxious to talk about the topic of the day, the issue of the day, welfare reform.

Mr. KINGSTON. I am. But before we leave that, I do want to get one other thing on taxes.

There was a big discussion about the Clinton tax increase went to balancing the budget 1993, when Clinton passed the largest tax increase in the history of America, $245 billion. That money did not go into deficit reduction. That money went into more Federal Government.

Now, you know, the thinking that Americans do not deserve tax relief right after the President just passed such a huge tax credit—what the Republican Party was trying to do was

basically say we want to give you back some of the money that the President took from you in 1993, and one of those was a $500 per child tax credit.

So, working person, and I love to tell the story about John Johnson who works for UPS, U–P–S, in my district, and he said to me:

You know, I make pretty good money. I do a lot of overtime. I worked hard. My wife is a school teacher, and between the two of us we do OK. But we have got three kids. And at the end of the month we are not able to go down to Florida or go up to Atlanta and see a Braves game or do some of the nice things because we have got to buy a new set of tires, a new dryer. We have got to spend money on groceries, and so forth, and we cannot get ahead.

And this is a real story.

Now, with the $500 per child tax credit, he and his wife could have had $1,500 in their pocket that they could have spent any way they wanted to. And I think they know how to do it a heck of a lot better than Washington bureaucrats.

Mr. EHRLICH. If the gentleman will yield, what is so dangerous, what is so radical, and my favorite term in this Congress, what is so extreme about working people in this country taking home just a little bit more money? And I think I have the answer to that question: Class warfare works in elections.

How much class warfare do we see on this floor every day? How many times do we hear this phrase, the rich, the rich? And you know what? Those folks you just mentioned in your district, they are rich. They do not know it.

Mr. KINGSTON. Yes, they are, because under the liberal Washington definition of rich, that means you hold a job and you pay taxes.

You know another thing: marriage tax penalty. Two people living together doing everything that a married couple does pay less taxes than if they go down to the chapel and get a ring around their finger. That is absurd. Marriage is the key foundation block of the family in America, and here the first thing we do right off the bat is tell a couple:

Hey, it is cheaper to live together than it is to get married.

Mr. EHRLICH. If the gentleman will yield, what is the basic fabric of the free enterprise system in America? Small business people, small businessmen, and particularly small business women. Yet, we make it extremely difficult for these small business folks, who create 80 to 85 percent of the jobs in this country, to transfer their small businesses to the next generation. We punish success.

Of course, that is what class warfare is all about, punishing success. And I rally think it is incumbent upon this Congress—and now we have been joined by the President of the freshman class, the gentleman from California [Mr. RADANOVICH], and I know he has very strong views on this issue, being a business man himself.

We make it for some reason part of the political atmosphere in this country to practice this class warfare, generation warfare to make that person who is making $25,000 a year jealous of that person making $38,000 a year, which is not the way it is supposed to be. Yet every day in this House we hear from across the aisle:

Class warfare.

Tired of it.

Mr. KINGSTON. I have a friend of mine named Ted Fox, and Ted says this is what Congress' basic mentality is, that it is the three of us right here. We are walking down the street together, and one had more money than the other two. The other two could vote to take your money, and it would be morally fine and justified.

□ 2130

That is exactly, that is the whole left-wing premise: It is okay to steal, as long as you vote it as law in Congress. That is their whole mentality.

I want to yield to the gentleman from California [Mr. RADANOVICH] because he has been involved in so many of these good changes we have done. First, I want to say this, the idea behind class warfare is a loser. You are just bashing people.

The other day we had a leading Democrat say in the CONGRESSIONAL RECORD, and I will give you both and anybody else interested a copy of this, that the employer-employee relationship is similar to the jailer and prisoner relationship or the slave and the master relationship. That was from a leading Democrat, in one of the pro-family debates we were having.

Mr. Speaker, I yield to the gentleman from California [Mr. RADANOVICH].

Mr. RADANOVICH. My thanks to the gentleman from Georgia, Mr. Speaker, I was interested in the debate and wanted to come down and share the gentleman's comments and concerns.

In my perception, I think, of what we have seen in the brief year and a half and a little bit more that we have been in Washington as freshmen, it has been one of continual amazement in our dialog with the American people and how we think our Government relates to society in general, and how we are coming up against some pretty old ideas that have been around town for the last 40 years about government and its relationship with the people, as if that is the only relationship that is in America today.

It kind of epitomizes the Great Society and some of the ways of thinking of the last 40 years, in that the only relationship in America is Americans, with their government, and that there is only a two-way street there.

In coming to Washington and having to develop ideas on how to solve complex problems, like the deficit that we have, the up to $200 billion deficit and $5 trillion worth of debt, we have to begin to think in terms of other relationships that comprise America; that there are other institutions out there that are perhaps fundamentally more suited to the solving of some of our society's problems.

So when we get people coming on the House floor debating class warfare and this idea that there is a pot with only so much in it and you have to divvy it up among the people in the United States, and the only relationship that Americans have is with their Government, they are some of the ideas we have to begin to defuse. In so doing, we have to remind the American people that there are other institutions out there that are perhaps more suited to taking up the responsibilities that we have seen fit over the last 40 years to assume.

There are family units, there is business, legitimate business, and there are religious and civic institutions. Some of those jobs that government is doing right now are far more suited to these other institutions. Rather than get into this dialog about there being finite resources and we have to promote class warfare to get our piece of the pie, and that government should be involved in doing all these things and that is the only way we are going to solve our problem, I think what we need to do is to speak in terms of what other institutions in this country are better suited to solving these problems. If we were thinking in those terms we would probably not be $5 trillion in debt right now.

Mr. KINGSTON. I will say one thing, Mr. Speaker, that we all who are parents know the joy of holding our own child for the first time. You can hold your nephew or niece, you can hold a friend's baby, and you can love that baby and go to bat for him time and time again and care for him very deeply, but when you hold your own baby it is a whole new ball game.

The difference is we have Washington bureaucrats, and as well-minded as they may be about the children in California, in Maryland, in Georgia, and I am sure they love them to death, and I am sure they would never use children as political pawns, but the fact is the folks in Georgia, California, and Maryland love our kids a heck of a lot better than Washington bureaucrats, regardless of how great they may be up here.

WELFARE

Mr. Speaker, we want to move to our next topic, which ties into the family. It ties into the tax burden. That is that of welfare. The gentleman from Maryland [Mr. EHRLICH] had mentioned that earlier. I could tell he was chomping at the bit. I need to congratulate the two gentlemen for their leadership on this issue, because it is truly because their freshman class has been so persistent when the President has twice vetoed welfare reform, and you two have fought hard to bring it back to the floor time and time again.

Mr. Speaker, I am disappointed the President vetoed welfare twice, but that is part of the process. The fact is in our American system, hey, it is 3 months away from election, and he is

going to sign it. He is going to sign it for that reason. I understand that, and I will not complain about it if we get a bill and we help get children out of the poverty trap, so they can enjoy the social and economic mainstream.

Mr. EHRLICH. If the gentleman will continue to yield, once we think about getting some other bills on which we have had vetoes in the past, maybe a clean products liability bill, maybe we can get that signed. The president of the class is here and I know he would love that.

Before I begin my remarks on welfare, I have to be maybe the first in the entire House to congratulate my friend on his engagement, the gentleman from California [Mr. RADANOVICH]. I am very proud of the gentleman, and so is my wife.

Welfare reform. It is a great day, a great day for America. Substance triumphs over politics: Real work requirements, real reform of our legal immigration system, real time limits. It really leads into what the gentleman from California [Mr. RADANOVICH] was talking about just 2 minutes ago: what institutions do when we realize finally that government cannot do everything; that $5 trillion to $6 trillion in debt has made us at this point a permanent debtor nation, and we all know no superpower can live on for very long being a permanent debtor nation.

What institutions will take over for government? One is the private sector: jobs, real work, a quid pro quo for the Federal taxpayer. You want hard-earned tax money to live? Fine. It is a legitimate thing for government to do, to provide temporary assistance to folks. No one argues that. It should not be generational, it should not be multigenerational. Look what it has done to the society.

What is part of the answer? Work. The very foundation, the philosophical foundation of our welfare bill, which is quite similar to what the President vetoed last year, is work.

Mr. RADANOVICH. Mr. Speaker, if the gentleman will continue to yield, it also is fair in saying too that when we are dealing with generations of people who are used to being on the welfare rolls, we have to be concerned a little more about conscience-building among those ranks to get them off. Work is a moral responsibility. It really is not something that government should be teaching right now.

Every citizen in this country has the obligation of work, but it is very hard to instill those values, being a government institution. That is why block granting and getting these ideas away from government and starting to think about religious and civic institutions instilling those morals, and in the business institutions learning to work, so people go out and get the job and get the satisfaction of a day's pay for a day's work. It will be a wonderful thing. Government cannot teach those things.

Mr. KINGSTON. One of the things that is dear to the heart of every American citizen, Mr. Speaker, and particularly Virginia legislators, because it has the first House of Burgesses, which was the first legislative body in America, Jamestown, as the gentleman recalls from our history, the Jamestown Colony, many of the people who came over had their job classification as gentlemen. They thought they were coming to America, to the streets of gold, and so forth, the land of opportunity. They did not realize it had a work requirement to it. As a result, I think half of the crew perished that first and very harsh winter. Then Captain John Smith said, all right, there is going to be a new game. Everybody is going to work. When they did, the colony survived.

What we are saying is that if you are able to work, you are going to be required to work, and you are going to be better for it because you can join the socioeconomic mainstream. President Clinton loves to tell the story about the little boy who says, ''The best thing about my Mama being off welfare is because when people ask me what she does, I can say she has a job,'' so we are very much in line, here.

Mr. Speaker, I wanted to recognize the gentleman from Arizona [Mr. SHADEGG], who is here to join us, and I will yield to the gentleman.

Mr. EHRLICH. Mr. Speaker, we have our classmate outnumbered, 3 to 1. The gentleman from Arizona [Mr. SHADEGG] is a good friend of all of us and a great leader in our class. Before he speaks, I just want to say one thing.

All of us go back to our districts every weekend and talk to our constituents. That is part of the job. The modern House has evolved into that. It is such an important part of our jobs. Housing policy is a major issue in my district, particularly a settlement in Baltimore, which I know my friends in the class know about too well; welfare reform, personal responsibility as a concept.

What I see as the common denominator to all these issues is just a working class interest in having people work. It is a working class resentment toward those who will not, not cannot, but will not. I see it time and time again in comments from people I represent who stop me in shopping malls, gas stations, the hardware store, wherever, and they say, ''We work very hard to send our kids to school, to pay our mortgage, to buy our car. We do everything, EHRLICH, you want us to do. Yet we see in the newspaper every day people who will not who are rewarded for it.''

Mr. KINGSTON. Mr. Speaker let me apologize to the gentleman who I said earlier was from Nevada. We have so many good-looking freshmen faces that sometimes I just assume they are from all out West somewhere, and throw all those categories out there. I apologize, and I yield to the gentleman from Arizona.

Mr. SHADEGG. No apology necessary, Mr. Speaker. I am just pleased to join you all in celebrating what I think is a great victory for America today.

Today really is not a day for partisanship, it is a day for celebration. The truth is all across America, Americans understand that the welfare system we have, though well-intended, simply is not working. It is not working for the Americans that are at work and paying taxes, now paying taxes of close to half of their income, supporting those people. It is not working for them.

But even more importantly, the welfare system that we have created in this Nation, out of a desire to help our fellow man and our fellow women and the poor children in this country, simply is not benefiting them. I think the beauty of it, and it is well put in the gentleman's quote about the young boy who says, ''Now I can say that my mother has a job, or is not on welfare any longer,'' is the benefit for those people who are right now trapped in the system.

In a way, God created us to respond to incentives. The incentives in the current system are very bad. The incentives encourage people not to go back to work. They encourage people to have multiple illegitimate births. They encourage people to engage in lifestyles which are self-destructive.

All Americans recognize that there ought to be a safety net there to help those in need, but the safety net we have built has become not only a safety net but a trap. People try to climb out of that net and are caught up in it. Indeed, they spend way too long in it. It destroys them, it destroys their self-respect, and it destroys their families.

What we have done with this welfare bill, and I commend the President. I do not really care what his reasons are. He opposed it twice before. Now he has joined us. The bottom line point is we are going to make America better. We are fulfilling his promise to end welfare as we know it, because way back 3 years ago when he made that promise Americans understood welfare as we know it was a failure.

Now we are embarked on a program which will redesign welfare in America to help those that need help, but not just help them at their down point in their lives, help them get back into the job market, help them make themselves productive citizens again, help them attain back that point in their lives when they can respect what they do and when they can feel good about it, and when they can hold their head high and become participants in this economy and in the great experiment which is America, which is that we are going to reward initiative, that we are going to reward hard work. That is what this Nation was built on.

We have been cutting a whole block of Americans out from under that dream, saying to them, ''No, you really cannot work. We know you are not able to work, so we are going to take care of you.'' That is not an answer, and that

is not giving them hope, it is not giving them a future.

I just think it is a tremendous day to celebrate the fact that we are in fact revising a failed system and making the Nation better, not only for the people trapped in the system but for those of us who are picking up the tab, as well.

Mr. KINGSTON. Mr. Speaker, we now have with us another freshman, the gentleman from Washington, Mr. RANDY TATE, and I will attribute him to the State of Washington, rightly or wrongly. I know it is west of the Mississippi.

Mr. TATE. I would like to thank the gentleman from Georgia, Mr. Speaker. To folks out in the real Washington, this is an exciting day. To me welfare reform is not about balancing the budget. It has nothing to do with that, from my perspective. It is about helping people that are trapped in a system that has destroyed their self-esteem, that is taking their initiative away, that has trapped families and hurt children. We have spent, I have heard that number many times, $5 trillion since the 1960s. If we put that in real dollars, that is more than we spent fighting the Japanese and Germans during World War II, and we won that battle.

Everyone agrees welfare has failed. President Clinton said just right here during his State of the Union that this is the year to end welfare as we know it. Today, in the House of Representatives, we began to end welfare as we know it, not for the sake of balancing the budget, not sitting there and counting beans. It is about helping people. That is what this whole debate is about, breaking down the system to make it work for people again, to help families, to help moms, to help dads, to help kids have a better future.

□ 2145

Mr. EHRLICH. The gentleman has really brought up the fifth topic of the evening, which is words and actions.

Mr. KINGSTON. Before going to the fifth topic, I want to make it very abundantly clear for the record that we would not be in a position of having a welfare bill today if not for the action of the freshman class and the leadership of the 4 of you and many of your colleagues, because I can say this having come the previous term. We all talked about welfare, we never could get a bill on the floor of the House. You have been persistent.

I would like to say also, I do not think there is anything extreme about saying able-bodied people who can work would be required to work, and I do not think there is anything extreme about getting people out of the poverty trap, and I do not think there is anything extreme about saying to noncitizens, you cannot have our welfare benefits if that is the reason you have come into the country.

I know your class has caught lots of criticism, but this victory today belongs to your class. I think that is very important.

Mr. RADANOVICH. If the gentleman would yield, I would like to add to that comment and appreciate the sentiment. Before saying what I am going to say, there are two things that need to be said. One is that it does not matter who gets credit for this, it passed and it was good for America. So it does not make any difference if the President gets credit or Congress gets credit.

However, having said that, I would say one thing, and that is during the dark times of late December, early January, when we were struck in the middle of a Government shutdown, when the freshmen were getting a lot of flak for standing on resolve and keeping certain people to their word, this is the fruit of that.

I think that I am not at all out of line to say that had we not gone through a Government shutdown, we would not have had the President of the United States in the Chamber saying that the era of big Government is over and we would not have a President in here signing welfare reform that changes welfare as we know it simply because he knew that there were people in the House of Representatives that were going to keep him to his word, come heck or high water.

I think that that needs to be said. We are seeing the fruits of that shutdown. I know it is a tough subject, I know it is not what people want to go back to and talk about, but the American people know that that was absolutely necessary in order to get the changes that we are beginning to see the fruit of now.

Mr. EHRLICH. The President of the class just used the word ''fortitude,'' and the word ''integrity'' gets brought up, and the word ''consistency.'' Now you are joined by 4 freshman, the gentleman from Georgia is really surrounded; five actually with the gentleman from California [Mr. BILBRAY]. There is a quote right next to the gentleman. One of the President's closest advisers made that quote recently, I believe on Larry King Live, in February 1996. It is really interesting for the freshmen and certainly for the nonfreshmen in this Congress to look at quotes like this and wonder what is meant.

I know when I go back home on weekends, people come up to me, and I get a lot of credit for doing the easiest thing in the world, what no politician should get credit for in any legislative body anywhere, which is keeping his or her word. We should not get credit for it, yet we all get credit for it every weekend, every day, and in talking to my colleagues, I know we do. It is somewhat of a symbol of how far we have fallen, and this institution has fallen, our profession. We hate to admit it now, but we are full-time politicians, Members of Congress.

''For this President, words are actions.'' Mr. Stephanopoulos, words are not actions. Words are cheap, words are meaningless. Words, whether it is the State of the Union, these words we are speaking tonight, if they are not backed up with real actions, are without meaning.

I know the gentleman from Arizona is chomping at the bit over there.

Mr. SHADEGG. If the gentleman will yield, let me just make this point. If Mr. Stephanopoulos said this, ''For this President, words are actions,'' it pretty well defines the situation. I guess then saying that we should end welfare as we know it means that you have ended it. And yet in the first 3 years of this administration, nothing changed for America, not until the rubber hit the road, not until the votes were cast on the floor of this House to actually change the welfare system as written in the law did anything meaningful ever happen.

I would like to add one point to that. The victory, while it may been driven in part by the freshman class, as our colleague from Georgia has just pointed out, it was really driven by Main Street, America. This today was and is, and I guess we can claim victory today because the President has come forward and to his credit he has said he will sign this bill, that is victory for Main Street, America, because the values that freshmen have been advocating, the ideas of changing welfare to make it work for all Americans, those in the system and those paying for the system, those ideas came not from freshmen, they came from Main Street, America. They came from the people that we went to and asked what they wanted to see happen in this country and they want change. That is the point.

Mr. BILBRAY. If the gentleman will yield, I think the word was used quite appropriately, ''integrity.'' There are those that have been in this town for a long time who think that the freshmen and the new majority is somehow radical because we have brought with us from mainstream America the concept of integrity, that words without commitment, words without action, words that are said without the intent to perform lack integrity. And yet there are those in Washington who are terrified of the 73 freshmen who came here and said, I will not sacrifice either my integrity personally or the integrity of the commitment to the people of the United States. Frankly, I have to sort of chuckle at the fact that Washington is so terrified of a group that is finally bringing some integrity to the House floor.

I want to say this about the welfare reform. I served as the chairman of San Diego County, which has a welfare system larger than 32 States in the Union. We in 1978 proposed a concept that at that time they called cruel and mean-spirited. That concept in 1978 was workfare. Every bureaucrat and every obstructionist tried to stop us from executing a concept that would bring dignity back into the public assistance programs. When we were fighting on things like welfare fraud, as an administrator I looked at it, at the cards and

said ''There is not even a picture on the ID. Let's put a picture on the ID.'' Common sense. Washington said no, because they said it would violate the privacy of the welfare recipient.

These are just a few of many stories where every time you try to do something right with welfare, Washington stood in the way. Tonight we finally brought the integrity of the system before the American people and said if you want to promise that we are going to change welfare as we know it, then you have got to have the guts to change it.

Mr. KINGSTON. Let me reclaim the time just to remind everybody we have about 4 minutes left. So if each of you want to have a closing statement of 1 minute each.

Mr. EHRLICH. Just to back up what the gentleman from California had to say, I know the gentleman has another quote right next to him: ''The President has kept all the promises he meant to keep.''

What does that mean? The American people deserve to know what that means. They deserve to know when the President makes a promise which promise he means and which promise he does not mean. I do not care if you are liberal, conservative, Republican, Democrat. Your words should have meaning. Your words should have, as the gentleman said, integrity behind them if you sit in any legislative body, particularly the Congress of the United States.

Mr. TATE. I could not agree more. What does that mean? Are there promises you did not mean to keep, Mr. President? That is the question that I think is quite clear. The President did not mean to keep his tax cut for the middle class because he never provided a plan to do that. He never meant to balance the budget.

We had to bring him kicking and screaming all the way to the dance, so to speak, all the way to actually provide a plan finally, 3 years into his term, and, lastly, welfare reform today. It was not until the last moment, after he had already vetoed it twice, did he finally agree to sign welfare reform.

So I think I know exactly what it meant. Say one thing when you run, do another thing when you get elected. That is not what this Republican Congress is all about.

Mr. BILBRAY. I think the sad part about it is America and this Congress knows that if it was not election year, we would not have gotten three-quarters of Congress supporting what the American people are demanding. We operate a welfare system in this society that we would not do to our own children. But we justify it under the guise of being merciful. It would be illegal for us to do to our own children what we do on welfare. We pay underage children to live alone and send them a check. If you and I did that to our own children, it would not only be child abandonment, it would be child abuse.

But there are those here who claim they care about the children and hide behind the words they care about the children when in fact what they are doing is government-subsidized child abuse.

Tonight we had a great victory, and the American people had the great victory of making politics work for the American people, changing the system. I worry that without the American people keeping a clear message in the next election, that there are those who will try to go back to the old, worn-out, corrupt systems of the old Washington rather than moving forward with the integrity of the new majority.

Mr. Kingston. Let me reclaim the time just to yield to the president of the freshman class that has made all these changes possible. We are closing our discussion of illegal immigration, drug use, higher wages, lower taxes and, of course, welfare reform. I yield to the gentleman from California [Mr. RADANOVICH].

Mr. RADANOVICH. I thank the gentleman. My final words are promises made, promises kept; the promise to the American people that until we start keeping word and following through in Washington, it will be a long time even then before they begin to feel the results on Main Street, America. This is really truly where is happens. That is the commitment that we intend to keep to the American people.

Mr. KINGSTON. Mr. Speaker, I thank the gentleman from Arizona [Mr. SHADEGG], the gentleman from Washington [Mr. TATE], the gentleman from California [Mr. BILBRAY], the gentleman from California [Mr. RADANOVICH], the gentleman from Pennsylvania [Mr. WELDON], and the Gentleman from Maryland [Mr. EHRLICH] for participating in this special order.

IN SUPPORT OF CONFERENCE REPORT ON H.R. 3230, NATIONAL DEFENSE AUTHORIZATION ACT

The SPEAKER pro tempore (Mr. TAYLOR of North Carolina). Under the Speaker's announced policy of May 12, 1995, the gentleman from Pennsylvania [Mr. WELDON] is recognized for 60 minutes.

Mr. WELDON of Pennsylvania. Mr. Speaker, I will attempt to not take the entire hour, but I did want to rise this evening first of all to commend my colleagues for the excellent work they did in discussing the message of the Republican Party, and not just the Republican Party but, as evidenced by the vote on the welfare reform bill today, the overwhelming majority of Members of this institution. In fact, on the final vote there were 98 Democrats who voted for the bill and 98 who opposed it. So it truly was a bipartisan effort.

While there is much perceptual criticism of the Republicans in the Congress this year, the fact is that most of our initiatives have passed with bipartisan support and our colleagues on the other side have joined us.

That leads me to my point of discussion tonight, which is also bipartisan and which I expect to hit the House floor tomorrow, and that is the final conference report on the defense authorization bill for 1997.

Mr. Speaker, I rise as the chairman of the Subcommittee on Research and Development for the House Committee on National Security and one of the conferees who chaired two of the panels with the Senate in deliberating the final conference report that will come before us tomorrow.

Let me start out by saying, Mr. Speaker, that I think it is a good bill. It is not everything that I had wanted. I will talk about some of the weaknesses that I think we did not get in this bill, but all in all it is a good piece of legislation that deserves the support from a bipartisan standpoint of the majority of the Members of this institution.

But I want to start off by clearing up some misconceptions. The President and certain members of his administration and some on the other side in the more liberal wing of the Democratic Party have gone around the country talking about the Republicans wanting to have massive plus-ups in defense spending and that in fact the Republicans are giving the Pentagon programs that they really do not want, that we are just about buying more weapons systems and that we really are not concerned about the human problems that people in this country face.

Let me start out by saying, Mr. Speaker, that I come to this body as a public school teacher. I taught for 7 years in the public schools of Pennsylvania. I ran a chapter 1 program for 3 years in one of my depressed communities like West Philadelphia, then worked for a corporation running their training department and ran for office as the mayor of my hometown. All of those things I did to try to help people and to try to make a difference.

In my 10 years in Washington, I have tried to exercise in every possible way through my votes and my actions support and compassion for those needs that ordinary people have. In fact, I take great pride this year in the fact that, working with my colleague the gentleman from New York, RICK LAZIO, after Speaker GINGRICH had asked RICK and I to cochair an effort dealing with anti-poverty initiatives, that we were able to plus-up the funding for the community services block grant program in the appropriate appropriations bill on the House floor by $100 million.

This money goes directly to a network of 1100 community action agencies nationwide that basically is totally consistent with the Republican philosophy of empowering people locally to solve the problems of the poor. This plus-up in funding did not get much play in the national media. It was the single largest plus-up in the

community services block grant program in the history of that program, which dates back to prior to the 1980's.

□ 2200

In fact, these CAA's nationwide leverage, on average, $2 to $3 of private money for every $1 of public money we put in. So it is a tremendous investment in helping local folks through the nonprofit CAA's nationwide solve the problems of poverty and ways that we can work to empower people who have the greatest needs.

That is just one example of the kinds of things that this Congress has done that have largely been ignored by the American media in its rush to embrace the liberal wing of the Democrat Party and this President, who talk a good game but do not seem to follow through with the deeds that match their rhetoric.

I say that, Mr. Speaker, because we have also heard the rhetoric coming out of both the White House and the liberal wing of the Democratic Party that somehow we have dramatically increased defense spending. I want to get to that point because that is the topic of my special order tonight. Again, the facts do not bear that out.

The analysis that I use, Mr. Speaker, is to take defense spending and compare it today versus what we were spending back in the 1960's. I pick the time period of the 1960's because we were at relative peace in the world. It was after Korea and it was before Vietnam. John Kennedy, a Democrat, was our President. He believed in a strong defense for our country and worked hard to maintain our national security interests.

During John Kennedy's tenure, Mr. Speaker, we were spending about 9 percent of our country's gross national product on the military. We were spending about 55 cents of every Federal dollar that we take in in terms of taxes on the defense of this country—55 cents of every Federal dollar and 9 percent of our total gross national product.

This year's defense budget that will be finally approved tomorrow, in the final conference report that we will vote on, will see us spend less than 3 percent of our gross national product on the military and about 16 cents of the total Federal dollar that we take in this year.

Now, those are glaring differences, Mr. Speaker; 9 percent of our GNP in the 1960's versus 3 percent of our GNP today; 55 cents of every Federal dollar in the 1960s versus 16 cents of the Federal dollar that we take in today.

In addition to those numbers, Mr. Speaker, we have to let the American people know that there are some differences in today's environment. First of all, we have an all-volunteer military. We no longer have the draft. We pay those people who join the services a much higher salary and, in fact, a much larger percentage of our military personnel today are married and they have kids. So we have added housing costs, we have cost-of-living increases, we have a much larger health care system.

The quality of life for our service personnel today is dramatically improved over what it was back in the 1960's and, in fact, a much larger percentage of that lesser amount of Federal money is going for the quality of life for those men and women who serve in the various branches of our Armed Services.

So, in fact, while we have decreased the percentage of Federal spending on our national defense, we in fact, Mr. Speaker, are spending more of today's defense dollar on the quality-of-life issues for our men and women who serve in the military.

We have over the past 8 and 9 years made dramatic cuts in defense spending. Now, these were not all done at the suggestion of President Clinton. I am not here to say that tonight. In fact, some of these cuts were proposed under the Bush administration because the world was changing. And, in fact, many of those cuts I supported, but nowhere near the draconian cuts that are taking place today.

Those cuts, Mr. Speaker, that were proposed during the Bush administration were based on threat assessments that we were given from the situations that existed around the world that threatened American Security Interests and our allies' security interests. Today's dollars that we spend on the military are largely not spent based on threat assessments, they are largely determined by numbers pulled out of the air.

The Clinton administration, in fact, just pulled a number out of the air and said this is what we are going to spend on defense, in spite of the fact that when Les Aspin served as Secretary of Defense and completed his bottom-up review, he said we would need enough money to be able to fund the support for two simultaneous conflicts.

The General Accounting Office has said on the record that there is no way, given the Clinton administration numbers, that we could ever come close to funding up two simultaneous operations.

So, in fact, Mr. Speaker, the numbers that we are basing our defense budget on today are not based on reality, they are not even based on the philosophy that this administration established for our military leaders, and that was established in the bottom-up review headed up by then-Secretary of Defense Les Aspin.

What is more ironic, Mr. Speaker, with where we are today is that in dramatically cutting defense spending over the past 3 years, by the most significant cuts in the last 50 years in this country in terms of our military, we have seen 1 million men and women lose their jobs.

Now, Mr. Speaker, the defense budget is not a jobs bill. It is not like public works projects and it is not designed to ultimately just employ people, but we have to understand the irony of what is occurring in the country today, Mr. Speaker, and I want to point it out.

We have the Clinton administration over the past 3 years cutting defense spending by draconian amounts, resulting in the forced layoffs and cutbacks in defense industries and subcontractors that have caused 1 million men and women to lose their jobs in America.

Now, Mr. Speaker, the irony here is that most of those 1 million men and women were union employees. They were members of the United Auto Workers, the International Association of Machinists, the IUE, the electrical workers. They were involved in the building trades who worked in our bases and in our facilities.

So the bulk of the 1 million men and women who lost their jobs over the past 3 years, caused by this administration's actions, were union personnel. Not only did they lose their jobs, and all across this country, Mr. Speaker, we know of hundreds of thousands of our constituents who are out of work today who were employed at defense plants and subcontracting machine shops and subcontracting companies, but the irony is that the national AFL–CIO this year is forcing from every union employee in this country a $39 assessment. That $39 assessment is being taken out of the pockets of union personnel who work in defense plants to defeat Republican Members who have supported the dollars to fund their jobs.

Now, that has to be the ultimate irony. I look particularly at one plant, McDonnell-Douglas. My understanding is they have 8,000 union employees. Mr. Speaker, if we look at the amount of assessment that the AFL–CIO has levied on those defense workers working for McDonnell-Douglas, it amounts to over $300,000, and that money is being targeted not to people who are voting against their jobs, but it is being targeted to support the ideals of the Democratic Congressional Campaign Committee, and only to target freshmen Republican Members, most of whom supported a more robust defense budget which in effect provided the dollars for those very jobs.

That is the ultimate irony, Mr. Speaker. And all of this money is being taken from those rank-and-file union workers without their support and without their ability to determine where that money should be spent, in spite of the fact that in the 1994 elections, 40 percent of the rank-and-file union workers in this country voted for Republican candidates.

Mr. Speaker, that is outrageous; yet we have not heard one national labor leader in Washington talk about the Clinton elimination of 1 million union jobs in this country.

We are now in the process, Mr. Speaker, of taking that message to every plant in this Nation. And why are we going to do that? Because this President will go to every one of those

plants and stand up on the podium next to the CEO and the union leader and talk about the jobs that are there, and he will talk about what his administration is doing to keep those workers employed.

Yet this administration, in concert with the national AFL–CIO leadership, is in fact targeting, through forced contributions, funds to eliminate those freshman Members who have largely voted for the defense funding level that we are going to have on this floor tomorrow. To me, Mr. Speaker, that is outrageous.

Now, the further hypocrisy of this administration, Mr. Speaker, is that last year the Congress, bipartisan support, plussed up defense spending by about $5.5 billion above the President's mark. We did not pull that number out of the air, Mr. Speaker, we took it from the recommendations of the Joint Chiefs of Staff. They are not political appointees, they are career servants of the military, whose command responsibilities are to protect the lives of our troops.

We met with them and, based upon their advice, we funded the Defense Department funding levels to the requests that they gave us. Actually they wanted more money than we could provide.

This year, Mr. Speaker, when the President again chose in a draconian way to cut defense spending, we brought in the service chiefs, and the service chiefs were very candid. They said the budget proposed was unacceptable.

In fact, Mr. Speaker, when the House Committee on National Security had the four service chiefs in front of us, it was the late Admiral Boorda, the CNO of the Navy, and a very fine leader of our naval forces who said publicly, when asked if he had the ability to provide a wish list for additional funds, where would he put those dollars, and he replied back to us, Congressmen, there is no wish list. These priorities that I will give you are absolutely essential to protect the sailors under my command.

We then went to the Commandant of the Marine Corps and when the Commandant, General Krulak, had his chance to respond, he likewise said, look Congressmen and Congresswomen, I am not going to make any bones about what we need here. My warriors need additional funding, and the request I give you is going to be real.

To every last one of the four service chiefs, they gave us the dollar amounts that they need to support the internationalist escapades of this administration around the world; to fund the operations in Somalia, to fund the $3 to $4 billion we are currently spending in Bosnia, the $2 to $3 billion we are spending in Haiti, the escapades that the President is committing our men and women all over the world. These four leaders told us the dollar amounts that they felt were absolutely necessary to meet the requirements of quality of life and protection of these troops.

Mr. Speaker, the bill that we will provide tomorrow will begin to do that. It will not completely provide the support they requested from us, because we cannot get additional dollars in this budget environment where we are committed to balancing the budget over a set period of time. We do not have additional money to put into the military. Therefore, we have to make do with this plus-up that we are providing.

Now, here is the outrage again, Mr. Speaker, the outrage that I feel every day I serve in this body. This President criticized this Congress last year for plussing up defense spending over his request. When Secretary Perry came before our committee this year, he had a chart showing the amount of defense spending that the Clinton administration would provide.

In that chart, it was a line graph, he showed a flattening out of the cuts in the acquisition programs to buy new equipment and he said that the Clinton administration was taking steps to stop the decline and that decline, in fact, stopped in 1996.

I said to the Secretary of Defense, this is an outrage. It is the most outrageous presentation I have seen from a Secretary of Defense. Why? Because here we had the Secretary of Defense, who last year joined with President Clinton in criticizing us for plussing up defense spending, now this year taking credit for what they criticized us for doing last year.

That same thing will happen this year, Mr. Speaker. My prediction is that with all the criticisms from the White House and from the Secretary of Defense, they in fact will accept the final bill that we pass, the funding will be provided, and then this President will go to every one of those plants and every one of those bases, and this President will take credit for those items that we funded through a bipartisan action of this Congress that he opposed and criticized us for.

It even gets worse than that, Mr. Speaker. The hypocrisy coming from the White House is unbelievable. The B–2 bomber is a perfect case in point. Let me say, Mr. Speaker, that some would say you are just down here as a Republican hawk who supports every defense weapon system and that is why you are mad at President Clinton.

□ 2045

That is not the case. Let me give the example of the B–2. I have opposed the B–2 bomber for the last 3 years, Mr. Speaker, even though I chair the National Security Research and Development Subcommittee. My party leadership, as you know, has supported the B–2 bomber; in fact, the majority of my colleagues on the Republican side support the B–2 bomber.

I felt it was great technology, but we cannot afford it. Given the budget numbers that we have to work with, we cannot afford to spend money on a program that we cannot continue. Therefore, over the past 3 years I have consistently, in committee and on the House floor, opposed money for the B–2.

Now this President, Mr. Speaker, has said that he too opposes the B–2 bomber, just like he has criticized us for plussing up defense spending. But after the President signed the defense appropriation bill last year, which had B–2 funding in it, what did this President do? He went out to southern California and he went to the plant where the B–2 bomber is manufactured and he gave a speech with the head of the union and the head of the company standing on both sides of him and what did he say? He said to those workers, I am here to support building one more B–2 bomber. And then he went on to say, and I have authorized the commission of a study that is going to be done that will determine whether or not we need more deep strike bombing capabilities.

Now, there is the President, who supposedly was against the B–2, had criticized this Congress for funding it, now out at the plant where the program is under way taking credit for it and, furthermore, leaving all of these workers in southern California believing that somehow this President is having a change of heart and leaving the option out there that perhaps there will be a change, and after the election is over, somehow will reverse and we will start building more B–2's.

In fact, the President told these workers that that study will be released at end of November. Which oh, by the way, Mr. Speaker, is a couple of weeks after the Presidential election.

All of those B–2 workers, Mr. Speaker, are union employees. Where is the outrage from the national leadership? There is none.

The hypocrisy of this administration on defense programs is mind boggling.

One final example, Mr. Speaker, this President went before AIPAC, a national association of Jews in America who support Israel as much as I do. He went before AIPAC, they had a thousand or so people here in the Capital, and he gave a very commanding speech about our relationship with Israel and especially Israel's national security. And during that speech, he pledged publicly that he would move forward with a bold new defense program called Nautilus.

This new missile defense technology would protect the Israeli people from the threat of a Russian Katyusha rocket being launched into Israel, like we saw the Scuds launched in there during Desert Storm. That speech was met with thunderous applause as the AIPAC members stood up and applauded President Clinton for his bold words of support for protecting the Israeli people.

But again, Mr. Speaker, we have to look beyond the rhetoric and the words. In fact, Mr. Speaker, as I said the next day after I read the text of the President's speech, the Clinton administration for the past 3 years has zeroed out funding for the high energy laser

program each year. In fact, this year they put $3 million in their budget request to kill the program totally. That was in January.

Mr. Speaker, the high energy laser program is Nautilus. So here we had a President standing before thousands of supporters of Israel's protection and freedom, getting rave reviews and cheers, not telling these same people that he has tried to kill that program 3 straight years. Only because of the Congress' action, Democrats and Republicans alike, was the high energy laser program kept intact and can we now fully fund that tomorrow in the bill that we will bring before this body.

In fact, Mr. Speaker, there was no request by this administration for funding for the Nautilus program at all this year. Now that is outrageous. The President gave a speech; the President said he was for the program. There was never a request given to this body or our committee for funding the Nautilus program.

We funded it. Democrats and Republicans working together made sure the full funding for Nautilus is in this bill. And tomorrow we vote on it and it will be there.

My bill, Mr. Speaker, in fact, is a good bill. It provides for the quality-of-life issues that are important for our service people. It provides for a pay raise. The first year of the Clinton administration he did not even request a pay raise for our troops. He wanted them to forgo a pay raise; send them to Somalia or Bosnia or Haiti, but do not give them a pay raise. Extend the deployments. Have them go 6, 8, 9, 12 months, but do not give them a pay raise. We found the money in the Congress to fully fund the pay raise the first couple of years of the Clinton administration.

In this year's bill, Mr. Speaker, that we will vote on tomorrow, a pay raise for our troops is consistent with other Federal employees. We have also provided funds for a COLA for our retired military employees.

We have also, Mr. Speaker, taken aggressive steps to deal with those human issues of impact aid to affect those school districts where kids of people who are in the military go to school to make sure we take care of those extra costs associated with the sons and daughters of our enlisted personnel.

We have also, Mr. Speaker, gone to great lengths to provide for the quality-of-life support for our men and women in the military. And much of the increase that we provide, over the President's request that he has criticized us for, will go for day care centers, will go for family housing, will go for cost-of-living adjustments for those men and women serving this country around the world.

They are justified. They are right, and they are supported by an overwhelmingly bipartisan group of this body and the other body. I am happy to say they are in the bill.

Mr. Speaker, our defense bill that we will finally enact tomorrow with the help of our colleagues also does some other things. In my particular area of concern, there are some new initiatives. For instance, we fully fund our laboratories. The laboratories allow us to maintain state-of-the-art research on new technologies. That, in fact, is a key part of the R&D portion of our conference report tomorrow. We fund our national science and technology initiative to make sure that our universities are continuing to do research in new technologies, in new materials, to make sure that we are always on the cutting edge.

The bill that we enact tomorrow, Mr. Speaker, and we will vote on tomorrow, does some other things that are very important. It provides a whole new oceans partnership initiative that Congress and PAT KENNEDY and I offer. This new initiative, Mr. Speaker, again bipartisan, allows the Navy to take the lead in bringing together all of our Federal agencies that do oceanographic research to better coordinate the dollars that we spend and provide new partnerships with the private sector with academic institutions like Woods Hole and Scripps and those other facilities around the country that are looking at the environmental impact of our oceans and what needs to be done to protect coral reefs and our ocean ecosystems.

Much of the work that we are seeing off the coast of New York in searching for those remains of TWA flight 800 are being done with the Navy, because of the extensive capabilities the Navy has. And there is a whole new initiative in tomorrow's bill to further enhance the Navy's capability in the area of oceanographic work, oceanographic mapping, and ocean partnership activities.

Mr. Speaker, we have also taken great steps forward to keep in place a dual-use initiative so that we encourage the military to use dual use wherever possible, so it is not just benefitting the military but it is also benefitting civilian life so that wherever we can take a technology, use it for the military, but also have civilian benefit, that we provide the dollars to make those kinds of things happen. That is a major part of our bill that we will be voting on tomorrow.

But, Mr. Speaker, the real purpose of my special order tonight is to focus on what I think are the two major threats that we face as a Nation, both of which are addressed in this bill and both of which the leadership has come not from 1600 Pennsylvania Avenue, but rather from this body.

Democrats and Republicans working together have crafted a bill that has allowed us to address the two major threats that we face as a Nation. These threats are critical, they are real, and we see evidence of them as we just look around the world today.

The first is terrorism, and we see it every day in every possible aspect of our society and our lives, whether it be in the air, on the ground, or whatever. It is a major problem and a major concern. The other is missile proliferation.

Those are the two major threats, Mr. Speaker, that we see emerging around the world which this bill directly addresses and they both involve weapons of mass destruction, whether they be the use of chemical, biological, nuclear or conventional arms.

How did we address that, Mr. Speaker? Despite, again, the words and the rhetoric coming out of the White House because of the downing of the TWA and because of the bombing of our troops in Saudi Arabia, it was this Congress, Mr. Speaker, that in the last 2 years plussed up funding under Republican leadership for chemical and biological research and development.

My subcommittee and our full committee and the final conference in last year's bill and this year's bill plussed up funding in that area so that our military spends more money and more focus on the threat from chemical, biological, nuclear and conventional weapons of mass destruction. It is money that has been in the bill since we started this process last January; not money that we put in because of the TWA incident or because of the Saudi Arabia bombing. Money that we put in because the hearings that we held last fall and this winter showed that the administration was not requesting enough dollars. Well, we met the shortfall and we put the money in.

We put the money in another area where the President was quick to criticize our actions. Now though, changing his course, he wants to have a huge meeting at the White House about what can we do about the threat of terrorism and chemical and biological weapons. Again, because the media's focus is there, the President is there. Well, this Congress has been there long before the media was focused on these kinds of incidents.

Mr. Speaker, we also provide additional funding for what is being called Nunn-Lugar Two. We did not accept everything that SAM NUNN and RICHARD LUGAR wanted in the other body, but we took their recommendations dealing with terrorism and disposal of nuclear weapons in Russia and other former Soviet States and we modified and changed it and we modified the domestic side, so that we have a robust program to assist our towns and cities in dealing with terrorist acts around the country.

Now, again, Mr. Speaker, these are not new issues. I introduced a piece of legislation three sessions ago that would have required FEMA to establish a computerize inventory of every possible resource that a city mayor, a fire chief, or an incident command scene coordinator could have at his or her disposal if a mass incident occurred, whether it be the World Trade Center bombing or the Oklahoma City bombing or some other incident. FEMA has still not acted on that request. That is in our bill tomorrow.

Mr. Speaker, that will be part of the requirement; that FEMA working with the DOD and other Federal agencies has to computerize every resource that this Federal Government provides that could be brought to use in the case of a disaster in our cities, our towns, our rural areas, wherever it might be. And it is about time that took place. That did not come about because the White House said it was important; it came about because this Congress took the action.

Mr. Speaker, we also provide a new thrust for local emergency response personnel. Our portion that we forced through the conference process on the House side and agreed to by the other body provides dollars to train local emergency response personnel, firefighters, EMT's, paramedics, police officers, so that when they are called upon to respond to disasters involving terrorist acts and terrorist weapons, they know what they are dealing with and they can respond accordingly. Those plus-ups are in this bill. They are valid and they are worthy of our support tomorrow.

Last week in one of our other appropriation bills we plussed up money, $5 million, for a local emergency responder, so it adds to that effort that we have already approved in this body.

Mr. Speaker, we go a long way to addressing the issue of responding to terrorist acts and to better equip not just our military, but to better equip those civilian entities around the country that are the first responders in these types of situations.

The bill also, Mr. Speaker, addresses the second major threat that we face as a Nation, and that is the threat of missile proliferation. Mr. Speaker, around the world, there is a mad rush by scores of countries to develop new capabilities in terms of missile technology and these new capabilities, Mr. Speaker, present real challenges for the United States and our allies.

□ 2230

We, to look at Israel and see the concern of just those very antiquated Scuds being fired and the damage they caused during the Desert Storm. In fact, Mr. Speaker, the only major loss of life from one single incident in Desert Storm to American troops was caused by an Iraqi Scud missile being fired into one of our barracks.

If we would have developed and deployed systems that we know we have the capability of putting into place today, perhaps we could have prevented those kinds of incidents from ever occurring.

The threat of missile proliferation is more real than it has ever been and countries around the world today are developing capabilities that we have never seen before.

This Congress, Mr. Speaker, has taken the effort to plus up funding in the area of defending our country against a missile attack. There has been a lot of misinformation, Mr. Speaker. The liberal media and the White House basically rails against missile spending, saying we should not be spending this money. We have not been talking about building new offensive weapons. We are not talking about building MX missiles. What we are talking about, Mr. Speaker, is defense, protecting the American people, our troops and our allies against an accidental or deliberate launch by one or two missiles.

Today, Mr. Speaker, we have no such capability. Our troops are vulnerable and our people are vulnerable. What we want to do in this Congress is, we want to deploy those technologies that we know are available today and will be available over the next several years.

It is the single biggest area of disagreement with this administration, how fast and how much we should be developing and deploying missile defense systems for the troops, for our allies and for the people of this country.

The Clinton administration would have us believe that the world is rosy. Again, the President has misinformed the American people. Remember what we heard earlier about words. Words seem to be everything in this White House. Actions and facts seem to fall by the wayside.

On two occasions, Mr. Speaker, the President of the United States has stood at this podium right behind me in the State of the Union speech and he has said to the American people, as he bit his lip, that the children of America can sleep well tonight because for the first time in 20 or 30 years, there are no Russian offensive missiles pointed at America's children.

During the past year, Mr. Speaker, we have totally refuted what the President said, not by Republican experts but by his own personnel working in the military.

First of all, Mr. Speaker, during a series of 14 hearings we held in this session of the Congress, we had the experts from the Air Force, from the intelligence community come in and tell us on the record there is no way for us to verify whether or not the Russians have retargeted their offensive weapons. We have no way of verifying that. The President has no way of verifying it because our intelligence community cannot verify it. But the President made the statement.

The second thing is, Mr. Speaker, if we even could verify that, our targeting experts have said on the record that we can retarget an offensive missile in less than 30 seconds. Why then would the President say this? Because the President wants to create this impression that somehow all is so well and somehow the American people do not have to worry.

Let me make a point here, Mr. Speaker, I am not a reactionary alarmist. In fact, I probably do more work with the Russians that any other Member of the Congress. I will talk about those initiatives again tonight.

Since my undergraduate degree in Russian studies and since my days in speaking the Russian language and in my numerous visits to Russia, I have worked in helping them with their energy needs, their environmental needs, and, in fact, I am right now setting up a new initiative that the Speaker has tasked me to do with Mr. Vladimir Lukin, chairman of the International Affairs Committee for the Russian Duma, that will have Members of this Congress and the Russian Duma come together for the first time in a real way on an ongoing basis. It will be an institutional process that will last beyond Members.

Right now I am working with the ambassador of Russia to help develop a new technology transfer center in America for Russian technology. I put money in the defense bill, Mr. Speaker, this year for $20 million of joint Russian-American missile defense technology so that we work with the Russians, so that we do not try to squirrel one up on them.

I was the one last year who opposed those in my party who wanted to offer an amendment on the defense bill last year that would have forced the President to abrogate the ABM treaty. Mr. Speaker, I am not some rabid conservative who thinks that perhaps the Russian government is still the evil empire.

I want the same ultimate objective that I think Bill Clinton wants. I want the same ultimate objective that I think Strobe Talbott wants; that is, a free, democratic Russia to succeed with free markets and security and less of a threat to America and the rest of the world.

But there is one key difference, Mr. Speaker. I am willing to go to the Russians when there are problems that we have to confront them with and confront them openly. This administration's pattern has been to ignore reality and in effect to try to bury or brush over or create a perception that there are no problems there.

We all know that Russia is going through problems of severe internal turmoil. We were all happy that Boris Yeltsin won the presidential election a few short weeks ago. And we are all happy the Duma is committed to working with him.

Mr. Speaker, there is one very important fact we have to keep in mind. The leadership in the Russian military today is the same leadership that was there during the Soviet Communist domination. Perestroika and glasnost has not come with the Russian military. In fact, Mr. Speaker, I obtained a document earlier this year that was published by one of the leading Russian think tanks, the Institute for Defense Analysis, it was published by a gentleman of the name of Anton Surikov. It is called the Surikov document.

This document, which was briefed to the former defense minister Pavel Grazhdye and the current chief of command for the Russian military, General Kalesnakov, has some very interesting material in it that every American and

every one of our colleagues should read.

It says in it that in the end America is always going to be an enemy of Russia. In the end America is always going to be a threat to Russia's sovereignty. In the the end, the Russian government should look to establish linkages with emerging rogue Islamic nations and it names them. It names Libya. It names Iraq, Syria as those allies of Russia that should be nurtured and where technology should be transferred to benefit a mutual relationship.

This is not put out by some American think tank. This is an internal document published within Russia.

Mr. Speaker, I am not here to say that every Russian believes this because they do not. Boris Yeltsin does not believe this, I firmly believe. But there are people in the Russian military who still believe this, and this President and this administration do not want to call them on that. That is what is so outrageous.

Mr. Speaker, we have seen some evidence of that. Last year about this time there was a transfer of accelerometers and gyroscopes that went from Russia to Iraq. Why is that so important? Mr. Speaker, gyroscopes and the accelerometers and the gyroscopes that were retrieved by the Jordanian intelligence agency and the Israeli intelligence agency could only be used for one purpose: They are so sophisticated that their only purpose is to be used in long range missiles; that is, short range Scuds, long range missiles, long range missiles that ultimately could pose a threat to the U.S.

Now these missiles, these devices, the accelerometers and the gyroscopes were going from Russia to Iraq. The Washington Post, in December, reported the story on the front page, that the Jordanians and Israelis had intercepted these devices.

I asked the administration to give me a briefing on it. I got some remark that it was too early.

I was in Moscow in January, and I met with our ambassador at the time, Ambassador Pickering, who is a fine gentleman and I think doing a great job in Moscow. I said to him, Mr. Ambassador, what is the response of the Russian government to the fact that we have intercepted these devices being transferred to Iraq, because it is a direct violation of the Missile Technology Control Regime. The MTCR, which is very complicated, is basically an arms control agreement that we brought Russia into that says they will not transfer technology involving missiles to another rogue Nation. This is a clear violation.

When I asked the ambassador what the Russian response was, he said, Congressman, we have not asked them yet. I said, What do you mean you have not asked them yet. We have not requested them yet. We have not officially asked the Russians why and how these materials were being transferred from Russia to Iraq.

I came back to the U.S. and I asked the question again and again. In fact, I wrote to the President in late February. I did not get a response until April 3. The President's response to me was, Mr. Congressman, we have asked the Russians for a full explanation and they have promised us they will get it to us. I have asked when and we have no answer.

But the important point, Mr. Speaker, is, that is a violation of an arms control agreement that this administration maintains is the cornerstone of our relationship with Russia.

Now, if we are not going to hold nations accountable when they violate arms control agreements that this President feels are the cornerstone of our relationship, how can we expect the Russian people to have any respect for us? We cannot, because they do not. Missile technology is being transferred around the world.

I am not saying it is being done openly by the Russian government, because I do not think they would do that. But it is happening. The rise of the Mafia in Russia that has stolen nuclear material, nuclear fissile material, that has transferred technology, that has gained control of certain elements of the arms control system in Russia, is spreading around the world and this administration is not taking aggressive steps to deal with that. This Congress is. This Congress is dealing in reality, Mr. Speaker.

And we are not doing it in such a way to tweak the Russians. Everything I have talked about is to do it holding the leadership's hands in Russia, to show them that we want to work with them. We want Russia to succeed. We are not about getting an edge up on that. We do not want to gain an advantage over Russia. But we do want to provide a protection for our people that we do not have that the Russian people have had for the past 15 years.

Mr. Speaker, under the ABM treaty, each country is allowed to have one missile defense system. The Russians have one. They have had it for 15 years. They have upgraded it four times. We have none.

We have none because the liberals in this city have never wanted the U.S. to be able to achieve its rightful place in providing a defensive system to protect the people of America.

Mr. Speaker, that is outrageous. We are not talking about offensive missiles. We are not talking about killing people. We are talking about a defensive system that Russia already has.

Mr. Speaker, I hope this becomes a major issue in this year's presidential race because this President is totally and completely vulnerable on the issue of arms control and our relations with not just Russia but those nations developing missile technology. This Congress is doing something about that. This Congress does not wait until Israel gets hit by some Scuds and it goes before AIPAC and makes a big speech and then tries to put money in. This Congress looks at the facts.

This Congress has deliberated, Democrats and Republicans, and based on the threat as we understand it, has said we are not doing enough to protect the American people and our troops.

In fact, Mr. Speaker, it has become somewhat outrageous. Last year the commanding officer for our troops in South Korea wrote to General Shalikashvili, the commander's name is General Luck. General Luck is charged by the people of this country with the responsibility of protecting the lives of our sons and daughters who are in South Korea today. General Luck wrote to General Shalikashvili and he said, I need to have a theater missile defense system as soon as possible, because I feel that my troops are vulnerable and I need you to give me a deployment as soon as you can give it to me. The system he is talking about, Mr. Speaker, is not national missile defense. It is not the new variation of protecting our own country. It is theater missile defense, which this President has said publicly he supports.

It is called THAAD. The Navy version is called Navy Upper Tier. Now this President has come out and said he supports theater missile defense. This Congress supports theater missile defense. But in this year's defense bill, Mr. Speaker, that we are now implementing, the 1996 defense bill, we put two specific dates in that bill for deploying THAAD and Navy Upper Tier.

Never once did this President or the Secretary of Defense or any general come to us and tell us those dates were unattainable. Never once did they say, do not put them in there, we cannot meet them. The dates were 2000 and 2001, the earliest possible dates for having systems in place to protect our troops.

☐ 2245

This President signed that bill into law in February of this year. Within a week of signing that bill into law, his people came before the Congress and said: We are going to restructure the program, we are not going to be able to meet those dates, we are not going to obey the law. We are going to slip the THAAD program until 2006. We are going to slip the program requested by the general in charge of our troops in South Korea by 6 years, even though it is law and even though this President signed that bill into law, and even though this President never objected to that date, and even though the commander in chief of our troops over there says it is vitally important we have them in place.

We have no recourse, Mr. Speaker. We are suing the President in Federal court right now to get him to abide like the law like we all have to do.

There are major areas of disagreement, Mr. Speaker, between this Congress and that White House in terms of national missile defense, theater missile defense, and cruise missile defense. Unfortunately, we have an administration that waits until the right media

opportunity, the APAC speech, the Scud attack, the Saudi attack, the TWA bombing, and then raises its hands, calls a press conference, invites people to stand behind the President, and then all of a sudden there is concern that we are going to do something to solve the problem.

Yet all along while this Congress is in a very deliberate way providing the dollars to meet those very threats and needs, this President and his people are criticizing this Congress and attempting to make the case to the American people of providing funds to meet threats that do not exist.

Mr. Speaker, to me as someone who devotes the bulk of my time to both national security and Russian relations, it is outrageous, and I am not going to stand for it. I am going to use every possible opportunity I have for the next 3 months to expose this administration for the hypocrisy that occurs every day. Whether it is the lack of enforcement of arms control agreements, whether it is the lack of calling the Chinese on the transfer of ring magnets to Pakistan, or whether it is the M–11 missile technology transfers, or whether it is the accelerometers and gyroscopes going from Russia to Iraq, we are going to call this administration.

But that is not enough, Mr. Speaker, because the world is dangerous. The Russians are hurting for cash right now. In our bill tomorrow we are going to provide some dollars to help them dismantle nuclear weapons, and I will stand up and I will support that on the floor, as I have done repeatedly, but that is not enough.

In the rush of the Russians to try to find new markets, they are now offering for market sale their most sophisticated offensive strategic weapons. These are long-range weapons. The SS–25 is what they are technically referred to: These missiles have a range of 10,000 kilometers, which means that these missiles can hit any city in the United States from any place in Russia.

Now, Mr. Speaker, I am not here to say tonight that I think Russia is going to launch a SS–25 at America, so I do not want my liberal friends to go out saying, ''There goes WELDON, scaring the American people.'' I am not saying that. There is a possibility of a rogue event occurring. The Russian military has tremendous problems with morale—underpaid, finding proper housing. They have got problems with crime. But I still have some degree of confidence in the Russian military's control of their systems.

We are not talking about that, Mr. Speaker. What we are talking about is taking a SS–25 launcher, and we know the Russians have over 400 of them, they are all mobile, they are on the back of a truck, you can drive them any place. They are on rubber tires. You can drive them through the country, and the CIA has said on the record it would be possible to move one of those launchers out of Russia without our surveillance camera detecting it.

Here is the rub, Mr. Speaker, I do not really think that the threat comes from Iraq developing its own long-range missile. I do not think it is going to come from Libya developing its own long-range missile. What I think is going to happen is one of those nations will pay the right price to buy one of those mobile launched SS–25 systems that is currently being marketed for space launch purposes.

Now the Russians tell us that they are controlling the launches, that they are all going to occur on their soil, even though they originally wanted to have a launch capacity in both Brazil and South Africa until we objected. But the point is, at some point in time in the future, mark my works, Mr. Speaker, there will be an incident involving a transfer of one of those launch systems, and when that occurs, we have no protection.

Mr. Speaker, we have no system in this country today to protect the American people. If we are threatened, we have nothing we can do except offensively go in and attempt to take that missile launcher out, if we know in advance it is going to occur.

That is where the threat is, Mr. Speaker, and that does not even include the threat coming from North Korea and China. The Chinese are now on their latest variation of the CSS–5A. This missile has a range of 13,000 kilometers. We know it can hit any city in America.

Now the Clinton administration tells us we do not need missile defense because we have the ABM Treaty and therefore, since Russia is part of the ABM Treaty, we do not have to worry about Russia attacking us. China is not and never was a signatory to the ABM Treaty. There is no prohibition in China, and their offensive weapons today have the capacity to hit any city in the United States. North Korea is developing the Tae Po Dong and the Tae Po Dong II. These missiles will eventually have the range, very shortly, in a matter of years, of hitting Hawaii and Alaska.

Again the outrage, Mr. Speaker. Instead of this President talking honestly to the American people about the threat, what did he have the intelligence community do? In a threat assessment that was leaked to two Democrats last December before it was done, even though General O'Neill was the customer for that threat assessment, this administration said in their intelligence report there is no threat to the continental United States that we have to worry about for the next 10 to 15 years.

Now the intelligence community is going back now and kind of rethinking what they said there, but here is the important thing. Here is an administration that would go to this length, in terms of disagreeing between the Congress and the White House over missile defense initiatives, to say no threat to the continental United States. In other words, forget about Alaska and Hawaii. Because they are not a part of the continental United States, we are not going to worry about the North Koreans having the capability of hitting Hawaii or parts of Alaska.

Mr. Speaker, that is outrageous. This administration said that, and this administration has sold that to Members of Congress and the American people. Thank goodness this Congress has not bought it.

Mr. Speaker, our bill tomorrow provides full funding for missile defense in response to what the President's own ballistic missile defense organization said it could use. We did not go out and put money into programs just because we felt they are important, and I have no programs anywhere near my district in this area at all. We went to General O'Neill, who ran the President's own operation up until he retired last month, and said where would you put the dollars, and that is where we put the money.

But this President, Mr. Speaker, is not providing honest information to the American people about reality today, reality in terms of the threat and reality in terms of what we should be doing to protect the American people and our troops. Here we are putting our troops around the world, yet not giving them the protection they need through capabilities that we have technically available today.

There are two major provisions that were deleted from the final conference bill that I am very disappointed with. The first would have prevented the administration from making any changes to the ABM Treaty in terms of adding in other nations without the advice and consent of the U.S. Senate. To me that is outrageous.

This administration right now is over in Geneva negotiating changes to the ABM Treaty. They want to bring in other former Soviet states. Why is that so significant? Because when we want to modify that treaty, we do not just have to get Russia's approval, we have got to get Belorussia's approval, Ukraine's approval, Kazakhstan's approval, Tadzhikistan's approval, none of whom have offensive nuclear weapons.

When I was over in Geneva as the only Member of Congress to visit the discussions and the negotiations taking place this year, for 2½ hours I sat across from the chief Russian negotiator General Kotunov. He is a hardliner, but a decent person. We had a frank discussion. Sitting next to me was our chief American negotiator, Stanley Riveles. I looked General Kotunov right in the eye and I said:

''General, tell me, why does Russia want to amend the treaty to bring in all of these other countries? They do not have offensive weapons, they do not have offensive missiles.''

He said, ''Congressman, you are asking that question of the wrong person. I have not raised the issue of multilateralizing the treaty. You should be asking that of the person sitting next to you.

Mr. Speaker, I cannot believe that our administration would be so beholden to an arms control treaty that they would want to involve other countries so it would be more difficult for us to amend that treaty down the road. That is what I feel this administration is doing, and I feel that is wrong. It is also certainly wrong without the advice and consent of the Senate. We had to remove that language from the bill because this President threatened to veto it, and the Senate would not go along with us.

The second thing we had to remove from this bill was on further discussions in Geneva relative to demarcation. Now there are not many people who understand the demarcation issue because, to be honest with you, I cannot understand it fully myself. But I can tell you what is going on.

This administration, unlike the previous 12 years of administrations dealing with Russia, has interpreted the ABM Treaty in such a way to require us to go in and negotiate systems that we have never before felt came under the terms of the ABM Treaty. This administration is right now about to give us an agreement, probably in October, that will limit our ability to fully develop our Navy upper-tier theater missile defense system. We call it dumbing-down our technology. There is no reason for it, Mr. Speaker.

The previous two administrations set a standard that this Congress, Democrats and Republicans, agreed to. It is called the demonstrated standard in terms of where the ABM Treaty applies. This administration went over to Geneva and opened up a whole new can of worms, and so we are going to negotiate an agreement with the Russians on what is or is not allowed in terms of theater missile defense systems; the bottom line being, we are going to further limit, self-limit and self-impose, limitations on our own capabilities.

It reminds me of what we did with the Patriot system. A lot of us saw the Patriot used during Desert Storm and we thought what a great system. Do you know, Mr. Speaker, that system was dumbed-down? That system was originally designed to take out planes and not missiles. We had a change at the eleventh hour because of the missiles coming into Israel.

Is that what is going to happen here? Are we going to wait until something happens, and then let the President have a major national press conference and pound the table and talk about his commitment to missile defense for our troops? Are we going to wait until we have a missile land in South Korea and then say that we are working hard on this new initiative? Are we going to wait until we have a Third World nation get a capability that threatens our sovereignty and then say we are going to move ahead?

That is not what this Congress is doing. This Congress is taking steps to protect our troops and to protect our American people in spite of this administration. I just hope that as this year goes on our colleagues join with us in telling the message of truth about what is happening to our national security.

THE DEFENSE NEEDS OF OUR NATION

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Maine [Mr. LONGLEY] is recognized for 5 minutes.

Mr. LONGLEY. Mr. Speaker, I recognize that the hour is late and I will only speak but for a few minutes, but I was in my office listening to the gentleman from Pennsylvania, and was very struck by his remarks, and felt that it would be appropriate to perhaps follow along with what the gentleman from Pennsylvania has been saying. He is a fellow member of the Committee on National Security, but he is making some very important points. It was a masterful summary of the provisions of the defense conference report that we will be discussing in the House tomorrow, but, more importantly, the focus on the reality of the problems, the threats that confront us as a Nation, and the issues and how they affect our defense and national security could not have been better stated.

I want to particularly make reference to his comments in the light of the unfortunate incident of barely 2 weeks ago, the downing of TWA Flight 800. I think that we are all greatly sorry that that aircraft was downed in the manner that it was. But I have to say very honestly that I think we do know what caused the aircraft to come down, and I am very concerned that we seem to be somewhat afraid of actually stating the reason.

From all circumstances, and again I have no particular knowledge, but from all the circumstantial evidence it appears very clear that this aircraft was taken down by an act of sabotage.

Again, it has not been proven yet, but the suggestion is very strong that it was some form of an altitude detonated device that sent 230 innocent men women and children to their deaths in the Atlantic off of Long Island.

□ 2300

To the extent that that is true, I think as a Nation we need to be looking at our defense bill, not only in the context of that terrible, tragic accident, but also in the context of the prior bombing of the Dhahran barracks barely another 2 weeks prior to that, where another 19 or 20 young Americans lost their lives in Saudi Arabia, and then going back to last November in Riyadh and the attack, again, on innocent Americans, the five that were killed in that maintenance facility in Saudi Arabia.

One of the things that is becoming very clear about the previous two attacks is that they were well-planned and very sophisticated and required a high level of training and expertise to be carried out. I am advised, for instance, that the bomb that destroyed the facility in Riyadh was timed to detonate at precisely noon, or roughly during the time of noon prayer, when any non-American personnel were likely to be at the nearby mosque for noon prayers; or that the bomb that detonated the barracks in Dhahran was actually a very sophisticated mix of military and commercial grade explosives, well over 5,000 to 10,000 pounds of explosives, again, that were structured in a highly sophisticated and detailed manner designed, in effect, and executed by professionals.

Again, we do not know yet the answer to TWA Flight 800, but it is very clear that many of the terrorist groups in the Middle East who have taken credit, small or large, for the prior attacks are also invoking their name in the context of TWA Flight 800.

To that extent, it is a serious, serious issue that I hope this Congress will demand very honest and candid answers to; because to the extent that there is a connection between these three incidents, to the extent that they document a very serious threat that is being mounted against this country, then I think that while it is appropriate that we be engaging in a discussion of what security measures are appropriate and how we might best protect ourselves as a Nation, as a group of innocent people, concerned with the danger that might be raised against innocent men and women and children, then it is also appropriate that we consider, to the extent that it is possible to do so, from whence these attacks have arisen; what is the cause, who were the perpetrators, why are innocent men and women and children and American servicemen and women being targeted in the manner they are being targeted?

I also say this with reference to my service in Desert Storm and as a veteran of that conflict. I am very much aware of the fact that 95 percent of our seaborne traffic, our military support that supported American troops in Desert Storm and Saudi Arabia, transited into the Persian Gulf through the Straits of Hormuz, past the three islands that are currently occupied by the country of Iran, islands that have been fortified with chemical weapons, islands that have been fortified with antiship and anti-air missiles, and islands the sovereignty over which has been claimed by a country that openly proclaims its intentions of driving the United States from the Middle East, driving the United States from the Persian Gulf, and in effect, asserting control over the tremendous oil resources of that region and threatening the economic lifeblood of the western and free world, including the United States.

Mr. Speaker, I have tried to raise several very important questions. I think they are very serious in the context of the prior tour de force that was conducted by the gentleman from

Pennsylvania, Mr. WELDON, relating to our defense needs and the method in which we have attempted to address them in the upcoming conference report.

RECESS

The SPEAKER pro tempore (Mr. TAYLOR of North Carolina). Pursuant to clause 12 of rule I, the House stands in recess subject to the call of the Chair.

Accordingly (at 11 o'clock and 2 minutes p.m.), the House stood in recess subject to the call of the Chair.

□ 2343

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. TAYLOR of North Carolina) at 11 o'clock and 43 minutes p.m.

REPORT ON H.R. 3103, HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

Mr. HASTERT submitted the following conference report and statement on the bill (H.R. 3103) to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.

CONFERENCE REPORT (H. REPT. 104–736)

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3103), to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes, having met, after full and free conference, and agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Health Insurance Portability and Accountability Act of 1996''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

Subtitle A—Group Market Rules

PART 1—PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

Sec. 101. Through the Employee Retirement Income Security Act of 1974.

''PART 7—GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

''Sec. 701. Increased portability through limitation on preexisting condition exclusions.

''Sec. 702. Prohibiting discrimination against individual participants and beneficiaries based on health status.

''Sec. 703. Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements.

''Sec. 704. Preemption; State flexibility; construction.

''Sec. 705. Special rules relating to group health plans.

''Sec. 706. Definitions.

''Sec. 707. Regulations.

Sec. 102. Through the Public Health Service Act.

''TITLE XXVII—ASSURING PORTABILITY, AVAILABILITY, AND RENEWABILITY OF HEALTH INSURANCE COVERAGE

''PART A—GROUP MARKET REFORMS

''SUBPART 1—PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

''Sec. 2701. Increased portability through limitation on preexisting condition exclusions.

''Sec. 2702. Prohibiting discrimination against individual participants and beneficiaries based on health status.

''SUBPART 2—PROVISIONS APPLICABLE ONLY TO HEALTH INSURANCE ISSUERS

''Sec. 2711. Guaranteed availability of coverage for employers in the group market.

''Sec. 2712. Guaranteed renewability of coverage for employers in the group market.

''Sec. 2713. Disclosure of information.

''SUBPART 3—EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION

''Sec. 2721. Exclusion of certain plans.

''Sec. 2722. Enforcement.

''Sec. 2723. Preemption; State flexibility; construction.

''PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

''Sec. 2791. Definitions.

''Sec. 2792. Regulations.

Sec. 103. Reference to implementation through the Internal Revenue Code of 1986.

Sec. 104. Assuring coordination.

Subtitle B—Individual Market Rules

Sec. 111. Amendment to Public Health Service Act.

''PART B—INDIVIDUAL MARKET RULES

''Sec. 2741. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

''Sec. 2742. Guaranteed renewability of individual health insurance coverage.

''Sec. 2743. Certification of coverage.

''Sec. 2744. State flexibility in individual market reforms.

''Sec. 2745. Enforcement.

''Sec. 2746. Preemption.

''Sec. 2747. General exceptions.

Subtitle C—General and Miscellaneous Provisions

Sec. 191. Health coverage availability studies.

Sec. 192. Report on medicare reimbursement of telemedicine.

Sec. 193. Allowing Federally-qualified HMOs to offer high deductible plans.

Sec. 194. Volunteer services provided by health professionals at free clinics.

Sec. 195. Findings; severability.

TITLE II—PREVENTING HEALTH CARE FRAUD AND ABUSE; ADMINISTRATIVE SIMPLIFICATION; MEDICAL LIABILITY REFORM

Sec. 200. References in title.

Subtitle A—Fraud and Abuse Control Program

Sec. 201. Fraud and abuse control program.

Sec. 202. Medicare integrity program.

Sec. 203. Beneficiary incentive programs.

Sec. 204. Application of certain health antifraud and abuse sanctions to fraud and abuse against Federal health care programs.

Sec. 205. Guidance regarding application of health care fraud and abuse sanctions.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

Sec. 211. Mandatory exclusion from participation in medicare and State health care programs.

Sec. 212. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from medicare and State health care programs.

Sec. 213. Permissive exclusion of individuals with ownership or control interest in sanctioned entities.

Sec. 214. Sanctions against practitioners and persons for failure to comply with statutory obligations.

Sec. 215. Intermediate sanctions for medicare health maintenance organizations.

Sec. 216. Additional exception to anti-kickback penalties for risk-sharing arrangements.

Sec. 217. Criminal penalty for fraudulent disposition of assets in order to obtain medicaid benefits.

Sec. 218. Effective date.

Subtitle C—Data Collection

Sec. 221. Establishment of the health care fraud and abuse data collection program.

Subtitle D—Civil Monetary Penalties

Sec. 231. Social security act civil monetary penalties.

Sec. 232. Penalty for false certification for home health services.

Subtitle E—Revisions to Criminal Law

Sec. 241. Definitions relating to Federal health care offense.

Sec. 242. Health care fraud.

Sec. 243. Theft or embezzlement.

Sec. 244. False Statements.

Sec. 245. Obstruction of criminal investigations of health care offenses.

Sec. 246. Laundering of monetary instruments.

Sec. 247. Injunctive relief relating to health care offenses.

Sec. 248. Authorized investigative demand procedures.

Sec. 249. Forfeitures for Federal health care offenses.

Sec. 250. Relation to ERISA authority.

Subtitle F—Administrative Simplification

Sec. 261. Purpose.

Sec. 262. Administrative simplification.

''PART C—ADMINISTRATIVE SIMPLIFICATION

''Sec. 1171. Definitions.

''Sec. 1172. General requirements for adoption of standards.

''Sec. 1173. Standards for information transactions and data elements.

''Sec. 1174. Timetables for adoption of standards.

''Sec. 1175. requirements.

''Sec. 1176. General penalty for failure to comply with requirements and standards.

''Sec. 1177. Wrongful disclosure of individually identifiable health information.

''Sec. 1178. Effect on State law.
''Sec. 1179. Processing payment transactions.
Sec. 263. Changes in membership and duties of National Committee on Vital and Health Statistics.
Sec. 264. Recommendations with respect to privacy of certain health information.
Subtitle G—Duplication and Coordination of Medicare-Related Plans
Sec. 271. Duplication and coordination of medicare-related plans.
Subtitle H—Patent Extension
Sec. 281. Patent extension.
TITLE III—TAX-RELATED HEALTH PROVISIONS
Sec. 300. Amendment of 1986 Code.
Subtitle A—Medical Savings Accounts
Sec. 301. Medical savings accounts.
Subtitle B—Increase in Deduction for Health Insurance Costs of Self-Employed Individuals
Sec. 311. Increase in deduction for health insurance costs of self-employed individuals.
Subtitle C—Long-Term Care Services and Contracts
PART I—GENERAL PROVISIONS
Sec. 321. Treatment of long-term care insurance.
Sec. 322. Qualified long-term care services treated as medical care.
Sec. 323. Reporting requirements.
PART II—CONSUMER PROTECTION PROVISIONS
Sec. 325. Policy requirements.
Sec. 326. Requirements for issuers of qualified long-term care insurance contracts.
Sec. 327. Effective dates.
Subtitle D—Treatment of Accelerated Death Benefits
Sec. 331. Treatment of accelerated death benefits by recipient.
Sec. 332. Tax treatment of companies issuing qualified accelerated death benefit riders.
Subtitle E—State Insurance Pools
Sec. 341. Exemption from income tax for State-sponsored organizations providing health coverage for high-risk individuals.
Sec. 342. Exemption from income tax for State-sponsored workmen's compensation reinsurance organizations.
Subtitle F—Organizations Subject to Section 833
Sec. 351. Organizations subject to section 833.
Subtitle G—IRA Distributions to the Unemployed
Sec. 361. Distributions from certain plans may be used without additional tax to pay financially devastating medical expenses.
Subtitle H—Organ and Tissue Donation Information Included With Income Tax Refund Payments
Sec. 371. Organ and tissue donation information included with income tax refund payments.
TITLE IV—APPLICATION AND ENFORCEMENT OF GROUP HEALTH PLAN REQUIREMENTS
Subtitle A—Application and Enforcement of Group Health Plan Requirements
Sec. 401. Group health plan portability, access, and renewability requirements.
Sec. 402. Penalty on failure to meet certain group health plan requirements.
Subtitle B—Clarification of Certain Continuation Coverage Requirements
Sec. 421. COBRA clarifications.
TITLE V—REVENUE OFFSETS
Sec. 500. Amendment of 1986 Code.
Subtitle A—Company-Owned Life Insurance
Sec. 501. Denial of deduction for interest on loans with respect to company-owned life insurance.
Subtitle B—Treatment of Individuals Who Lose United States Citizenship
Sec. 511. Revision of income, estate, and gift taxes on individuals who lose United States citizenship.
Sec. 512. Information on individuals losing United States citizenship.
Sec. 513. Report on tax compliance by United States citizens and residents living abroad.
Subtitle C—Repeal of Financial Institution Transition Rule to Interest Allocation Rules
Sec. 521. Repeal of financial institution transition rule to interest allocation rules.

TITLE I—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

Subtitle A—Group Market Rules

PART 1—PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

SEC. 101. THROUGH THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new part:

''PART 7—GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

''SEC. 701. INCREASED PORTABILITY THROUGH LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

''(a) LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD; CREDITING FOR PERIODS OF PREVIOUS COVERAGE.—Subject to subsection (d), a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

''(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

''(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

''(3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (if any, as defined in subsection (c)(1)) applicable to the participant or beneficiary as of the enrollment date.

''(b) DEFINITIONS.—For purposes of this part—

''(1) PREEXISTING CONDITION EXCLUSION.—

''(A) IN GENERAL.—The term 'preexisting condition exclusion' means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

''(B) TREATMENT OF GENETIC INFORMATION.—Genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

''(2) ENROLLMENT DATE.—The term 'enrollment date' means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

''(3) LATE ENROLLEE.—The term 'late enrollee' means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

''(A) the first period in which the individual is eligible to enroll under the plan, or

''(B) a special enrollment period under subsection (f).

''(4) WAITING PERIOD.—The term 'waiting period' means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

''(c) RULES RELATING TO CREDITING PREVIOUS COVERAGE.—

''(1) CREDITABLE COVERAGE DEFINED.—For purposes of this part, the term 'creditable coverage' means, with respect to an individual, coverage of the individual under any of the following:

''(A) A group health plan.

''(B) Health insurance coverage.

''(C) Part A or part B of title XVIII of the Social Security Act.

''(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

''(E) Chapter 55 of title 10, United States Code.

''(F) A medical care program of the Indian Health Service or of a tribal organization.

''(G) A State health benefits risk pool.

''(H) A health plan offered under chapter 89 of title 5, United States Code.

''(I) A public health plan (as defined in regulations).

''(J) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 706(c)).

''(2) NOT COUNTING PERIODS BEFORE SIGNIFICANT BREAKS IN COVERAGE.—

''(A) IN GENERAL.—A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

''(B) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2)) shall not be taken into account in determining the continuous period under subparagraph (A).

''(3) METHOD OF CREDITING COVERAGE.—

''(A) STANDARD METHOD.—Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan, and a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

''(B) ELECTION OF ALTERNATIVE METHOD.—A group health plan, or a health insurance issuer offering group health insurance coverage, may elect to apply subsection (a)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

''(C) PLAN NOTICE.—In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall—

''(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

''(ii) include in such statements a description of the effect of this election.

''(4) ESTABLISHMENT OF PERIOD.—Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

''(d) EXCEPTIONS.—

''(1) EXCLUSION NOT APPLICABLE TO CERTAIN NEWBORNS.—Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

''(2) EXCLUSION NOT APPLICABLE TO CERTAIN ADOPTED CHILDREN.—Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

''(3) EXCLUSION NOT APPLICABLE TO PREGNANCY.—A group health plan, and health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

''(4) LOSS IF BREAK IN COVERAGE.—Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

''(e) CERTIFICATIONS AND DISCLOSURE OF COVERAGE.—

''(1) REQUIREMENT FOR CERTIFICATION OF PERIOD OF CREDITABLE COVERAGE.—

''(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subparagraph (B)—

''(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

''(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

''(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

''(B) CERTIFICATION.—The certification described in this subparagraph is a written certification of—

''(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

''(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

''(C) ISSUER COMPLIANCE.—To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

''(2) DISCLOSURE OF INFORMATION ON PREVIOUS BENEFITS.—In the case of an election described in subsection (c)(3)(B) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

''(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

''(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

''(3) REGULATIONS.—The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

''(f) SPECIAL ENROLLMENT PERIODS.—

''(1) INDIVIDUALS LOSING OTHER COVERAGE.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

''(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

''(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

''(C) The employee's or dependent's coverage described in subparagraph (A)—

''(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

''(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.

''(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

''(2) FOR DEPENDENT BENEFICIARIES.—

''(A) IN GENERAL.—If—

''(i) a group health plan makes coverage available with respect to a dependent of an individual,

''(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

''(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

''(B) DEPENDENT SPECIAL ENROLLMENT PERIOD.—A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

''(i) the date dependent coverage is made available, or

''(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

''(C) NO WAITING PERIOD.—If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

''(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

''(ii) in the case of a dependent's birth, as of the date of such birth; or

''(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

''(g) USE OF AFFILIATION PERIOD BY HMOS AS ALTERNATIVE TO PREEXISTING CONDITION EXCLUSION.—

''(1) IN GENERAL.—In the case of a group health plan that offers medical care through health insurance coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if—

''(A) no preexisting condition exclusion is imposed with respect to coverage through the organization,

''(B) the period is applied uniformly without regard to any health status-related factors, and

''(C) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

''(2) AFFILIATION PERIOD.—

''(A) DEFINED.—For purposes of this part, the term 'affiliation period' means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

''(B) BEGINNING.—Such period shall begin on the enrollment date.

''(C) RUNS CONCURRENTLY WITH WAITING PERIODS.—An affiliation period under a plan shall run concurrently with any waiting period under the plan.

''(3) ALTERNATIVE METHODS.—A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of part A of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''SEC. 702. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

''(a) IN ELIGIBILITY TO ENROLL.—

''(1) IN GENERAL.—Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

''(A) Health status.

''(B) Medical condition (including both physical and mental illnesses).

''(C) Claims experience.

''(D) Receipt of health care.

''(E) Medical history.

''(F) Genetic information.

''(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

''(H) Disability.

''(2) NO APPLICATION TO BENEFITS OR EXCLUSIONS.—To the extent consistent with section 701, paragraph (1) shall not be construed—

''(A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or

''(B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

''(3) CONSTRUCTION.—For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

''(b) IN PREMIUM CONTRIBUTIONS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

''(A) to restrict the amount that an employer may be charged for coverage under a group health plan; or

''(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

''SEC. 703. GUARANTEED RENEWABILITY IN MULTIEMPLOYER PLANS AND MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

''A group health plan which is a multiemployer plan or which is a multiple employer welfare arrangement may not deny an employer whose employees are covered under such a plan continued access to the same or different coverage under the terms of such a plan, other than—

''(1) for nonpayment of contributions;

''(2) for fraud or other intentional misrepresentation of material fact by the employer;

''(3) for noncompliance with material plan provisions;

''(4) because the plan is ceasing to offer any coverage in a geographic area;

''(5) in the case of a plan that offers benefits through a network plan, there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or any health status-related factor in relation to such individuals or their dependents; and

''(6) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

''SEC. 704. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

''(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

''(1) IN GENERAL.—Subject to paragraph (2) and except as provided in subsection (b), this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

''(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this part shall be construed to affect or modify the provisions of section 514 with respect to group health plans.

''(b) SPECIAL RULES IN CASE OF PORTABILITY REQUIREMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the provisions of this part relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

''(2) EXCEPTIONS.—Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

''(i) substitutes for the reference to '6-month period' in section 701(a)(1) a reference to any shorter period of time;

''(ii) substitutes for the reference to '12 months' and '18 months' in section 701(a)(2) a reference to any shorter period of time;

''(iii) substitutes for the references to '63' days in sections 701(c)(2)(A) and 701(d)(4)(A) a reference to any greater number of days;

''(iv) substitutes for the reference to '30-day period' in sections 701(b)(2) and 701(d)(1) a reference to any greater period;

''(v) prohibits the imposition of any preexisting condition exclusion in cases not described in section 701(d) or expands the exceptions described in such section;

''(vi) requires special enrollment periods in addition to those required under section 701(f); or

''(vii) reduces the maximum period permitted in an affiliation period under section 701(g)(1)(B).

''(c) RULES OF CONSTRUCTION.—Nothing in this part shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

''(d) DEFINITIONS.—For purposes of this section—

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

''(2) STATE.—The term 'State' includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

''SEC. 705. SPECIAL RULES RELATING TO GROUP HEALTH PLANS.

''(a) GENERAL EXCEPTION FOR CERTAIN SMALL GROUP HEALTH PLANS.—The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

''(b) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 706(c)(1).

''(c) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—

''(1) LIMITED, EXCEPTED BENEFITS.—The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 706(c)(2) if the benefits—

''(A) are provided under a separate policy, certificate, or contract of insurance; or

''(B) are otherwise not an integral part of the plan.

''(2) NONCOORDINATED, EXCEPTED BENEFITS.—The requirements of this part shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 706(c)(3) if all of the following conditions are met:

''(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

''(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

''(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

''(3) SUPPLEMENTAL EXCEPTED BENEFITS.—The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 706(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

''(d) TREATMENT OF PARTNERSHIPS.—For purposes of this part—

''(1) TREATMENT AS A GROUP HEALTH PLAN.—Any plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (2)) as an employee welfare benefit plan which is a group health plan.

''(2) EMPLOYER.—In the case of a group health plan, the term 'employer' also includes the partnership in relation to any partner.

''(3) PARTICIPANTS OF GROUP HEALTH PLANS.—In the case of a group health plan, the term 'participant' also includes—

''(A) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

''(B) in connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the self-employed individual,

if such individual is, or may become, eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

''SEC. 706. DEFINITIONS.

''(a) GROUP HEALTH PLAN.—For purposes of this part—

''(1) IN GENERAL.—The term 'group health plan' means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

''(2) MEDICAL CARE.—The term 'medical care' means amounts paid for—

''(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

''(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

''(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

''(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—For purposes of this part—

''(1) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for

as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

''(2) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2)). Such term does not include a group health plan.

''(3) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' means—

''(A) a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

''(B) an organization recognized under State law as a health maintenance organization, or

''(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

''(4) GROUP HEALTH INSURANCE COVERAGE.—The term 'group health insurance coverage' means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

''(c) EXCEPTED BENEFITS.—For purposes of this part, the term 'excepted benefits' means benefits under one or more (or any combination thereof) of the following:

''(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

''(A) Coverage only for accident, or disability income insurance, or any combination thereof.

''(B) Coverage issued as a supplement to liability insurance.

''(C) Liability insurance, including general liability insurance and automobile liability insurance.

''(D) Workers' compensation or similar insurance.

''(E) Automobile medical payment insurance.

''(F) Credit-only insurance.

''(G) Coverage for on-site medical clinics.

''(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

''(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

''(A) Limited scope dental or vision benefits.

''(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

''(C) Such other similar, limited benefits as are specified in regulations.

''(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

''(A) Coverage only for a specified disease or illness.

''(B) Hospital indemnity or other fixed indemnity insurance.

''(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

''(d) OTHER DEFINITIONS.—For purposes of this part—

''(1) COBRA CONTINUATION PROVISION.—The term 'COBRA continuation provision' means any of the following:

''(A) Part 6 of this subtitle.

''(B) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

''(C) Title XXII of the Public Health Service Act.

''(2) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' means any of the factors described in section 702(a)(1).

''(3) NETWORK PLAN.—The term 'network plan' means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

''(4) PLACED FOR ADOPTION.—The term 'placement', or being 'placed', for adoption, has the meaning given such term in section 609(c)(3)(B).

''SEC. 707. REGULATIONS.

''The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this part. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this part.''.

(b) ENFORCEMENT WITH RESPECT TO HEALTH INSURANCE ISSUERS.—Section 502(b) of such Act (29 U.S.C. 1132(b)) is amended by adding at the end the following new paragraph:

''(3) The Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 706(a)(1)). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.''.

(c) DISCLOSURE OF INFORMATION TO PARTICIPANTS AND BENEFICIARIES.—

(1) IN GENERAL.—Section 104(b)(1) of such Act (29 U.S.C. 1024(b)(1)) is amended in the matter following subparagraph (B)—

(A) by striking ''102(a)(1),'' and inserting ''102(a)(1) (other than a material reduction in covered services or benefits provided in the case of a group health plan (as defined in section 706(a)(1))),''; and

(B) by adding at the end the following new sentences: ''If there is a modification or change described in section 102(a)(1) that is a material reduction in covered services or benefits provided under a group health plan (as defined in section 706(a)(1)), a summary description of such modification or change shall be furnished to participants and beneficiaries not later than 60 days after the date of the adoption of the modification or change. In the alternative, the plan sponsors may provide such description at regular intervals of not more than 90 days. The Secretary shall issue regulations within 180 days after the date of enactment of the Health Insurance Portability and Accountability Act of 1996, providing alternative mechanisms to delivery by mail through which group health plans (as so defined) may notify participants and beneficiaries of material reductions in covered services or benefits.''.

(2) PLAN DESCRIPTION AND SUMMARY.—Section 102(b) of such Act (29 U.S.C. 1022(b)) is amended—

(A) by inserting ''in the case of a group health plan (as defined in section 706(a)(1)), whether a health insurance issuer (as defined in section 706(b)(2)) is responsible for the financing or administration (including payment of claims) of the plan and (if so) the name and address of such issuer;'' after ''type of administration of the plan;''; and

(B) by inserting ''including the office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights under this Act and the Health Insurance Portability and Accountability Act of 1996 with respect to health benefits that are offered through a group health plan (as defined in section 706(a)(1))'' after ''benefits under the plan''.

(d) TREATMENT OF HEALTH INSURANCE ISSUERS OFFERING HEALTH INSURANCE COVERAGE TO NONCOVERED PLANS.—Section 4(b) of such Act (29 U.S.C. 1003(b)) is amended by adding at the end (after and below paragraph (5)) the following:

''The provisions of part 7 of subtitle B shall not apply to a health insurance issuer (as defined in section 706(b)(2)) solely by reason of health insurance coverage (as defined in section 706(b)(1)) provided by such issuer in connection with a group health plan (as defined in section 706(a)(1)) if the provisions of this title do not apply to such group health plan.''.

(e) REPORTING AND ENFORCEMENT WITH RESPECT TO CERTAIN ARRANGEMENTS.—

(1) IN GENERAL.—Section 101 of such Act (29 U.S.C. 1021) is amended—

(A) by redesignating subsection (g) as subsection (h), and

(B) by inserting after subsection (f) the following new subsection:

''(g) REPORTING BY CERTAIN ARRANGEMENTS.—The Secretary may, by regulation, require multiple employer welfare arrangements providing benefits consisting of medical care (within the meaning of section 706(a)(2)) which are not group health plans to report, not more frequently than annually, in such form and such manner as the Secretary may require for the purpose of determining the extent to which the requirements of part 7 are being carried out in connection with such benefits.''.

(2) ENFORCEMENT.—

(A) IN GENERAL.—Section 502 of such Act (29 U.S.C. 1132) is amended—

(i) in subsection (a)(6), by striking ''under subsection (c)(2) or (i) or (l)'' and inserting ''under paragraph (2), (4), or (5) of subsection (c) or under subsection (i) or (l)''; and

(ii) in the last 2 sentences of subsection (c), by striking ''For purposes of this paragraph'' and all that follows through ''The Secretary and'' and inserting the following:

''(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 101(g).

''(6) The Secretary and''.

(B) TECHNICAL AND CONFORMING AMENDMENT.—Section 502(c)(1) of such Act (29 U.S.C. 1132(c)(1)) is amended by adding at the end the following sentence: ''For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.''.

(3) COORDINATION.—Section 506 of such Act (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(c) COORDINATION OF ENFORCEMENT WITH STATES WITH RESPECT TO CERTAIN ARRANGEMENTS.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority under sections 502 and 504 to enforce the requirements under part 7 in connection with multiple employer welfare arrangements, providing medical care (within the meaning of section 706(a)(2)), which are not group health plans.''.

(f) CONFORMING AMENDMENTS.—

(1) Section 514(b) of such Act (29 U.S.C. 1144(b)) is amended by adding at the end the following new paragraph:

''(9) For additional provisions relating to group health plans, see section 704.''.

(2)(A) Part 6 of subtitle B of title I of such Act (29 U.S.C. 1161 et seq.) is amended by striking the heading and inserting the following:

''PART 6—CONTINUATION COVERAGE AND ADDITIONAL STANDARDS FOR GROUP HEALTH PLANS''.

(B) The table of contents in section 1 of such Act is amended by striking the item relating to the heading for part 6 of subtitle B of title I and inserting the following:

''PART 6—CONTINUATION COVERAGE AND ADDITIONAL STANDARDS FOR GROUP HEALTH PLANS''.

(3) The table of contents in section 1 of such Act (as amended by the preceding provisions of this section) is amended by inserting after the items relating to part 6 the following new items:

''PART 7—GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

''Sec. 701. Increased portability through limitation on preexisting condition exclusions.
''Sec. 702. Prohibiting discrimination against individual participants and beneficiaries based on health status.
''Sec. 703. Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements.
''Sec. 704. Preemption; State flexibility; construction.
''Sec. 705. Special rules relating to group health plans.
''Sec. 706. Definitions.
''Sec. 707. Regulations.''.

(g) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in this section, this section (and the amendments made by this section) shall apply with respect to group health plans for plan years beginning after June 30, 1997.

(2) DETERMINATION OF CREDITABLE COVERAGE.—

(A) PERIOD OF COVERAGE.—

(i) IN GENERAL.—Subject to clause (ii), no period before July 1, 1996, shall be taken into account under part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as added by this section) in determining creditable coverage.

(ii) SPECIAL RULE FOR CERTAIN PERIODS.—The Secretary of Labor, consistent with section 104, shall provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for clause (i) may be given credit for creditable coverage for such periods through the presentation of documents or other means.

(B) CERTIFICATIONS, ETC.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), subsection (e) of section 701 of the Employee Retirement Income Security Act of 1974 (as added by this section) shall apply to events occurring after June 30, 1996.

(ii) NO CERTIFICATION REQUIRED TO BE PROVIDED BEFORE JUNE 1, 1997.—In no case is a certification required to be provided under such subsection before June 1, 1997.

(iii) CERTIFICATION ONLY ON WRITTEN REQUEST FOR EVENTS OCCURRING BEFORE OCTOBER 1, 1996.—In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under such subsection unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

(C) TRANSITIONAL RULE.—In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996—

(i) the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

(ii) a group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan's or issuer's crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under the amendments made by this section.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2), in the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, part 7 of subtitle B of title I of Employee Retirement Income Security Act of 1974 (other than section 701(e) thereof) shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) July 1, 1997.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement of such part shall not be treated as a termination of such collective bargaining agreement.

(4) TIMELY REGULATIONS.—The Secretary of Labor, consistent with section 104, shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section.

(5) LIMITATION ON ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before January 1, 1998, or, if later, the date of issuance of regulations referred to in paragraph (4), if the plan or issuer has sought to comply in good faith with such requirements.

SEC. 102. THROUGH THE PUBLIC HEALTH SERVICE ACT.

(a) IN GENERAL.—The Public Health Service Act is amended by adding at the end the following new title:

''TITLE XXVII—ASSURING PORTABILITY, AVAILABILITY, AND RENEWABILITY OF HEALTH INSURANCE COVERAGE

''PART A—GROUP MARKET REFORMS

''SUBPART 1—PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

''SEC. 2701. INCREASED PORTABILITY THROUGH LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

''(a) LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD; CREDITING FOR PERIODS OF PREVIOUS COVERAGE.—Subject to subsection (d), a group health plan, and a health insurance issuer offering group health insurance coverage, may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

''(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

''(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

''(3) the period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage (if any, as defined in subsection (c)(1)) applicable to the participant or beneficiary as of the enrollment date.

''(b) DEFINITIONS.—For purposes of this part—

''(1) PREEXISTING CONDITION EXCLUSION.—

''(A) IN GENERAL.—The term 'preexisting condition exclusion' means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

''(B) TREATMENT OF GENETIC INFORMATION.—Genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

''(2) ENROLLMENT DATE.—The term 'enrollment date' means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

''(3) LATE ENROLLEE.—The term 'late enrollee' means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

''(A) the first period in which the individual is eligible to enroll under the plan, or

''(B) a special enrollment period under subsection (f).

''(4) WAITING PERIOD.—The term 'waiting period' means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

''(c) RULES RELATING TO CREDITING PREVIOUS COVERAGE.—

''(1) CREDITABLE COVERAGE DEFINED.—For purposes of this title, the term 'creditable coverage' means, with respect to an individual, coverage of the individual under any of the following:

''(A) A group health plan.

''(B) Health insurance coverage.

''(C) Part A or part B of title XVIII of the Social Security Act.

''(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

''(E) Chapter 55 of title 10, United States Code.

''(F) A medical care program of the Indian Health Service or of a tribal organization.

''(G) A State health benefits risk pool.

''(H) A health plan offered under chapter 89 of title 5, United States Code.

''(I) A public health plan (as defined in regulations).

''(J) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 2791(c)).

''(2) NOT COUNTING PERIODS BEFORE SIGNIFICANT BREAKS IN COVERAGE.—

''(A) IN GENERAL.—A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

''(B) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2)) shall not be taken into account in determining the continuous period under subparagraph (A).

''(3) METHOD OF CREDITING COVERAGE.—

''(A) STANDARD METHOD.—Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan, and a health insurance issuer offering group health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

''(B) ELECTION OF ALTERNATIVE METHOD.—A group health plan, or a health insurance issuer offering group health insurance, may elect to apply subsection (a)(3) based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

''(C) PLAN NOTICE.—In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance

coverage is provided in connection with such plan), the plan shall—

''(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

''(ii) include in such statements a description of the effect of this election.

''(D) ISSUER NOTICE.—In the case of an election under subparagraph (B) with respect to health insurance coverage offered by an issuer in the small or large group market, the issuer—

''(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and

''(ii) shall include in such statements a description of the effect of such election.

''(4) ESTABLISHMENT OF PERIOD.—Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

''(d) EXCEPTIONS.—

''(1) EXCLUSION NOT APPLICABLE TO CERTAIN NEWBORNS.—Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

''(2) EXCLUSION NOT APPLICABLE TO CERTAIN ADOPTED CHILDREN.—Subject to paragraph (4), a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

''(3) EXCLUSION NOT APPLICABLE TO PREGNANCY.—A group health plan, and health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

''(4) LOSS IF BREAK IN COVERAGE.—Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

''(e) CERTIFICATIONS AND DISCLOSURE OF COVERAGE.—

''(1) REQUIREMENT FOR CERTIFICATION OF PERIOD OF CREDITABLE COVERAGE.—

''(A) IN GENERAL.—A group health plan, and a health insurance issuer offering group health insurance coverage, shall provide the certification described in subparagraph (B)—

''(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

''(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

''(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

''(B) CERTIFICATION.—The certification described in this subparagraph is a written certification of—

''(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

''(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

''(C) ISSUER COMPLIANCE.—To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

''(2) DISCLOSURE OF INFORMATION ON PREVIOUS BENEFITS.—In the case of an election described in subsection (c)(3)(B) by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

''(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

''(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

''(3) REGULATIONS.—The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

''(f) SPECIAL ENROLLMENT PERIODS.—

''(1) INDIVIDUALS LOSING OTHER COVERAGE.—A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

''(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

''(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

''(C) The employee's or dependent's coverage described in subparagraph (A)—

''(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

''(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.

''(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

''(2) FOR DEPENDENT BENEFICIARIES.—

''(A) IN GENERAL.—If—

''(i) a group health plan makes coverage available with respect to a dependent of an individual,

''(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

''(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

''(B) DEPENDENT SPECIAL ENROLLMENT PERIOD.—A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

''(i) the date dependent coverage is made available, or

''(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

''(C) NO WAITING PERIOD.—If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

''(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

''(ii) in the case of a dependent's birth, as of the date of such birth; or

''(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

''(g) USE OF AFFILIATION PERIOD BY HMOS AS ALTERNATIVE TO PREEXISTING CONDITION EXCLUSION.—

''(1) IN GENERAL.—A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if—

''(A) such period is applied uniformly without regard to any health status-related factors; and

''(B) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

''(2) AFFILIATION PERIOD.—

''(A) DEFINED.—For purposes of this title, the term 'affiliation period' means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

''(B) BEGINNING.—Such period shall begin on the enrollment date.

''(C) RUNS CONCURRENTLY WITH WAITING PERIODS.—An affiliation period under a plan shall run concurrently with any waiting period under the plan.

''(3) ALTERNATIVE METHODS.—A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of this part for the State involved with respect to such issuer.

''SEC. 2702. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

''(a) IN ELIGIBILITY TO ENROLL.—

''(1) IN GENERAL.—Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage

in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

''(A) Health status.

''(B) Medical condition (including both physical and mental illnesses).

''(C) Claims experience.

''(D) Receipt of health care.

''(E) Medical history.

''(F) Genetic information.

''(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

''(H) Disability.

''(2) NO APPLICATION TO BENEFITS OR EXCLUSIONS.—To the extent consistent with section 701, paragraph (1) shall not be construed—

''(A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or

''(B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

''(3) CONSTRUCTION.—For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

''(b) IN PREMIUM CONTRIBUTIONS.—

''(1) IN GENERAL.—A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

''(A) to restrict the amount that an employer may be charged for coverage under a group health plan; or

''(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

''SUBPART 2—PROVISIONS APPLICABLE ONLY TO HEALTH INSURANCE ISSUERS

''SEC. 2711. GUARANTEED AVAILABILITY OF COVERAGE FOR EMPLOYERS IN THE GROUP MARKET.

''(a) ISSUANCE OF COVERAGE IN THE SMALL GROUP MARKET.—

''(1) IN GENERAL.—Subject to subsections (c) through (f), each health insurance issuer that offers health insurance coverage in the small group market in a State—

''(A) must accept every small employer (as defined in section 2791(e)(4)) in the State that applies for such coverage; and

''(B) must accept for enrollment under such coverage every eligible individual (as defined in paragraph (2)) who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health plan and may not place any restriction which is inconsistent with section 2702 on an eligible individual being a participant or beneficiary.

''(2) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'eligible individual' means, with respect to a health insurance issuer that offers health insurance coverage to a small employer in connection with a group health plan in the small group market, such an individual in relation to the employer as shall be determined—

''(A) in accordance with the terms of such plan,

''(B) as provided by the issuer under rules of the issuer which are uniformly applicable in a State to small employers in the small group market, and

''(C) in accordance with all applicable State laws governing such issuer and such market.

''(b) ASSURING ACCESS IN THE LARGE GROUP MARKET.—

''(1) REPORTS TO HHS.—The Secretary shall request that the chief executive officer of each State submit to the Secretary, by not later December 31, 2000, and every 3 years thereafter a report on—

''(A) the access of large employers to health insurance coverage in the State, and

''(B) the circumstances for lack of access (if any) of large employers (or one or more classes of such employers) in the State to such coverage.

''(2) TRIENNIAL REPORTS TO CONGRESS.—The Secretary, based on the reports submitted under paragraph (1) and such other information as the Secretary may use, shall prepare and submit to Congress, every 3 years, a report describing the extent to which large employers (and classes of such employers) that seek health insurance coverage in the different States are able to obtain access to such coverage. Such report shall include such recommendations as the Secretary determines to be appropriate.

''(3) GAO REPORT ON LARGE EMPLOYER ACCESS TO HEALTH INSURANCE COVERAGE.—The Comptroller General shall provide for a study of the extent to which classes of large employers in the different States are able to obtain access to health insurance coverage and the circumstances for lack of access (if any) to such coverage. The Comptroller General shall submit to Congress a report on such study not later than 18 months after the date of the enactment of this title.

''(c) SPECIAL RULES FOR NETWORK PLANS.—

''(1) IN GENERAL.—In the case of a health insurance issuer that offers health insurance coverage in the small group market through a network plan, the issuer may—

''(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

''(B) within the service area of such plan, deny such coverage to such employers if the issuer has demonstrated, if required, to the applicable State authority that—

''(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees, and

''(ii) it is applying this paragraph uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

''(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the small group market within such service area for a period of 180 days after the date such coverage is denied.

''(d) APPLICATION OF FINANCIAL CAPACITY LIMITS.—

''(1) IN GENERAL.—A health insurance issuer may deny health insurance coverage in the small group market if the issuer has demonstrated, if required, to the applicable State authority that—

''(A) it does not have the financial reserves necessary to underwrite additional coverage; and

''(B) it is applying this paragraph uniformly to all employers in the small group market in the State consistent with applicable State law and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to such employees and dependents.

''(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the small group market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

''(e) EXCEPTION TO REQUIREMENT FOR FAILURE TO MEET CERTAIN MINIMUM PARTICIPATION OR CONTRIBUTION RULES.—

''(1) IN GENERAL.—Subsection (a) shall not be construed to preclude a health insurance issuer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group health plan in the small group market, as allowed under applicable State law.

''(2) RULES DEFINED.—For purposes of paragraph (1)—

''(A) the term 'employer contribution rule' means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries; and

''(B) the term 'group participation rule' means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

''(f) EXCEPTION FOR COVERAGE OFFERED ONLY TO BONA FIDE ASSOCIATION MEMBERS.—Subsection (a) shall not apply to health insurance coverage offered by a health insurance issuer if such coverage is made available in the small group market only through one or more bona fide associations (as defined in section 2791(d)(3)).

''SEC. 2712. GUARANTEED RENEWABILITY OF COVERAGE FOR EMPLOYERS IN THE GROUP MARKET.

''(a) IN GENERAL.—Except as provided in this section, if a health insurance issuer offers health insurance coverage in the small or large group market in connection with a group health plan, the issuer must renew or continue in force such coverage at the option of the plan sponsor of the plan.

''(b) GENERAL EXCEPTIONS.—A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small or large group market based only on one or more of the following:

''(1) NONPAYMENT OF PREMIUMS.—The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

''(2) FRAUD.—The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

''(3) VIOLATION OF PARTICIPATION OR CONTRIBUTION RULES.—The plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, as permitted under section 2711(e) in the case of the small group market or pursuant to applicable State law in the case of the large group market.

''(4) TERMINATION OF COVERAGE.—The issuer is ceasing to offer coverage in such market in accordance with subsection (c) and applicable State law.

''(5) MOVEMENT OUTSIDE SERVICE AREA.—In the case of a health insurance issuer that offers

health insurance coverage in the market through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business) and, in the case of the small group market, the issuer would deny enrollment with respect to such plan under section 2711(c)(1)(A).

''(6) ASSOCIATION MEMBERSHIP CEASES.—In the case of health insurance coverage that is made available in the small or large group market (as the case may be) only through one or more bona fide associations, the membership of an employer in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any covered individual.

''(c) REQUIREMENTS FOR UNIFORM TERMINATION OF COVERAGE.—

''(1) PARTICULAR TYPE OF COVERAGE NOT OFFERED.—In any case in which an issuer decides to discontinue offering a particular type of group health insurance coverage offered in the small or large group market, coverage of such type may be discontinued by the issuer in accordance with applicable State law in such market only if—

''(A) the issuer provides notice to each plan sponsor provided coverage of this type in such market (and participants and beneficiaries covered under such coverage) of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

''(B) the issuer offers to each plan sponsor provided coverage of this type in such market, the option to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan in such market; and

''(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

''(2) DISCONTINUANCE OF ALL COVERAGE.—

''(A) IN GENERAL.—In any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the small group market or the large group market, or both markets, in a State, health insurance coverage may be discontinued by the issuer only in accordance with applicable State law and if—

''(i) the issuer provides notice to the applicable State authority and to each plan sponsor (and participants and beneficiaries covered under such coverage) of such discontinuation at least 180 days prior to the date of the discontinuation of such coverage; and

''(ii) all health insurance issued or delivered for issuance in the State in such market (or markets) are discontinued and coverage under such health insurance coverage in such market (or markets) is not renewed.

''(B) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under subparagraph (A) in a market, the issuer may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

''(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.—At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a product offered to a group health plan—

''(1) in the large group market; or

''(2) in the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such modification is consistent with State law and effective on a uniform basis among group health plans with that product.

''(e) APPLICATION TO COVERAGE OFFERED ONLY THROUGH ASSOCIATIONS.—In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, a reference to 'plan sponsor' is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

''SEC. 2713. DISCLOSURE OF INFORMATION.

''(a) DISCLOSURE OF INFORMATION BY HEALTH PLAN ISSUERS.—In connection with the offering of any health insurance coverage to a small employer, a health insurance issuer—

''(1) shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of the availability of information described in subsection (b), and

''(2) upon request of such a small employer, provide such information.

''(b) INFORMATION DESCRIBED.—

''(1) IN GENERAL.—Subject to paragraph (3), with respect to a health insurance issuer offering health insurance coverage to a small employer, information described in this subsection is information concerning—

''(A) the provisions of such coverage concerning issuer's right to change premium rates and the factors that may affect changes in premium rates;

''(B) the provisions of such coverage relating to renewability of coverage;

''(C) the provisions of such coverage relating to any preexisting condition exclusion; and

''(D) the benefits and premiums available under all health insurance coverage for which the employer is qualified.

''(2) FORM OF INFORMATION.—Information under this subsection shall be provided to small employers in a manner determined to be understandable by the average small employer, and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

''(3) EXCEPTION.—An issuer is not required under this section to disclose any information that is proprietary and trade secret information under applicable law.

''SUBPART 3—EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION

''SEC. 2721. EXCLUSION OF CERTAIN PLANS.

''(a) EXCEPTION FOR CERTAIN SMALL GROUP HEALTH PLANS.—The requirements of subparts 1 and 2 shall not apply to any group health plan (and health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

''(b) LIMITATION ON APPLICATION OF PROVISIONS RELATING TO GROUP HEALTH PLANS.—

''(1) IN GENERAL.—The requirements of subparts 1 and 2 shall apply with respect to group health plans only—

''(A) subject to paragraph (2), in the case of a plan that is a nonfederal governmental plan, and

''(B) with respect to health insurance coverage offered in connection with a group health plan (including such a plan that is a church plan or a governmental plan).

''(2) TREATMENT OF NONFEDERAL GOVERNMENTAL PLANS.—

''(A) ELECTION TO BE EXCLUDED.—If the plan sponsor of a nonfederal governmental plan which is a group health plan to which the provisions of subparts 1 and 2 otherwise apply makes an election under this subparagraph (in such form and manner as the Secretary may by regulations prescribe), then the requirements of such subparts insofar as they apply directly to group health plans (and not merely to group health insurance coverage) shall not apply to such governmental plans for such period except as provided in this paragraph.

''(B) PERIOD OF ELECTION.—An election under subparagraph (A) shall apply—

''(i) for a single specified plan year, or

''(ii) in the case of a plan provided pursuant to a collective bargaining agreement, for the term of such agreement.

An election under clause (i) may be extended through subsequent elections under this paragraph.

''(C) NOTICE TO ENROLLEES.—Under such an election, the plan shall provide for—

''(i) notice to enrollees (on an annual basis and at the time of enrollment under the plan) of the fact and consequences of such election, and

''(ii) certification and disclosure of creditable coverage under the plan with respect to enrollees in accordance with section 2701(e).

''(c) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of subparts 1 and 2 shall not apply to any group health plan (or group health insurance coverage) in relation to its provision of excepted benefits described in section 2791(c)(1).

''(d) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—

''(1) LIMITED, EXCEPTED BENEFITS.—The requirements of subparts 1 and 2 shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(2) if the benefits—

''(A) are provided under a separate policy, certificate, or contract of insurance; or

''(B) are otherwise not an integral part of the plan.

''(2) NONCOORDINATED, EXCEPTED BENEFITS.—The requirements of subparts 1 and 2 shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(3) if all of the following conditions are met:

''(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

''(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

''(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

''(3) SUPPLEMENTAL EXCEPTED BENEFITS.—The requirements of this part shall not apply to any group health plan (and group health insurance coverage) in relation to its provision of excepted benefits described in section 27971(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

''(e) TREATMENT OF PARTNERSHIPS.—For purposes of this part—

''(1) TREATMENT AS A GROUP HEALTH PLAN.—Any plan, fund, or program which would not be (but for this subsection) an employee welfare benefit plan and which is established or maintained by a partnership, to the extent that such plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, shall be treated (subject to paragraph (2)) as an employee welfare benefit plan which is a group health plan.

''(2) EMPLOYER.—In the case of a group health plan, the term 'employer' also includes the partnership in relation to any partner.

''(3) PARTICIPANTS OF GROUP HEALTH PLANS.—In the case of a group health plan, the term 'participant' also includes—

''(A) in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or

''(B) in connection with a group health plan maintained by a self-employed individual

(under which one or more employees are participants), the self-employed individual,

if such individual is, or may become, eligible to receive a benefit under the plan or such individual's beneficiaries may be eligible to receive any such benefit.

"SEC. 2722. ENFORCEMENT.

"(a) STATE ENFORCEMENT.—

"(1) STATE AUTHORITY.—Subject to section 2723, each State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the small or large group markets meet the requirements of this part with respect to such issuers.

"(2) FAILURE TO IMPLEMENT PROVISIONS.—In the case of a determination by the Secretary that a State has failed to substantially enforce a provision (or provisions) in this part with respect to health insurance issuers in the State, the Secretary shall enforce such provision (or provisions) under subsection (b) insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans in such State.

"(b) SECRETARIAL ENFORCEMENT AUTHORITY.—

"(1) LIMITATION.—The provisions of this subsection shall apply to enforcement of a provision (or provisions) of this part only—

"(A) as provided under subsection (a)(2); and

"(B) with respect to group health plans that are nonfederal governmental plans.

"(2) IMPOSITION OF PENALTIES.—In the cases described in paragraph (1)—

"(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, any nonfederal governmental plan that is a group health plan and any health insurance issuer that fails to meet a provision of this part applicable to such plan or issuer is subject to a civil money penalty under this subsection.

"(B) LIABILITY FOR PENALTY.—In the case of a failure by—

"(i) a health insurance issuer, the issuer is liable for such penalty, or

"(ii) a group health plan that is a nonfederal governmental plan which is—

"(I) sponsored by 2 or more employers, the plan is liable for such penalty, or

"(II) not so sponsored, the employer is liable for such penalty.

"(C) AMOUNT OF PENALTY.—

"(i) IN GENERAL.—The maximum amount of penalty imposed under this paragraph is $100 for each day for each individual with respect to which such a failure occurs.

"(ii) CONSIDERATIONS IN IMPOSITION.—In determining the amount of any penalty to be assessed under this paragraph, the Secretary shall take into account the previous record of compliance of the entity being assessed with the applicable provisions of this part and the gravity of the violation.

"(iii) LIMITATIONS.—

"(I) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No civil money penalty shall be imposed under this paragraph on any failure during any period for which it is established to the satisfaction of the Secretary that none of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

"(II) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No civil money penalty shall be imposed under this paragraph on any failure if such failure was due to reasonable cause and not to willful neglect, and such failure is corrected during the 30-day period beginning on the first day any of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that such failure existed.

"(D) ADMINISTRATIVE REVIEW.—

"(i) OPPORTUNITY FOR HEARING.—The entity assessed shall be afforded an opportunity for hearing by the Secretary upon request made within 30 days after the date of the issuance of a notice of assessment. In such hearing the decision shall be made on the record pursuant to section 554 of title 5, United States Code. If no hearing is requested, the assessment shall constitute a final and unappealable order.

"(ii) HEARING PROCEDURE.—If a hearing is requested, the initial agency decision shall be made by an administrative law judge, and such decision shall become the final order unless the Secretary modifies or vacates the decision. Notice of intent to modify or vacate the decision of the administrative law judge shall be issued to the parties within 30 days after the date of the decision of the judge. A final order which takes effect under this paragraph shall be subject to review only as provided under subparagraph (E).

"(E) JUDICIAL REVIEW.—

"(i) FILING OF ACTION FOR REVIEW.—Any entity against whom an order imposing a civil money penalty has been entered after an agency hearing under this paragraph may obtain review by the United States district court for any district in which such entity is located or the United States District Court for the District of Columbia by filing a notice of appeal in such court within 30 days from the date of such order, and simultaneously sending a copy of such notice by registered mail to the Secretary.

"(ii) CERTIFICATION OF ADMINISTRATIVE RECORD.—The Secretary shall promptly certify and file in such court the record upon which the penalty was imposed.

"(iii) STANDARD FOR REVIEW.—The findings of the Secretary shall be set aside only if found to be unsupported by substantial evidence as provided by section 706(2)(E) of title 5, United States Code.

"(iv) APPEAL.—Any final decision, order, or judgment of the district court concerning such review shall be subject to appeal as provided in chapter 83 of title 28 of such Code.

"(F) FAILURE TO PAY ASSESSMENT; MAINTENANCE OF ACTION.—

"(i) FAILURE TO PAY ASSESSMENT.—If any entity fails to pay an assessment after it has become a final and unappealable order, or after the court has entered final judgment in favor of the Secretary, the Secretary shall refer the matter to the Attorney General who shall recover the amount assessed by action in the appropriate United States district court.

"(ii) NONREVIEWABILITY.—In such action the validity and appropriateness of the final order imposing the penalty shall not be subject to review.

"(G) PAYMENT OF PENALTIES.—Except as otherwise provided, penalties collected under this paragraph shall be paid to the Secretary (or other officer) imposing the penalty and shall be available without appropriation and until expended for the purpose of enforcing the provisions with respect to which the penalty was imposed.

"SEC. 2723. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

"(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

"(1) IN GENERAL.—Subject to paragraph (2) and except as provided in subsection (b), this part and part C insofar as it relates to this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

"(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this part shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

"(b) SPECIAL RULES IN CASE OF PORTABILITY REQUIREMENTS.—

"(1) IN GENERAL.—Subject to paragraph (2), the provisions of this part relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

"(2) EXCEPTIONS.—Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

"(i) substitutes for the reference to '6-month period' in section 2701(a)(1) a reference to any shorter period of time;

"(ii) substitutes for the reference to '12 months' and '18 months' in section 2701(a)(2) a reference to any shorter period of time;

"(iii) substitutes for the references to '63' days in sections 2701(c)(2)(A) and 2701(d)(4)(A) a reference to any greater number of days;

"(iv) substitutes for the reference to '30-day period' in sections 2701(b)(2) and 2701(d)(1) a reference to any greater period;

"(v) prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d) or expands the exceptions described in such section;

"(vi) requires special enrollment periods in addition to those required under section 2701(f); or

"(vii) reduces the maximum period permitted in an affiliation period under section 2701(g)(1)(B).

"(c) RULES OF CONSTRUCTION.—Nothing in this part shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

"(d) DEFINITIONS.—For purposes of this section—

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

"(2) STATE.—The term 'State' includes a State (including the Northern Mariana Islands), any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

"PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

"SEC. 2791. DEFINITIONS.

"(a) GROUP HEALTH PLAN.—

"(1) DEFINITION.—The term 'group health plan' means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

"(2) MEDICAL CARE.—The term 'medical care' means amounts paid for—

"(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

"(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

"(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

"(3) TREATMENT OF CERTAIN PLANS AS GROUP HEALTH PLAN FOR NOTICE PROVISION.—A program under which creditable coverage described in subparagraph (C), (D), (E), or (F) of section 2701(c)(1) is provided shall be treated as a group health plan for purposes of applying section 2701(e).

''(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—

''(1) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

''(2) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974). Such term does not include a group health plan.

''(3) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' means—

''(A) a Federally qualified health maintenance organization (as defined in section 1301(a)),

''(B) an organization recognized under State law as a health maintenance organization, or

''(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

''(4) GROUP HEALTH INSURANCE COVERAGE.—The term 'group health insurance coverage' means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

''(5) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term 'individual health insurance coverage' means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

''(c) EXCEPTED BENEFITS.—For purposes of this title, the term 'excepted benefits' means benefits under one or more (or any combination thereof) of the following:

''(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

''(A) Coverage only for accident, or disability income insurance, or any combination thereof.

''(B) Coverage issued as a supplement to liability insurance.

''(C) Liability insurance, including general liability insurance and automobile liability insurance.

''(D) Workers' compensation or similar insurance.

''(E) Automobile medical payment insurance.

''(F) Credit-only insurance.

''(G) Coverage for on-site medical clinics.

''(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

''(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

''(A) Limited scope dental or vision benefits.

''(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

''(C) Such other similar, limited benefits as are specified in regulations.

''(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

''(A) Coverage only for a specified disease or illness.

''(B) Hospital indemnity or other fixed indemnity insurance.

''(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

''(d) OTHER DEFINITIONS.—

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

''(2) BENEFICIARY.—The term 'beneficiary' has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974.

''(3) BONA FIDE ASSOCIATION.—The term 'bona fide association' means, with respect to health insurance coverage offered in a State, an association which—

''(A) has been actively in existence for at least 5 years;

''(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

''(C) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

''(D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

''(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

''(F) meets such additional requirements as may be imposed under State law.

''(4) COBRA CONTINUATION PROVISION.—The term 'COBRA continuation provision' means any of the following:

''(A) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

''(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of such Act.

''(C) Title XXII of this Act.

''(5) EMPLOYEE.—The term 'employee' has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974.

''(6) EMPLOYER.—The term 'employer' has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that such term shall include only employers of two or more employees.

''(7) CHURCH PLAN.—The term 'church plan' has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974.

''(8) GOVERNMENTAL PLAN.—(A) The term 'governmental plan' has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any Federal governmental plan.

''(B) FEDERAL GOVERNMENTAL PLAN.—The term 'Federal governmental plan' means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

''(C) NONFEDERAL GOVERNMENTAL PLAN.—The term 'nonfederal governmental plan' means a governmental plan that is not a Federal governmental plan.

''(9) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' means any of the factors described in section 2702(a)(1).

''(10) NETWORK PLAN.—The term 'network plan' means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

''(11) PARTICIPANT.—The term 'participant' has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974.

''(12) PLACED FOR ADOPTION DEFINED.—The term 'placement', or being 'placed', for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

''(13) PLAN SPONSOR.—The term 'plan sponsor' has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

''(14) STATE.—The term 'State' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

''(e) DEFINITIONS RELATING TO MARKETS AND SMALL EMPLOYERS.—For purposes of this title:

''(1) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such terms includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of a State that elects to regulate the coverage described in such clause as coverage in the small group market.

''(2) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

''(3) LARGE GROUP MARKET.—The term 'large group market' means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

''(4) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

''(5) SMALL GROUP MARKET.—The term 'small group market' means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

''(6) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection—

''(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

''(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

''(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

"SEC. 2792. REGULATIONS.

''The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this title. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this title.''.

(b) APPLICATION OF RULES BY CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—Section 1301 of such Act (42 U.S.C. 300e) is amended by adding at the end the following new subsection:

''(d) An organization that offers health benefits coverage shall not be considered as failing to meet the requirements of this section notwithstanding that it provides, with respect to coverage offered in connection with a group health plan in the small or large group market (as defined in section 2791(e)), an affiliation period consistent with the provisions of section 2701(g).''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, part A of title XXVII of the Public Health Service Act (as added by subsection (a)) shall apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997.

(2) DETERMINATION OF CREDITABLE COVERAGE.—

(A) PERIOD OF COVERAGE.—

(i) IN GENERAL.—Subject to clause (ii), no period before July 1, 1996, shall be taken into account under part A of title XXVII of the Public Health Service Act (as added by this section) in determining creditable coverage.

(ii) SPECIAL RULE FOR CERTAIN PERIODS.—The Secretary of Health and Human Services, consistent with section 104, shall provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for clause (i) may be given credit for creditable coverage for such periods through the presentation of documents or other means.

(B) CERTIFICATIONS, ETC.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), subsection (e) of section 2701 of the Public Health Service Act (as added by this section) shall apply to events occurring after June 30, 1996.

(ii) NO CERTIFICATION REQUIRED TO BE PROVIDED BEFORE JUNE 1, 1997.—In no case is a certification required to be provided under such subsection before June 1, 1997.

(iii) CERTIFICATION ONLY ON WRITTEN REQUEST FOR EVENTS OCCURRING BEFORE OCTOBER 1, 1996.—In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under such subsection unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

(C) TRANSITIONAL RULE.—In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996—

(i) the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

(ii) a group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan's or issuer's crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under the amendments made by this section.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2)(B), in the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, part A of title XXVII of the Public Health Service Act (other than section 2701(e) thereof) shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) July 1, 1997.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement of such part shall not be treated as a termination of such collective bargaining agreement.

(4) TIMELY REGULATIONS.—The Secretary of Health and Human Services, consistent with section 104, shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section and section 111.

(5) LIMITATION ON ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before January 1, 1998, or, if later, the date of issuance of regulations referred to in paragraph (4), if the plan or issuer has sought to comply in good faith with such requirements.

(d) MISCELLANEOUS CORRECTION.—Section 2208(1) of the Public Health Service Act (42 U.S.C. 300bb–8(1)) is amended by striking ''section 162(i)(2)'' and inserting ''5000(b)''.

SEC. 103. REFERENCE TO IMPLEMENTATION THROUGH THE INTERNAL REVENUE CODE OF 1986.

For provisions amending the Internal Revenue Code of 1986 to provide for application and enforcement of rules for group health plans similar to those provided under the amendments made by section 101(a), see section 401.

SEC. 104. ASSURING COORDINATION.

The Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that—

(1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this subtitle (and the amendments made by this subtitle and section 401) are administered so as to have the same effect at all times; and

(2) coordination of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

Subtitle B—Individual Market Rules

SEC. 111. AMENDMENT TO PUBLIC HEALTH SERVICE ACT.

(a) IN GENERAL.—Title XXVII of the Public Health Service Act, as added by section 102(a) of this Act, is amended by inserting after part A the following new part:

''PART B—INDIVIDUAL MARKET RULES

"SEC. 2741. GUARANTEED AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE TO CERTAIN INDIVIDUALS WITH PRIOR GROUP COVERAGE.

''(a) GUARANTEED AVAILABILITY.—

''(1) IN GENERAL.—Subject to the succeeding subsections of this section and section 2744, each health insurance issuer that offers health insurance coverage (as defined in section 2791(b)(1)) in the individual market in a State may not, with respect to an eligible individual (as defined in subsection (b)) desiring to enroll in individual health insurance coverage—

''(A) decline to offer such coverage to, or deny enrollment of, such individual; or

''(B) impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A)) with respect to such coverage.

''(2) SUBSTITUTION BY STATE OF ACCEPTABLE ALTERNATIVE MECHANISM.—The requirement of paragraph (1) shall not apply to health insurance coverage offered in the individual market in a State in which the State is implementing an acceptable alternative mechanism under section 2744.

''(b) ELIGIBLE INDIVIDUAL DEFINED.—In this part, the term 'eligible individual' means an individual—

''(1)(A) for whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage (as defined in section 2701(c)) is 18 or more months and (B) whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

''(2) who is not eligible for coverage under (A) a group health plan, (B) part A or part B of title XVIII of the Social Security Act, or (C) a State plan under title XIX of such Act (or any successor program), and does not have other health insurance coverage;

''(3) with respect to whom the most recent coverage within the coverage period described in paragraph (1)(A) was not terminated based on a factor described in paragraph (1) or (2) of section 2712(b) (relating to nonpayment of premiums or fraud);

''(4) if the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

''(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

''(c) ALTERNATIVE COVERAGE PERMITTED WHERE NO STATE MECHANISM.—

''(1) IN GENERAL.—In the case of health insurance coverage offered in the individual market in a State in which the State is not implementing an acceptable alternative mechanism under section 2744, the health insurance issuer may elect to limit the coverage offered under subsection (a) so long as it offers at least two different policy forms of health insurance coverage both of which—

''(A) are designed for, made generally available to, and actively marketed to, and enroll both eligible and other individuals by the issuer; and

''(B) meet the requirement of paragraph (2) or (3), as elected by the issuer.

For purposes of this subsection, policy forms which have different cost-sharing arrangements or different riders shall be considered to be different policy forms.

''(2) CHOICE OF MOST POPULAR POLICY FORMS.—The requirement of this paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers the policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all such policy forms offered by the issuer in the State or applicable marketing or service area (as may be prescribed in regulation) by the issuer in the individual market in the period involved.

''(3) CHOICE OF 2 POLICY FORMS WITH REPRESENTATIVE COVERAGE.—

''(A) IN GENERAL.—The requirement of this paragraph is met, for health insurance coverage policy forms offered by an issuer in the individual market, if the issuer offers a lower-level coverage policy form (as defined in subparagraph (B)) and a higher-level coverage policy form (as defined in subparagraph (C)) each of which includes benefits substantially similar to other individual health insurance coverage offered by the issuer in that State and each of which is covered under a method described in section

2744(c)(3)(A) (relating to risk adjustment, risk spreading, or financial subsidization).

''(B) LOWER-LEVEL OF COVERAGE DESCRIBED.—A policy form is described in this subparagraph if the actuarial value of the benefits under the coverage is at least 85 percent but not greater than 100 percent of a weighted average (described in subparagraph (D)).

''(C) HIGHER-LEVEL OF COVERAGE DESCRIBED.—A policy form is described in this subparagraph if—

''(i) the actuarial value of the benefits under the coverage is at least 15 percent greater than the actuarial value of the coverage described in subparagraph (B) offered by the issuer in the area involved; and

''(ii) the actuarial value of the benefits under the coverage is at least 100 percent but not greater than 120 percent of a weighted average (described in subparagraph (D)).

''(D) WEIGHTED AVERAGE.—For purposes of this paragraph, the weighted average described in this subparagraph is the average actuarial value of the benefits provided by all the health insurance coverage issued (as elected by the issuer) either by that issuer or by all issuers in the State in the individual market during the previous year (not including coverage issued under this section), weighted by enrollment for the different coverage.

''(4) ELECTION.—The issuer elections under this subsection shall apply uniformly to all eligible individuals in the State for that issuer. Such an election shall be effective for policies offered during a period of not shorter than 2 years.

''(5) ASSUMPTIONS.—For purposes of paragraph (3), the actuarial value of benefits provided under individual health insurance coverage shall be calculated based on a standardized population and a set of standardized utilization and cost factors.

''(d) SPECIAL RULES FOR NETWORK PLANS.—

''(1) IN GENERAL.—In the case of a health insurance issuer that offers health insurance coverage in the individual market through a network plan, the issuer may—

''(A) limit the individuals who may be enrolled under such coverage to those who live, reside, or work within the service area for such network plan; and

''(B) within the service area of such plan, deny such coverage to such individuals if the issuer has demonstrated, if required, to the applicable State authority that—

''(i) it will not have the capacity to deliver services adequately to additional individual enrollees because of its obligations to existing group contract holders and enrollees and individual enrollees, and

''(ii) it is applying this paragraph uniformly to individuals without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

''(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the individual market within such service area for a period of 180 days after such coverage is denied.

''(e) APPLICATION OF FINANCIAL CAPACITY LIMITS.—

''(1) IN GENERAL.—A health insurance issuer may deny health insurance coverage in the individual market to an eligible individual if the issuer has demonstrated, if required, to the applicable State authority that—

''(A) it does not have the financial reserves necessary to underwrite additional coverage; and

''(B) it is applying this paragraph uniformly to all individuals in the individual market in the State consistent with applicable State law and without regard to any health status-related factor of such individuals and without regard to whether the individuals are eligible individuals.

''(2) 180-DAY SUSPENSION UPON DENIAL OF COVERAGE.—An issuer upon denying individual health insurance coverage in any service area in accordance with paragraph (1) may not offer such coverage in the individual market within such service area for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated, if required under applicable State law, to the applicable State authority that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. A State may provide for the application of this paragraph on a service-area-specific basis.

''(e) MARKET REQUIREMENTS.—

''(1) IN GENERAL.—The provisions of subsection (a) shall not be construed to require that a health insurance issuer offering health insurance coverage only in connection with group health plans or through one or more bona fide associations, or both, offer such health insurance coverage in the individual market.

''(2) CONVERSION POLICIES.—A health insurance issuer offering health insurance coverage in connection with group health plans under this title shall not be deemed to be a health insurance issuer offering individual health insurance coverage solely because such issuer offers a conversion policy.

''(f) CONSTRUCTION.—Nothing in this section shall be construed—

''(1) to restrict the amount of the premium rates that an issuer may charge an individual for health insurance coverage provided in the individual market under applicable State law; or

''(2) to prevent a health insurance issuer offering health insurance coverage in the individual market from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

''SEC. 2742. GUARANTEED RENEWABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.

''(b) GENERAL EXCEPTIONS.—A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

''(1) NONPAYMENT OF PREMIUMS.—The individual has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or the issuer has not received timely premium payments.

''(2) FRAUD.—The individual has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

''(3) TERMINATION OF PLAN.—The issuer is ceasing to offer coverage in the individual market in accordance with subsection (c) and applicable State law.

''(4) MOVEMENT OUTSIDE SERVICE AREA.—In the case of a health insurance issuer that offers health insurance coverage in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the issuer is authorized to do business) but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

''(5) ASSOCIATION MEMBERSHIP CEASES.—In the case of health insurance coverage that is made available in the individual market only through one or more bona fide associations, the membership of the individual in the association (on the basis of which the coverage is provided) ceases but only if such coverage is terminated under this paragraph uniformly without regard to any health status-related factor of covered individuals.

''(c) REQUIREMENTS FOR UNIFORM TERMINATION OF COVERAGE.—

''(1) PARTICULAR TYPE OF COVERAGE NOT OFFERED.—In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if—

''(A) the issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

''(B) the issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and

''(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

''(2) DISCONTINUANCE OF ALL COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (C), in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in a State, health insurance coverage may be discontinued by the issuer only if—

''(i) the issuer provides notice to the applicable State authority and to each individual of such discontinuation at least 180 days prior to the date of the expiration of such coverage, and

''(ii) all health insurance issued or delivered for issuance in the State in such market are discontinued and coverage under such health insurance coverage in such market is not renewed.

''(B) PROHIBITION ON MARKET REENTRY.—In the case of a discontinuation under subparagraph (A) in the individual market, the issuer may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

''(d) EXCEPTION FOR UNIFORM MODIFICATION OF COVERAGE.—At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with State law and effective on a uniform basis among all individuals with that policy form.

''(e) APPLICATION TO COVERAGE OFFERED ONLY THROUGH ASSOCIATIONS.—In applying this section in the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, a reference to an 'individual' is deemed to include a reference to such an association (of which the individual is a member).

''SEC. 2743. CERTIFICATION OF COVERAGE.

''The provisions of section 2701(e) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

''SEC. 2744. STATE FLEXIBILITY IN INDIVIDUAL MARKET REFORMS.

''(a) WAIVER OF REQUIREMENTS WHERE IMPLEMENTATION OF ACCEPTABLE ALTERNATIVE MECHANISM.—

''(1) IN GENERAL.—The requirements of section 2741 shall not apply with respect to health insurance coverage offered in the individual market in the State so long as a State is found to be implementing, in accordance with this section and consistent with section 2746(b), an alternative mechanism (in this section referred to as an 'acceptable alternative mechanism')—

''(A) under which all eligible individuals are provided a choice of health insurance coverage;

''(B) under which such coverage does not impose any preexisting condition exclusion with respect to such coverage;

''(C) under which such choice of coverage includes at least one policy form of coverage that is comparable to comprehensive health insurance coverage offered in the individual market in such State or that is comparable to a standard option of coverage available under the group or individual health insurance laws of such State; and

''(D) in a State which is implementing—

''(i) a model act described in subsection (c)(1),

''(ii) a qualified high risk pool described in subsection (c)(2), or

''(iii) a mechanism described in subsection (c)(3).

''(2) PERMISSIBLE FORMS OF MECHANISMS.—A private or public individual health insurance mechanism (such as a health insurance coverage pool or programs, mandatory group conversion policies, guaranteed issue of one or more plans of individual health insurance coverage, or open enrollment by one or more health insurance issuers), or combination of such mechanisms, that is designed to provide access to health benefits for individuals in the individual market in the State in accordance with this section may constitute an acceptable alternative mechanism.

''(b) APPLICATION OF ACCEPTABLE ALTERNATIVE MECHANISMS.—

''(1) PRESUMPTION.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, a State is presumed to be implementing an acceptable alternative mechanism in accordance with this section as of July 1, 1997, if, by not later than April 1, 1997, the chief executive officer of a State—

''(i) notifies the Secretary that the State has enacted or intends to enact (by not later than January 1, 1998, or July 1, 1998, in the case of a State described in subparagraph (B)(ii)) any necessary legislation to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism as of January 1, 1998, (or, in the case of a State described in subparagraph (B)(ii), July 1, 1998); and

''(ii) provides the Secretary with such information as the Secretary may require to review the mechanism and its implementation (or proposed implementation) under this subsection.

''(B) DELAY PERMITTED FOR CERTAIN STATES.—

''(i) EFFECT OF DELAY.—In the case of a State described in clause (ii) that provides notice under subparagraph (A)(i), for the presumption to continue on and after July 1, 1998, the chief executive officer of the State by April 1, 1998—

''(I) must notify the Secretary that the State has enacted any necessary legislation to provide for the implementation of a mechanism reasonably designed to be an acceptable alternative mechanism as of July 1, 1998; and

''(II) must provide the Secretary with such information as the Secretary may require to review the mechanism and its implementation (or proposed implementation) under this subsection.

''(ii) STATES DESCRIBED.—A State described in this clause is a State that has a legislature that does not meet within the 12-month period beginning on the date of enactment of this Act.

''(C) CONTINUED APPLICATION.—In order for a mechanism to continue to be presumed to be an acceptable alternative mechanism, the State shall provide the Secretary every 3 years with information described in subparagraph (A)(ii) or (B)(i)(II) (as the case may be).

''(2) NOTICE.—If the Secretary finds, after review of information provided under paragraph (1) and in consultation with the chief executive officer of the State and the insurance commissioner or chief insurance regulatory official of the State, that such a mechanism is not an acceptable alternative mechanism or is not (or no longer) being implemented, the Secretary—

''(A) shall notify the State of—

''(i) such preliminary determination, and

''(ii) the consequences under paragraph (3) of a failure to implement such a mechanism; and

''(B) shall permit the State a reasonable opportunity in which to modify the mechanism (or to adopt another mechanism) in a manner so that may be an acceptable alternative mechanism or to provide for implementation of such a mechanism.

''(3) FINAL DETERMINATION.—If, after providing notice and opportunity under paragraph (2), the Secretary finds that the mechanism is not an acceptable alternative mechanism or the State is not implementing such a mechanism, the Secretary shall notify the State that the State is no longer considered to be implementing an acceptable alternative mechanism and that the requirements of section 2741 shall apply to health insurance coverage offered in the individual market in the State, effective as of a date specified in the notice.

''(4) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not make a determination under paragraph (2) or (3) on any basis other than the basis that a mechanism is not an acceptable alternative mechanism or is not being implemented.

''(5) FUTURE ADOPTION OF MECHANISMS.—If a State, after January 1, 1997, submits the notice and information described in paragraph (1), unless the Secretary makes a finding described in paragraph (3) within the 90-day period beginning on the date of submission of the notice and information, the mechanism shall be considered to be an acceptable alternative mechanism for purposes of this section, effective 90 days after the end of such period, subject to the second sentence of paragraph (1).

''(c) PROVISION RELATED TO RISK.—

''(1) ADOPTION OF NAIC MODELS.—The model act referred to in subsection (a)(1)(D)(i) is the Small Employer and Individual Health Insurance Availability Model Act (adopted by the National Association of Insurance Commissioners on June 3, 1996) insofar as it applies to individual health insurance coverage or the Individual Health Insurance Portability Model Act (also adopted by such Association on such date).

''(2) QUALIFIED HIGH RISK POOL.—For purposes of subsection (a)(1)(D)(ii), a 'qualified high risk pool' described in this paragraph is a high risk pool that—

''(A) provides to all eligible individuals health insurance coverage (or comparable coverage) that does not impose any preexisting condition exclusion with respect to such coverage for all eligible individuals, and

''(B) provides for premium rates and covered benefits for such coverage consistent with standards included in the NAIC Model Health Plan for Uninsurable Individuals Act (as in effect as of the date of the enactment of this title).

''(3) OTHER MECHANISMS.—For purposes of subsection (a)(1)(D)(iii), a mechanism described in this paragraph—

''(A) provides for risk adjustment, risk spreading, or a risk spreading mechanism (among issuers or policies of an issuer) or otherwise provides for some financial subsidization for eligible individuals, including through assistance to participating issuers; or

''(B) is a mechanism under which each eligible individual is provided a choice of all individual health insurance coverage otherwise available.

''SEC. 2745. ENFORCEMENT.

''(a) STATE ENFORCEMENT.—

''(1) STATE AUTHORITY.—Subject to section 2746, each State may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the individual market meet the requirements established under this part with respect to such issuers.

''(2) FAILURE TO IMPLEMENT REQUIREMENTS.—In the case of a State that fails to substantially enforce the requirements set forth in this part with respect to health insurance issuers in the State, the Secretary shall enforce the requirements of this part under subsection (b) insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in the individual market in such State.

''(b) SECRETARIAL ENFORCEMENT AUTHORITY.—The Secretary shall have the same authority in relation to enforcement of the provisions of this part with respect to issuers of health insurance coverage in the individual market in a State as the Secretary has under section 2722(b)(2) in relation to the enforcement of the provisions of part A with respect to issuers of health insurance coverage in the small group market in the State.

''SEC. 2746. PREEMPTION.

''(a) IN GENERAL.—Subject to subsection (b), nothing in this part (or part C insofar as it applies to this part) shall be construed to prevent a State from establishing, implementing, or continuing in effect standards and requirements unless such standards and requirements prevent the application of a requirement of this part.

''(b) RULES OF CONSTRUCTION.—Nothing in this part (or part C insofar as it applies to this part) shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144).

''SEC. 2747. GENERAL EXCEPTIONS.

''(a) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in section 2791(c)(1).

''(b) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—The requirements of this part shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in paragraph (2), (3), or (4) of section 2791(c) if the benefits are provided under a separate policy, certificate, or contract of insurance.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, part B of title XXVII of the Public Health Service Act (as inserted by subsection (a)) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs.

(2) APPLICATION OF CERTIFICATION RULES.—The provisions of section 102(d)(2) of this Act shall apply to section 2743 of the Public Health Service Act in the same manner as it applies to section 2701(e) of such Act.

Subtitle C—General and Miscellaneous Provisions

SEC. 191. HEALTH COVERAGE AVAILABILITY STUDIES.

(a) STUDIES.—

(1) STUDY ON EFFECTIVENESS OF REFORMS.—The Secretary of Health and Human Services shall provide for a study on the effectiveness of the provisions of this title and the various State laws, in ensuring the availability of reasonably priced health coverage to employers purchasing group coverage and individuals purchasing coverage on a non-group basis.

(2) STUDY ON ACCESS AND CHOICE.—The Secretary also shall provide for a study on—

(A) the extent to which patients have direct access to, and choice of, health care providers, including specialty providers, within a network plan, as well as the opportunity to utilize providers outside of the network plan, under the various types of coverage offered under the provisions of this title; and

(B) the cost and cost-effectiveness to health insurance issuers of providing access to out-of-network providers, and the potential impact of providing such access on the cost and quality of health insurance coverage offered under provisions of this title.

(3) CONSULTATION.—The studies under this subsection shall be conducted in consultation with the Secretary of Labor, representatives of

State officials, consumers, and other representatives of individuals and entities that have expertise in health insurance and employee benefits.

(b) REPORTS.—Not later than January 1, 2000, the Secretary shall submit to the appropriate committees of Congress a report on each of the studies under subsection (a).

SEC. 192. REPORT ON MEDICARE REIMBURSEMENT OF TELEMEDICINE.

The Health Care Financing Administration shall complete its ongoing study of medicare reimbursement of all telemedicine services and submit a report to Congress on medicare reimbursement of telemedicine services by not later than March 1, 1997. The report shall—

(1) utilize data compiled from the current demonstration projects already under review and gather data from other ongoing telemedicine networks;

(2) include an analysis of the cost of services provided via telemedicine; and

(3) include a proposal for medicare reimbursement of such services.

SEC. 193. ALLOWING FEDERALLY-QUALIFIED HMOS TO OFFER HIGH DEDUCTIBLE PLANS.

Section 1301(b) of the Public Health Service Act (42 U.S.C. 300e(b)) is amended by adding at the end the following new paragraph:

''(6) A health maintenance organization that otherwise meets the requirements of this title may offer a high-deductible health plan (as defined in section 220(c)(2) of the Internal Revenue Code of 1986).''.

SEC. 194. VOLUNTEER SERVICES PROVIDED BY HEALTH PROFESSIONALS AT FREE CLINICS.

Section 224 of the Public Health Service Act (42 U.S.C. 233) is amended by adding at the end the following subsection:

''(o)(1) For purposes of this section, a free clinic health professional shall in providing a qualifying health service to an individual be deemed to be an employee of the Public Health Service for a calendar year that begins during a fiscal year for which a transfer was made under paragraph (6)(D). The preceding sentence is subject to the provisions of this subsection.

''(2) In providing a health service to an individual, a health care practitioner shall for purposes of this subsection be considered to be a free clinic health professional if the following conditions are met:

''(A) The service is provided to the individual at a free clinic, or through offsite programs or events carried out by the free clinic.

''(B) The free clinic is sponsoring the health care practitioner pursuant to paragraph (5)(C).

''(C) The service is a qualifying health service (as defined in paragraph (4)).

''(D) Neither the health care practitioner nor the free clinic receives any compensation for the service from the individual or from any third-party payor (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program). With respect to compliance with such condition:

''(i) The health care practitioner may receive repayment from the free clinic for reasonable expenses incurred by the health care practitioner in the provision of the service to the individual.

''(ii) The free clinic may accept voluntary donations for the provision of the service by the health care practitioner to the individual.

''(E) Before the service is provided, the health care practitioner or the free clinic provides written notice to the individual of the extent to which the legal liability of the health care practitioner is limited pursuant to this subsection (or in the case of an emergency, the written notice is provided to the individual as soon after the emergency as is practicable). If the individual is a minor or is otherwise legally incompetent, the condition under this subparagraph is that the written notice be provided to a legal guardian or other person with legal responsibility for the care of the individual.

''(F) At the time the service is provided, the health care practitioner is licensed or certified in accordance with applicable law regarding the provision of the service.

''(3)(A) For purposes of this subsection, the term 'free clinic' means a health care facility operated by a nonprofit private entity meeting the following requirements:

''(i) The entity does not, in providing health services through the facility, accept reimbursement from any third-party payor (including reimbursement under any insurance policy or health plan, or under any Federal or State health benefits program).

''(ii) The entity, in providing health services through the facility, either does not impose charges on the individuals to whom the services are provided, or imposes a charge according to the ability of the individual involved to pay the charge.

''(iii) The entity is licensed or certified in accordance with applicable law regarding the provision of health services.

''(B) With respect to compliance with the conditions under subparagraph (A), the entity involved may accept voluntary donations for the provision of services.

''(4) For purposes of this subsection, the term 'qualifying health service' means any medical assistance required or authorized to be provided in the program under title XIX of the Social Security Act, without regard to whether the medical assistance is included in the plan submitted under such program by the State in which the health care practitioner involved provides the medical assistance. References in the preceding sentence to such program shall as applicable be considered to be references to any successor to such program.

''(5) Subsection (g) (other than paragraphs (3) through (5)) and subsections (h), (i), and (l) apply to a health care practitioner for purposes of this subsection to the same extent and in the same manner as such subsections apply to an officer, governing board member, employee, or contractor of an entity described in subsection (g)(4), subject to paragraph (6) and subject to the following:

''(A) The first sentence of paragraph (1) applies in lieu of the first sentence of subsection (g)(1)(A).

''(B) This subsection may not be construed as deeming any free clinic to be an employee of the Public Health Service for purposes of this section.

''(C) With respect to a free clinic, a health care practitioner is not a free clinic health professional unless the free clinic sponsors the health care practitioner. For purposes of this subsection, the free clinic shall be considered to be sponsoring the health care practitioner if—

''(i) with respect to the health care practitioner, the free clinic submits to the Secretary an application meeting the requirements of subsection (g)(1)(D); and

''(ii) the Secretary, pursuant to subsection (g)(1)(E), determines that the health care practitioner is deemed to be an employee of the Public Health Service.

''(D) In the case of a health care practitioner who is determined by the Secretary pursuant to subsection (g)(1)(E) to be a free clinic health professional, this subsection applies to the health care practitioner (with respect to the free clinic sponsoring the health care practitioner pursuant to subparagraph C)) for any cause of action arising from an act or omission of the health care practitioner occurring on or after the date on which the Secretary makes such determination.

''(E) Subsection (g)(1)(F) applies to a health care practitioner for purposes of this subsection only to the extent that, in providing health services to an individual, each of the conditions specified in paragraph (2) is met.

''(6)(A) For purposes of making payments for judgments against the United States (together with related fees and expenses of witnesses) pursuant to this section arising from the acts or omissions of free clinic health professionals, there is authorized to be appropriated $10,000,000 for each fiscal year.

''(B) The Secretary shall establish a fund for purposes of this subsection. Each fiscal year amounts appropriated under subparagraph (A) shall be deposited in such fund.

''(C) Not later than May 1 of each fiscal year, the Attorney General, in consultation with the Secretary, shall submit to the Congress a report providing an estimate of the amount of claims (together with related fees and expenses of witnesses) that, by reason of the acts or omissions of free clinic health professionals, will be paid pursuant to this section during the calendar year that begins in the following fiscal year. Subsection (k)(1)(B) applies to the estimate under the preceding sentence regarding free clinic health professionals to the same extent and in the same manner as such subsection applies to the estimate under such subsection regarding officers, governing board members, employees, and contractors of entities described in subsection (g)(4).

''(D) Not later than December 31 of each fiscal year, the Secretary shall transfer from the fund under subparagraph (B) to the appropriate accounts in the Treasury an amount equal to the estimate made under subparagraph (C) for the calendar year beginning in such fiscal year, subject to the extent of amounts in the fund.

''(7)(A) This subsection takes effect on the date of the enactment of the first appropriations Act that makes an appropriation under paragraph (6)(A), except as provided in subparagraph (B)(i).

''(B)(i) Effective on the date of the enactment of the Health Insurance Portability and Accountability Act of 1996—

''(I) the Secretary may issue regulations for carrying out this subsection, and the Secretary may accept and consider applications submitted pursuant to paragraph (5)(C); and

''(II) reports under paragraph (6)(C) may be submitted to the Congress.

''(ii) For the first fiscal year for which an appropriation is made under subparagraph (A) of paragraph (6), if an estimate under subparagraph (C) of such paragraph has not been made for the calendar year beginning in such fiscal year, the transfer under subparagraph (D) of such paragraph shall be made notwithstanding the lack of the estimate, and the transfer shall be made in an amount equal to the amount of such appropriation.''.

SEC. 195. FINDINGS; SEVERABILITY.

(a) FINDINGS RELATING TO EXERCISE OF COMMERCE CLAUSE AUTHORITY.—Congress finds the following in relation to the provisions of this title:

(1) Provisions in group health plans and health insurance coverage that impose certain preexisting condition exclusions impact the ability of employees to seek employment in interstate commerce, thereby impeding such commerce.

(2) Health insurance coverage is commercial in nature and is in and affects interstate commerce.

(3) It is a necessary and proper exercise of Congressional authority to impose requirements under this title on group health plans and health insurance coverage (including coverage offered to individuals previously covered under group health plans) in order to promote commerce among the States.

(4) Congress, however, intends to defer to States, to the maximum extent practicable, in carrying out such requirements with respect to insurers and health maintenance organizations that are subject to State regulation, consistent with the provisions of the Employee Retirement Income Security Act of 1974.

(b) SEVERABILITY.—If any provision of this title or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this title and the application of the provisions of such to any person or circumstance shall not be affected thereby.

TITLE II—PREVENTING HEALTH CARE FRAUD AND ABUSE; ADMINISTRATIVE SIMPLIFICATION

SEC. 200. REFERENCES IN TITLE.

Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

Subtitle A—Fraud and Abuse Control Program

SEC. 201. FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

''FRAUD AND ABUSE CONTROL PROGRAM

''SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—Not later than January 1, 1997, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

''(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans,

''(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

''(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse,

''(D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts pursuant to section 1128D, and

''(E) to provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners pursuant to the data collection system established under section 1128E.

''(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

''(3) GUIDELINES.—

''(A) IN GENERAL.—The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

''(B) INFORMATION GUIDELINES.—

''(i) IN GENERAL.—Such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

''(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

''(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

''(4) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

''(5) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

''(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

''(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to by the payor, or otherwise.

''(2) CREDITING.—Funds received by the Inspector General under paragraph (1) as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of the deposit of such funds.

''(c) HEALTH PLAN DEFINED.—For purposes of this section, the term 'health plan' means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

''(1) a policy of health insurance;

''(2) a contract of a service benefit organization; and

''(3) a membership agreement with a health maintenance organization or other prepaid health plan.''.

(b) ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(k) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

''(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the 'Health Care Fraud and Abuse Control Account' (in this subsection referred to as the 'Account').

''(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

''(A) IN GENERAL.—There are hereby appropriated to the Trust Fund—

''(i) such gifts and bequests as may be made as provided in subparagraph (B);

''(ii) such amounts as may be deposited in the Trust Fund as provided in sections 242(b) and 249(c) of the Health Insurance Portability and Accountability Act of 1996, and title XI; and

''(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

''(B) AUTHORIZATION TO ACCEPT GIFTS.—The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account.

''(C) TRANSFER OF AMOUNTS.—The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

''(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 982(a)(6)(B) of title 18, United States Code).

''(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XIX, and chapter 38 of title 31, United States Code (except as otherwise provided by law).

''(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

''(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

''(D) APPLICATION.—Nothing in subparagraph (C)(iii) shall be construed to limit the availability of recoveries and forfeitures obtained under title I of the Employee Retirement Income Security Act of 1974 for the purpose of providing equitable or remedial relief for employee welfare benefit plans, and for participants and beneficiaries under such plans, as authorized under such title.

''(3) APPROPRIATED AMOUNTS TO ACCOUNT FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

''(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—

''(i) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation, in an amount not to exceed—

''(I) for fiscal year 1997, $104,000,000,

''(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent; and

''(III) for each fiscal year after fiscal year 2003, the limit for fiscal year 2003.

''(ii) MEDICARE AND MEDICAID ACTIVITIES.—For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the medicare and medicaid programs—

''(I) for fiscal year 1997, not less than $60,000,000 and not more than $70,000,000;

''(II) for fiscal year 1998, not less than $80,000,000 and not more than $90,000,000;

''(III) for fiscal year 1999, not less than $90,000,000 and not more than $100,000,000;

''(IV) for fiscal year 2000, not less than $110,000,000 and not more than $120,000,000;

''(V) for fiscal year 2001, not less than $120,000,000 and not more than $130,000,000;

''(VI) for fiscal year 2002, not less than $140,000,000 and not more than $150,000,000; and

''(VII) for each fiscal year after fiscal year 2002, not less than $150,000,000 and not more than $160,000,000.

''(B) FEDERAL BUREAU OF INVESTIGATION.—There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation—

''(i) for fiscal year 1997, $47,000,000;

''(ii) for fiscal year 1998, $56,000,000;

''(iii) for fiscal year 1999, $66,000,000;

''(iv) for fiscal year 2000, $76,000,000;

''(v) for fiscal year 2001, $88,000,000;

''(vi) for fiscal year 2002, $101,000,000; and

''(vii) for each fiscal year after fiscal year 2002, $114,000,000.

''(C) USE OF FUNDS.—The purposes described in this subparagraph are to cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

''(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

''(ii) investigations;

''(iii) financial and performance audits of health care programs and operations;

''(iv) inspections and other evaluations; and

''(v) provider and consumer education regarding compliance with the provisions of title XI.

''(4) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE INTEGRITY PROGRAM.—

''(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under section 1893, subject to subparagraph (B) and to be available without further appropriation.

''(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

''(i) For fiscal year 1997, such amount shall be not less than $430,000,000 and not more than $440,000,000.

''(ii) For fiscal year 1998, such amount shall be not less than $490,000,000 and not more than $500,000,000.

''(iii) For fiscal year 1999, such amount shall be not less than $550,000,000 and not more than $560,000,000.

''(iv) For fiscal year 2000, such amount shall be not less than $620,000,000 and not more than $630,000,000.

''(v) For fiscal year 2001, such amount shall be not less than $670,000,000 and not more than $680,000,000.

''(vi) For fiscal year 2002, such amount shall be not less than $690,000,000 and not more than $700,000,000.

''(vii) For each fiscal year after fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

''(5) ANNUAL REPORT.—Not later than January 1, the Secretary and the Attorney General shall submit jointly a report to Congress which identifies—

''(A) the amounts appropriated to the Trust Fund for the previous fiscal year under paragraph (2)(A) and the source of such amounts; and

''(B) the amounts appropriated from the Trust Fund for such year under paragraph (3) and the justification for the expenditure of such amounts.

''(6) GAO REPORT.—Not later than January 1 of 2000, 2002, and 2004, the Comptroller General of the United States shall submit a report to Congress which—

''(A) identifies—

''(i) the amounts appropriated to the Trust Fund for the previous two fiscal years under paragraph (2)(A) and the source of such amounts; and

''(ii) the amounts appropriated from the Trust Fund for such fiscal years under paragraph (3) and the justification for the expenditure of such amounts;

''(B) identifies any expenditures from the Trust Fund with respect to activities not involving the medicare program under title XVIII;

''(C) identifies any savings to the Trust Fund, and any other savings, resulting from expenditures from the Trust Fund; and

''(D) analyzes such other aspects of the operation of the Trust Fund as the Comptroller General of the United States considers appropriate.''.

SEC. 202. MEDICARE INTEGRITY PROGRAM.

(a) ESTABLISHMENT OF MEDICARE INTEGRITY PROGRAM.—Title XVIII is amended by adding at the end the following new section:

''MEDICARE INTEGRITY PROGRAM

''SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (in this section referred to as the 'Program') under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible entities to carry out the activities described in subsection (b).

''(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

''(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).

''(2) Audit of cost reports.

''(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

''(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

''(5) Developing (and periodically updating) a list of items of durable medical equipment in accordance with section 1834(a)(15) which are subject to prior authorization under such section.

''(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

''(1) the entity has demonstrated capability to carry out such activities;

''(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities;

''(3) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement; and

''(4) the entity meets such other requirements as the Secretary may impose.

In the case of the activity described in subsection (b)(5), an entity shall be deemed to be eligible to enter into a contract under the Program to carry out the activity if the entity is a carrier with a contract in effect under section 1842.

''(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

''(1) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

''(2) Competitive procedures to be used—

''(A) when entering into new contracts under this section;

''(B) when entering into contracts that may result in the elimination of responsibilities of an individual fiscal intermediary or carrier under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

''(C) at any other time considered appropriate by the Secretary,

except that the Secretary may continue to contract with entities that are carrying out the activities described in this section pursuant to agreements under section 1816 or contracts under section 1842 in effect on the date of the enactment of this section.

''(3) Procedures under which a contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

''(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.''.

(b) ELIMINATION OF FI AND CARRIER RESPONSIBILITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PROGRAM.—

(1) RESPONSIBILITIES OF FISCAL INTERMEDIARIES UNDER PART A.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

''(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.''.

(2) RESPONSIBILITIES OF CARRIERS UNDER PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

''(6) No carrier may carry out (or receive payment for carrying out) any activity pursuant to a contract under this subsection to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).''.

SEC. 203. BENEFICIARY INCENTIVE PROGRAMS.

(a) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall provide an explanation of benefits under the medicare program under title XVIII of the Social Security Act with respect to each item or service for which payment may be made under the program which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to the item or service.

(b) PROGRAM TO COLLECT INFORMATION ON FRAUD AND ABUSE.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging in or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1128, 1128A, or 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the medicare program under title XVIII of such act for which there is a sanction provided under law. The program shall discourage provision of, and not consider, information which is frivolous or otherwise not relevant or material to the imposition of such a sanction.

(2) PAYMENT OF PORTION OF AMOUNTS COLLECTED.—If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than any amount paid as a penalty under section 1128B of the Social Security Act), the Secretary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(c) PROGRAM TO COLLECT INFORMATION ON PROGRAM EFFICIENCY.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

SEC. 204. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST FEDERAL HEALTH CARE PROGRAMS.

(a) IN GENERAL.—Section 1128B (42 U.S.C. 1320a–7b) is amended as follows:

(1) In the heading, by striking ''MEDICARE OR STATE HEALTH CARE PROGRAMS'' and inserting ''FEDERAL HEALTH CARE PROGRAMS''.

(2) In subsection (a)(1), by striking ''a program under title XVIII or a State health care program (as defined in section 1128(h))'' and inserting ''a Federal health care program (as defined in subsection (f))''.

(3) In subsection (a)(5), by striking ''a program under title XVIII or a State health care program'' and inserting ''a Federal health care program''.

(4) In the second sentence of subsection (a)—

(A) by striking ''a State plan approved under title XIX'' and inserting ''a Federal health care program'', and

(B) by striking ''the State may at its option (notwithstanding any other provision of that title or of such plan)'' and inserting ''the administrator of such program may at its option (notwithstanding any other provision of such program)''.

(5) In subsection (b), by striking ''title XVIII or a State health care program'' each place it appears and inserting ''a Federal health care program''.

(6) In subsection (c), by inserting ''(as defined in section 1128(h))'' after ''a State health care program''.

(7) By adding at the end the following new subsection:

''(f) For purposes of this section, the term 'Federal health care program' means—

''(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code); or

''(2) any State health care program, as defined in section 1128(h).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1997.

SEC. 205. GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS.

Title XI (42 U.S.C. 1301 et seq.), as amended by section 201, is amended by inserting after section 1128C the following new section:

''GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

''SEC. 1128D. (a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

''(1) IN GENERAL.—

''(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1997, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

''(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

''(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) and shall not serve as the basis for an exclusion under section 1128(b)(7);

''(iii) advisory opinions to be issued pursuant to subsection (b); and

''(iv) special fraud alerts to be issued pursuant to subsection (c).

''(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

''(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as the 'Inspector General') shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

''(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

''(A) An increase or decrease in access to health care services.

''(B) An increase or decrease in the quality of health care services.

''(C) An increase or decrease in patient freedom of choice among health care providers.

''(D) An increase or decrease in competition among health care providers.

''(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

''(F) An increase or decrease in the cost to Federal health care programs (as defined in section 1128B(f)).

''(G) An increase or decrease in the potential overutilization of health care services.

''(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

''(i) whether to order a health care item or service; or

''(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

''(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in Federal health care programs (as so defined).

''(b) ADVISORY OPINIONS.—

''(1) ISSUANCE OF ADVISORY OPINIONS.—The Secretary, in consultation with the Attorney General, shall issue written advisory opinions as provided in this subsection.

''(2) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

''(A) What constitutes prohibited remuneration within the meaning of section 1128B(b).

''(B) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

''(C) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

''(D) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX within the meaning of section 1128B(b).

''(E) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

''(3) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

''(A) Whether the fair market value shall be, or was paid or received for any goods, services or property.

''(B) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

''(4) EFFECT OF ADVISORY OPINIONS.—

''(A) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

''(B) FAILURE TO SEEK OPINION.—The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

''(5) REGULATIONS.—

''(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

''(i) the procedure to be followed by a party applying for an advisory opinion;

''(ii) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

''(iii) the interval in which the Secretary shall respond;

''(iv) the reasonable fee to be charged to the party requesting an advisory opinion; and

''(v) the manner in which advisory opinions will be made available to the public.

''(B) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to subparagraph (A)—

''(i) the Secretary shall be required to issue to a party requesting an advisory opinion by not later than 60 days after the request is received; and

''(ii) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.

''(6) APPLICATION OF SUBSECTION.—This subsection shall apply to requests for advisory opinions made on or after the date which is 6 months after the date of enactment of this section and before the date which is 4 years after such date of enactment.

''(c) SPECIAL FRAUD ALERTS.—

''(1) IN GENERAL.—

''(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under the medicare program under title XVIII or a State health care program, as defined in section 1128(h) (in this subsection referred to as a 'special fraud alert').

''(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

''(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

''(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

''(B) the volume and frequency of the conduct that would be identified in the special fraud alert.''.

Subtitle B—Revisions to Current Sanctions for Fraud and Abuse

SEC. 211. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO HEALTH CARE FRAUD.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

''(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity that has

been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 1128(b) (42 U.S.C. 1320a–7(b)) is amended to read as follows:

''(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or State law—

''(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

''(i) in connection with the delivery of a health care item or service, or

''(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

''(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.''.

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted for an offense which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

SEC. 212. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

''(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

SEC. 213. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

Section 1128(b) (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

''(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—(A) Any individual—

''(i) who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)) of the action constituting the basis for the conviction or exclusion described in subparagraph (B); or

''(ii) who is an officer or managing employee (as defined in section 1126(b)) of such an entity.

''(B) For purposes of subparagraph (A), the term 'sanctioned entity' means an entity—

''(i) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

''(ii) that has been excluded from participation under a program under title XVIII or under a State health care program.''.

SEC. 214. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended by striking ''may prescribe)'' and inserting ''may prescribe, except that such period may not be less than 1 year)''.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) (42 U.S.C. 1320c–5(b)(2)) is amended by striking ''shall remain'' and inserting ''shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain''.

(b) REPEAL OF ''UNWILLING OR UNABLE'' CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking ''and determines'' and all that follows through ''such obligations,''; and

(2) by striking the third sentence.

SEC. 215. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

''(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).''.

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1), the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(ii) Civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

''(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

''(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an organization has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to the organization's attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(4) CONFORMING AMENDMENTS.—Section 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—Section 1876(i)(7)(A) (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking ''an agreement'' and inserting ''a written agreement''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1997.

SEC. 216. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PENALTIES FOR RISK-SHARING ARRANGEMENTS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(F) any remuneration between an organization and an individual or entity providing items or services, or a combination thereof, pursuant to a written agreement between the organization and the individual or entity if the organization is an eligible organization under section 1876 or if the written agreement, through a risk-sharing arrangement, places the individual or entity at substantial financial risk for the cost or utilization of the items or services, or a combination thereof, which the individual or entity is obligated to provide.''.

(b) NEGOTIATED RULEMAKING FOR RISK-SHARING EXCEPTION.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5, United States Code, standards relating to the exception for risk-sharing arrangements to the anti-kickback penalties described in section 1128B(b)(3)(F) of the Social Security Act, as added by subsection (a).

(B) FACTORS TO CONSIDER.—In establishing standards relating to the exception for risk-sharing arrangements to the anti-kickback penalties under subparagraph (A), the Secretary—

(i) shall consult with the Attorney General and representatives of the hospital, physician, other health practitioner, and health plan communities, and other interested parties; and

(ii) shall take into account—

(I) the level of risk appropriate to the size and type of arrangement;

(II) the frequency of assessment and distribution of incentives;

(III) the level of capital contribution; and

(IV) the extent to which the risk-sharing arrangement provides incentives to control the cost and quality of health care services.

(2) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this Act.

(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under paragraph (2), and for purposes of this subsection, the 'target date for publication' (referred to in section 564(a)(5) of such title) shall be January 1, 1997.

(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title under this subsection, '15 days' shall be substituted for '30 days'.

(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than October 1, 1996, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

(7) FINAL COMMITTEE REPORT.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to written agreements entered into on or after January 1, 1997, without regard to whether regulations have been issued to implement such amendments.

SEC. 217. CRIMINAL PENALTY FOR FRAUDULENT DISPOSITION OF ASSETS IN ORDER TO OBTAIN MEDICAID BENEFITS.

Section 1128B(a) (42 U.S.C. 1320a–7b(a)) is amended—

(1) by striking ''or'' at the end of paragraph (4);

(2) by adding ''or'' at the end of paragraph (5); and

(3) by inserting after paragraph (5) the following new paragraph:

''(6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),''.

SEC. 218. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this subtitle shall take effect January 1, 1997.

Subtitle C—Data Collection

SEC. 221. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.), as amended by sections 201 and 205, is amended by inserting after section 1128D the following new section:

''HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

''SEC. 1128E. (a) GENERAL PURPOSE.—Not later than January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c), and shall maintain a database of the information collected under this section.

''(b) REPORTING OF INFORMATION.—

''(1) IN GENERAL.—Each Government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

''(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

''(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

''(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner, who is the subject of a final adverse action, is affiliated or associated.

''(C) The nature of the final adverse action and whether such action is on appeal.

''(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

''(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

''(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

''(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

''(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

''(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section with respect to a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

''(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

''(B) procedures in the case of disputed accuracy of the information.

''(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

''(d) ACCESS TO REPORTED INFORMATION.—

''(1) AVAILABILITY.—The information in the database maintained under this section shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

''(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in such database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

''(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

''(f) COORDINATION WITH NATIONAL PRACTITIONER DATA BANK.—The Secretary shall implement this section in such a manner as to avoid duplication with the reporting requirements established for the National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).

''(g) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

''(1) FINAL ADVERSE ACTION.—

''(A) IN GENERAL.—The term 'final adverse action' includes:

''(i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.

''(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

''(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

''(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

''(II) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or

''(III) any other negative action or finding by such Federal or State agency that is publicly available information.

''(iv) Exclusion from participation in Federal or State health care programs (as defined in sections 1128B(f) and 1128(h), respectively).

''(v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

''(B) EXCEPTION.—The term does not include any action with respect to a malpractice claim.

''(2) PRACTITIONER.—The terms 'licensed health care practitioner', 'licensed practitioner', and 'practitioner' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

''(3) GOVERNMENT AGENCY.—The term 'Government agency' shall include:

''(A) The Department of Justice.

''(B) The Department of Health and Human Services.

''(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Veterans' Administration.

''(D) State law enforcement agencies.

''(E) State medicaid fraud control units.

''(F) Federal or State agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

''(4) HEALTH PLAN.—The term 'health plan' has the meaning given such term by section 1128C(c).

''(5) DETERMINATION OF CONVICTION.—For purposes of paragraph (1), the existence of a conviction shall be determined under paragraph (4) of section 1128(i).''.

(b) IMPROVED PREVENTION IN ISSUANCE OF MEDICARE PROVIDER NUMBERS.—Section 1842(r) (42 U.S.C. 1395u(r)) is amended by adding at the end the following new sentence: ''Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.''.

Subtitle D—Civil Monetary Penalties

SEC. 231. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES.

(a) GENERAL CIVIL MONETARY PENALTIES.—Section 1128A (42 U.S.C. 1320a–7a) is amended as follows:

(1) In the third sentence of subsection (a), by striking ''programs under title XVIII'' and inserting ''Federal health care programs (as defined in section 1128B(f)(1))''.

(2) In subsection (f)—

(A) by redesignating paragraph (3) as paragraph (4); and

(B) by inserting after paragraph (2) the following new paragraph:

''(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Insurance Portability and Accountability Act of 1996 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C).''.

(3) In subsection (i)—

(A) in paragraph (2), by striking ''title V, XVIII, XIX, or XX of this Act'' and inserting ''a Federal health care program (as defined in section 1128B(f))'',

(B) in paragraph (4), by striking ''a health insurance or medical services program under title XVIII or XIX of this Act'' and inserting ''a Federal health care program (as so defined)'', and

(C) in paragraph (5), by striking ''title V, XVIII, XIX, or XX'' and inserting ''a Federal health care program (as so defined)''.

(4) By adding at the end the following new subsection:

''(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

''(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

''(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

''(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

''(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 (5 U.S.C. App.) with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.''.

(b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) by striking ''or'' at the end of paragraph (1)(D);

(2) by striking '', or'' at the end of paragraph (2) and inserting a semicolon;

(3) by striking the semicolon at the end of paragraph (3) and inserting ''; or''; and

(4) by inserting after paragraph (3) the following new paragraph:

''(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection—

''(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

''(B) is an officer or managing employee (as defined in section 1126(b)) of such an entity;''.

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended in the matter following paragraph (4)—

(1) by striking ''$2,000'' and inserting ''$10,000'';

(2) by inserting ''; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs'' after ''false or misleading information was given''; and

(3) by striking ''twice the amount'' and inserting ''3 times the amount''.

(d) CLARIFICATION OF LEVEL OF KNOWLEDGE REQUIRED FOR IMPOSITION OF CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) in paragraphs (1) and (2), by inserting ''knowingly'' before ''presents'' each place it appears; and

(B) in paragraph (3), by striking ''gives'' and inserting ''knowingly gives or causes to be given''.

(2) DEFINITION OF STANDARD.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)), as amended by subsection (h)(2), is amended by adding at the end the following new paragraph:

''(7) The term 'should know' means that a person, with respect to information—

''(A) acts in deliberate ignorance of the truth or falsity of the information; or

''(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.''.

(e) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)), as amended by subsection (b), is amended—

(1) in subparagraph (A) by striking ''claimed,'' and inserting ''claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided,'';

(2) in subparagraph (C), by striking ''or'' at the end;

(3) in subparagraph (D), by striking the semicolon and inserting '', or''; and

(4) by inserting after subparagraph (D) the following new subparagraph:

''(E) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary;''.

(f) SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.—Section 1156(b)(3) (42 U.S.C. 1320c–5(b)(3)) is amended by striking ''the actual or estimated cost'' and inserting ''up to $10,000 for each instance''.

(g) PROCEDURAL PROVISIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)), as amended by section 215(a)(2), is amended by adding at the end the following new subparagraph:

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (B)(i) or (C)(i) in the same manner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).''.

(h) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended—

(A) by striking ''or'' at the end of paragraph (3);

(B) by striking the semicolon at the end of paragraph (4) and inserting ''; or''; and

(D) by inserting after paragraph (4) the following new paragraph:

''(5) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program (as so defined);''.

(2) REMUNERATION DEFINED.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

''(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term 'remuneration' does not include—

''(A) the waiver of coinsurance and deductible amounts by a person, if—

''(i) the waiver is not offered as part of any advertisement or solicitation;

''(ii) the person does not routinely waive coinsurance or deductible amounts; and

''(iii) the person—

''(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

''(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

''(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

''(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996; or

''(C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated.''.

(i) EFFECTIVE DATE.—The amendments made by this section shall apply to acts or omissions occurring on or after January 1, 1997.

SEC. 232. PENALTY FOR FALSE CERTIFICATION FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1128A(b) (42 U.S.C. 1320a–7a(b)) is amended by adding at the end the following new paragraph:

''(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

''(i) $5,000, or

''(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification.

''(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home health services furnished to the individual.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to certifications made on or after the date of the enactment of this Act.

Subtitle E—Revisions to Criminal Law

SEC. 241. DEFINITIONS RELATING TO FEDERAL HEALTH CARE OFFENSE.

(a) IN GENERAL.—Chapter 1 of title 18, United States Code, is amended by adding at the end the following:

''§ 24. Definitions relating to Federal health care offense

''(a) As used in this title, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

''(1) section 669, 1035, 1347, or 1518 of this title;

''(2) section 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title, if the violation or conspiracy relates to a health care benefit program.

''(b) As used in this title, the term 'health care benefit program' means any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 2 of title 18, United States Code, is amended by inserting after the item relating to section 23 the following new item:

''24. Definitions relating to Federal health care offense.''.

SEC. 242. HEALTH CARE FRAUD.

(a) OFFENSE.—

(1) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''§ 1347. Health care fraud

''Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—

''(1) to defraud any health care benefit program; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1347. Health care fraud.''.

(b) CRIMINAL FINES DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—The Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act (42 U.S.C. 1395i) an amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud).

SEC. 243. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''§ 669. Theft or embezzlement in connection with health care

''(a) Whoever knowingly and willfully embezzles, steals, or otherwise without authority converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $100 the defendant shall be fined under this title or imprisoned not more than one year, or both.

''(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''669. Theft or embezzlement in connection with health care.''.

SEC. 244. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

''§ 1035. False statements relating to health care matters

''(a) Whoever, in any matter involving a health care benefit program, knowingly and willfully—

''(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or

''(2) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry,

in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following new item:

''1035. False statements relating to health care matters.''.

SEC. 245. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following:

''§ 1518. Obstruction of criminal investigations of health care offenses

''(a) Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a Federal health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) As used in this section the term 'criminal investigator' means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of title 18, United States Code, is amended by adding at the end the following new item:

''1518. Obstruction of criminal investigations of health care offenses.''.

SEC. 246. LAUNDERING OF MONETARY INSTRUMENTS.

Section 1956(c)(7) of title 18, United States Code, is amended by adding at the end the following:

''(F) Any act or activity constituting an offense involving a Federal health care offense.''.

SEC. 247. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking ''or'' at the end of subparagraph (A);

(2) by inserting ''or'' at the end of subparagraph (B); and

(3) by adding at the end the following:

''(C) committing or about to commit a Federal health care offense.''.

(b) FREEZING OF ASSETS.—Section 1345(a)(2) of title 18, United States Code, is amended by inserting ''or a Federal health care offense'' after ''title)''.

SEC. 248. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

(a) IN GENERAL.—Chapter 223 of title 18, United States Code, is amended by adding after section 3485 the following:

''§ 3486. Authorized investigative demand procedures

''(a) AUTHORIZATION.—(1) In any investigation relating to any act or activity involving a Federal health care offense, the Attorney General or the Attorney General's designee may issue in writing and cause to be served a subpoena—

''(A) requiring the production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an authorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, or control; or

''(B) requiring a custodian of records to give testimony concerning the production and authentication of such records.

''(2) A subpoena under this subsection shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

''(3) The production of records shall not be required under this section at any place more than 500 miles distant from the place where the

subpoena for the production of such records is served.

''(4) Witnesses summoned under this section shall be paid the same fees and mileage that are paid witnesses in the courts of the United States.

''(b) SERVICE.—A subpoena issued under this section may be served by any person who is at least 18 years of age and is designated in the subpoena to serve it. Service upon a natural person may be made by personal delivery of the subpoena to him. Service may be made upon a domestic or foreign corporation or upon a partnership or other unincorporated association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service of process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

''(c) ENFORCEMENT.—In the case of contumacy by or refusal to obey a subpoena issued to any person, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, or in which he carries on business or may be found, to compel compliance with the subpoena. The court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, if so ordered, or to give testimony concerning the production and authentication of such records. Any failure to obey the order of the court may be punished by the court as a contempt thereof. All process in any such case may be served in any judicial district in which such person may be found.

''(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a summons under this section, who complies in good faith with the summons and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.

''(e) LIMITATION ON USE.—(1) Health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of and is directly related to receipt of health care or payment for health care or action involving a fraudulent claim related to health; or if authorized by an appropriate order of a court of competent jurisdiction, granted after application showing good cause therefor.

''(2) In assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

''(3) Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 223 of title 18, United States Code, is amended by inserting after the item relating to section 3485 the following new item:

''3486. Authorized investigative demand procedures.''.

(c) CONFORMING AMENDMENT.—Section 1510(b)(3)(B) of title 18, United States Code, is amended by inserting ''or a Department of Justice subpoena (issued under section 3486 of title 18),'' after ''subpoena''.

SEC. 249. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 982(a) of title 18, United States Code, is amended by adding after paragraph (5) the following new paragraph:

''(6) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.''.

(b) CONFORMING AMENDMENT.—Section 982(b)(1)(A) of title 18, United States Code, is amended by inserting ''or (a)(6)'' after ''(a)(1)''.

(c) PROPERTY FORFEITED DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—

(1) IN GENERAL.—After the payment of the costs of asset forfeiture has been made and after all restoration payments (if any) have been made, and notwithstanding any other provision of law, the Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act, as added by section 301(b), an amount equal to the net amount realized from the forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

(2) COSTS OF ASSET FORFEITURE.—For purposes of paragraph (1), the term ''payment of the costs of asset forfeiture'' means—

(A) the payment, at the discretion of the Attorney General, of any expenses necessary to seize, detain, inventory, safeguard, maintain, advertise, sell, or dispose of property under seizure, detention, or forfeited, or of any other necessary expenses incident to the seizure, detention, forfeiture, or disposal of such property, including payment for—

(i) contract services;

(ii) the employment of outside contractors to operate and manage properties or provide other specialized services necessary to dispose of such properties in an effort to maximize the return from such properties; and

(iii) reimbursement of any Federal, State, or local agency for any expenditures made to perform the functions described in this subparagraph;

(B) at the discretion of the Attorney General, the payment of awards for information or assistance leading to a civil or criminal forfeiture involving any Federal agency participating in the Health Care Fraud and Abuse Control Account;

(C) the compromise and payment of valid liens and mortgages against property that has been forfeited, subject to the discretion of the Attorney General to determine the validity of any such lien or mortgage and the amount of payment to be made, and the employment of attorneys and other personnel skilled in State real estate law as necessary;

(D) payment authorized in connection with remission or mitigation procedures relating to property forfeited; and

(E) the payment of State and local property taxes on forfeited real property that accrued between the date of the violation giving rise to the forfeiture and the date of the forfeiture order.

(3) RESTORATION PAYMENT.—Notwithstanding any other provision of law, if the Federal health care offense referred to in paragraph (1) resulted in a loss to an employee welfare benefit plan within the meaning of section 3(1) of the Employee Retirement Income Security Act of 1974, the Secretary of the Treasury shall transfer to such employee welfare benefit plan, from the amount realized from the forfeiture of property referred to in paragraph (1), an amount equal to such loss. For purposes of paragraph (1), the term 'restoration payment' means the amount transferred to an employee welfare benefit plan pursuant to this paragraph.''.

SEC. 250. RELATION TO ERISA AUTHORITY.

Nothing in this subtitle shall be construed as affecting the authority of the Secretary of Labor under section 506(b) of the Employee Retirement Income Security Act of 1974, including the Secretary's authority with respect to violations of title 18, United States Code (as amended by this subtitle).

Subtitle F—Administrative Simplification

SEC. 261. PURPOSE.

It is the purpose of this subtitle to improve the medicare program under title XVIII of the Social Security Act, the medicaid program under title XIX of such Act, and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.

SEC. 262. ADMINISTRATIVE SIMPLIFICATION.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

''PART C—ADMINISTRATIVE SIMPLIFICATION

''DEFINITIONS

''SEC. 1171. For purposes of this part:

''(1) CODE SET.—The term 'code set' means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

''(2) HEALTH CARE CLEARINGHOUSE.—The term 'health care clearinghouse' means a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' includes a provider of services (as defined in section 1861(u)), a provider of medical or other health services (as defined in section 1861(s)), and any other person furnishing health care services or supplies.

''(4) HEALTH INFORMATION.—The term 'health information' means any information, whether oral or recorded in any form or medium, that—

''(A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

''(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

''(5) HEALTH PLAN.—The term 'health plan' means an individual or group plan that provides, or pays the cost of, medical care (as such term is defined in section 2791 of the Public Health Service Act). Such term includes the following, and any combination thereof:

''(A) A group health plan (as defined in section 2791(a) of the Public Health Service Act), but only if the plan—

''(i) has 50 or more participants (as defined in section 3(7) of the Employee Retirement Income Security Act of 1974); or

''(ii) is administered by an entity other than the employer who established and maintains the plan.

''(B) A health insurance issuer (as defined in section 2791(b) of the Public Health Service Act).

''(C) A health maintenance organization (as defined in section 2791(b) of the Public Health Service Act).

''(D) Part A or part B of the medicare program under title XVIII.

''(E) The medicaid program under title XIX.

''(F) A medicare supplemental policy (as defined in section 1882(g)(1)).

''(G) A long-term care policy, including a nursing home fixed indemnity policy (unless the Secretary determines that such a policy does not provide sufficiently comprehensive coverage of a benefit so that the policy should be treated as a health plan).

''(H) An employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health benefits to the employees of 2 or more employers.

''(I) The health care program for active military personnel under title 10, United States Code.

''(J) The veterans health care program under chapter 17 of title 38, United States Code.

''(K) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in section 1072(4) of title 10, United States Code.

''(L) The Indian health service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(M) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

''(6) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term 'individually identifiable health information' means any information, including demographic information collected from an individual, that—

''(A) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

''(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and—

''(i) identifies the individual; or

''(ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

''(7) STANDARD.—The term 'standard', when used with reference to a data element of health information or a transaction referred to in section 1173(a)(1), means any such data element or transaction that meets each of the standards and implementation specifications adopted or established by the Secretary with respect to the data element or transaction under sections 1172 through 1174.

''(8) STANDARD SETTING ORGANIZATION.—The term 'standard setting organization' means a standard setting organization accredited by the American National Standards Institute, including the National Council for Prescription Drug Programs, that develops standards for information transactions, data elements, or any other standard that is necessary to, or will facilitate, the implementation of this part.

''GENERAL REQUIREMENTS FOR ADOPTION OF STANDARDS

''SEC. 1172. (a) APPLICABILITY.—Any standard adopted under this part shall apply, in whole or in part, to the following persons:

''(1) A health plan.

''(2) A health care clearinghouse.

''(3) A health care provider who transmits any health information in electronic form in connection with a transaction referred to in section 1173(a)(1).

''(b) REDUCTION OF COSTS.—Any standard adopted under this part shall be consistent with the objective of reducing the administrative costs of providing and paying for health care.

''(c) ROLE OF STANDARD SETTING ORGANIZATIONS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), any standard adopted under this part shall be a standard that has been developed, adopted, or modified by a standard setting organization.

''(2) SPECIAL RULES.—

''(A) DIFFERENT STANDARDS.—The Secretary may adopt a standard that is different from any standard developed, adopted, or modified by a standard setting organization, if—

''(i) the different standard will substantially reduce administrative costs to health care providers and health plans compared to the alternatives; and

''(ii) the standard is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

''(B) NO STANDARD BY STANDARD SETTING ORGANIZATION.—If no standard setting organization has developed, adopted, or modified any standard relating to a standard that the Secretary is authorized or required to adopt under this part—

''(i) paragraph (1) shall not apply; and

''(ii) subsection (f) shall apply.

''(3) CONSULTATION REQUIREMENT.—

''(A) IN GENERAL.—A standard may not be adopted under this part unless—

''(i) in the case of a standard that has been developed, adopted, or modified by a standard setting organization, the organization consulted with each of the organizations described in subparagraph (B) in the course of such development, adoption, or modification; and

''(ii) in the case of any other standard, the Secretary, in complying with the requirements of subsection (f), consulted with each of the organizations described in subparagraph (B) before adopting the standard.

''(B) ORGANIZATIONS DESCRIBED.—The organizations referred to in subparagraph (A) are the following:

''(i) The National Uniform Billing Committee.

''(ii) The National Uniform Claim Committee.

''(iii) The Workgroup for Electronic Data Interchange.

''(iv) The American Dental Association.

''(d) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for implementing each of the standards adopted under this part.

''(e) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, a standard adopted under this part shall not require disclosure of trade secrets or confidential commercial information by a person required to comply with this part.

''(f) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this part, the Secretary shall rely on the recommendations of the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)), and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register any recommendation of the National Committee on Vital and Health Statistics regarding the adoption of a standard under this part.

''(g) APPLICATION TO MODIFICATIONS OF STANDARDS.—This section shall apply to a modification to a standard (including an addition to a standard) adopted under section 1174(b) in the same manner as it applies to an initial standard adopted under section 1174(a).

''STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS

''SEC. 1173. (a) STANDARDS TO ENABLE ELECTRONIC EXCHANGE.—

''(1) IN GENERAL.—The Secretary shall adopt standards for transactions, and data elements for such transactions, to enable health information to be exchanged electronically, that are appropriate for—

''(A) the financial and administrative transactions described in paragraph (2); and

''(B) other financial and administrative transactions determined appropriate by the Secretary, consistent with the goals of improving the operation of the health care system and reducing administrative costs.

''(2) TRANSACTIONS.—The transactions referred to in paragraph (1)(A) are transactions with respect to the following:

''(A) Health claims or equivalent encounter information.

''(B) Health claims attachments.

''(C) Enrollment and disenrollment in a health plan.

''(D) Eligibility for a health plan.

''(E) Health care payment and remittance advice.

''(F) Health plan premium payments.

''(G) First report of injury.

''(H) Health claim status.

''(I) Referral certification and authorization.

''(3) ACCOMMODATION OF SPECIFIC PROVIDERS.—The standards adopted by the Secretary under paragraph (1) shall accommodate the needs of different types of health care providers.

''(b) UNIQUE HEALTH IDENTIFIERS.—

''(1) IN GENERAL.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. In carrying out the preceding sentence for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

''(2) USE OF IDENTIFIERS.—The standards adopted under paragraphs (1) shall specify the purposes for which a unique health identifier may be used.

''(c) CODE SETS.—

''(1) IN GENERAL.—The Secretary shall adopt standards that—

''(A) select code sets for appropriate data elements for the transactions referred to in subsection (a)(1) from among the code sets that have been developed by private and public entities; or

''(B) establish code sets for such data elements if no code sets for the data elements have been developed.

''(2) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under section 1174(b).

''(d) SECURITY STANDARDS FOR HEALTH INFORMATION.—

''(1) SECURITY STANDARDS.—The Secretary shall adopt security standards that—

''(A) take into account—

''(i) the technical capabilities of record systems used to maintain health information;

''(ii) the costs of security measures;

''(iii) the need for training persons who have access to health information;

''(iv) the value of audit trails in computerized record systems; and

''(v) the needs and capabilities of small health care providers and rural health care providers (as such providers are defined by the Secretary); and

''(B) ensure that a health care clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of the health care clearinghouse with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

''(2) SAFEGUARDS.—Each person described in section 1172(a) who maintains or transmits health information shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

''(A) to ensure the integrity and confidentiality of the information;

''(B) to protect against any reasonably anticipated—

''(i) threats or hazards to the security or integrity of the information; and

''(ii) unauthorized uses or disclosures of the information; and

''(C) otherwise to ensure compliance with this part by the officers and employees of such person.

''(e) ELECTRONIC SIGNATURE.—

''(1) STANDARDS.—The Secretary, in coordination with the Secretary of Commerce, shall adopt standards specifying procedures for the electronic transmission and authentication of signatures with respect to the transactions referred to in subsection (a)(1).

''(2) EFFECT OF COMPLIANCE.—Compliance with the standards adopted under paragraph (1) shall be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions referred to in subsection (a)(1).

''(f) TRANSFER OF INFORMATION AMONG HEALTH PLANS.—The Secretary shall adopt standards for transferring among health plans

appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

''TIMETABLES FOR ADOPTION OF STANDARDS

''SEC. 1174. (a) INITIAL STANDARDS.—The Secretary shall carry out section 1173 not later than 18 months after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, except that standards relating to claims attachments shall be adopted not later than 30 months after such date.

''(b) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under section 1173, and shall adopt modifications to the standards (including additions to the standards), as determined appropriate, but not more frequently than once every 12 months. Any addition or modification to a standard shall be completed in a manner which minimizes the disruption and cost of compliance.

''(2) SPECIAL RULES.—

''(A) FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary may not adopt any modification to a standard adopted under this part during the 12-month period beginning on the date the standard is initially adopted, unless the Secretary determines that the modification is necessary in order to permit compliance with the standard.

''(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

''(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

''(ii) ADDITIONAL RULES.—If a code set is modified under this subsection, the modified code set shall include instructions on how data elements of health information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set under this subsection shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

''REQUIREMENTS

''SEC. 1175. (a) CONDUCT OF TRANSACTIONS BY PLANS.—

''(1) IN GENERAL.—If a person desires to conduct a transaction referred to in section 1173(a)(1) with a health plan as a standard transaction—

''(A) the health plan may not refuse to conduct such transaction as a standard transaction;

''(B) the insurance plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the ground that the transaction is a standard transaction; and

''(C) the information transmitted and received in connection with the transaction shall be in the form of standard data elements of health information.

''(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirements under paragraph (1) by—

''(A) directly transmitting and receiving standard data elements of health information; or

''(B) submitting nonstandard data elements to a health care clearinghouse for processing into standard data elements and transmission by the health care clearinghouse, and receiving standard data elements through the health care clearinghouse.

''(3) TIMETABLE FOR COMPLIANCE.—Paragraph (1) shall not be construed to require a health plan to comply with any standard, implementation specification, or modification to a standard or specification adopted or established by the Secretary under sections 1172 through 1174 at any time prior to the date on which the plan is required to comply with the standard or specification under subsection (b).

''(b) COMPLIANCE WITH STANDARDS.—

''(1) INITIAL COMPLIANCE.—

''(A) IN GENERAL.—Not later than 24 months after the date on which an initial standard or implementation specification is adopted or established under sections 1172 and 1173, each person to whom the standard or implementation specification applies shall comply with the standard or specification.

''(B) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, paragraph (1) shall be applied by substituting '36 months' for '24 months'. For purposes of this subsection, the Secretary shall determine the plans that qualify as small health plans.

''(2) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modification to a standard or implementation specification under this part, each person to whom the standard or implementation specification applies shall comply with the modified standard or implementation specification at such time as the Secretary determines appropriate, taking into account the time needed to comply due to the nature and extent of the modification. The time determined appropriate under the preceding sentence may not be earlier than the last day of the 180-day period beginning on the date such modification is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines that such extension is appropriate.

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed to prohibit any person from complying with a standard or specification by—

''(A) submitting nonstandard data elements to a health care clearinghouse for processing into standard data elements and transmission by the health care clearinghouse; or

''(B) receiving standard data elements through a health care clearinghouse.

''GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS

''SEC. 1176. (a) GENERAL PENALTY.—

''(1) IN GENERAL.—Except as provided in subsection (b), the Secretary shall impose on any person who violates a provision of this part a penalty of not more than $100 for each such violation, except that the total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $25,000.

''(2) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this subsection in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

''(b) LIMITATIONS.—

''(1) OFFENSES OTHERWISE PUNISHABLE.—A penalty may not be imposed under subsection (a) with respect to an act if the act constitutes an offense punishable under section 1177.

''(2) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under subsection (a) with respect to a provision of this part if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision.

''(3) FAILURES DUE TO REASONABLE CAUSE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a penalty may not be imposed under subsection (a) if—

''(i) the failure to comply was due to reasonable cause and not to willful neglect; and

''(ii) the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

''(B) EXTENSION OF PERIOD.—

''(i) NO PENALTY.—The period referred to in subparagraph (A)(ii) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

''(ii) ASSISTANCE.—If the Secretary determines that a person failed to comply because the person was unable to comply, the Secretary may provide technical assistance to the person during the period described in subparagraph (A)(ii). Such assistance shall be provided in any manner determined appropriate by the Secretary.

''(4) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under subsection (a) that is not entirely waived under paragraph (3) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

''WRONGFUL DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

''SEC. 1177. (a) OFFENSE.—A person who knowingly and in violation of this part—

''(1) uses or causes to be used a unique health identifier;

''(2) obtains individually identifiable health information relating to an individual; or

''(3) discloses individually identifiable health information to another person,

shall be punished as provided in subsection (b).

''(b) PENALTIES.—A person described in subsection (a) shall—

''(1) be fined not more than $50,000, imprisoned not more than 1 year, or both;

''(2) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and

''(3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

''EFFECT ON STATE LAW

''SEC. 1178. (a) GENERAL EFFECT.—

''(1) GENERAL RULE.—Except as provided in paragraph (2), a provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 through 1174, shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

''(2) EXCEPTIONS.—A provision or requirement under this part, or a standard or implementation specification adopted or established under sections 1172 through 1174, shall not supersede a contrary provision of State law, if the provision of State law—

''(A) is a provision the Secretary determines—

''(i) is necessary—

''(I) to prevent fraud and abuse;

''(II) to ensure appropriate State regulation of insurance and health plans;

''(III) for State reporting on health care delivery or costs; or

''(IV) for other purposes; or

''(ii) addresses controlled substances; or

''(B) subject to section 264(c)(2) of the Health Insurance Portability and Accountability Act of 1996, relates to the privacy of individually identifiable health information.

''(b) PUBLIC HEALTH.—Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

''(c) STATE REGULATORY REPORTING.—Nothing in this part shall limit the ability of a State to require a health plan to report, or to provide access to, information for management audits,

financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification.

''PROCESSING PAYMENT TRANSACTIONS BY FINANCIAL INSTITUTIONS

''SEC. 1179. To the extent that an entity is engaged in activities of a financial institution (as defined in section 1101 of the Right to Financial Privacy Act of 1978), or is engaged in authorizing, processing, clearing, settling, billing, transferring, reconciling, or collecting payments, for a financial institution, this part, and any standard adopted under this part, shall not apply to the entity with respect to such activities, including the following:

''(1) The use or disclosure of information by the entity for authorizing, processing, clearing, settling, billing, transferring, reconciling or collecting, a payment for, or related to, health plan premiums or health care, where such payment is made by any means, including a credit, debit, or other payment card, an account, check, or electronic funds transfer.

''(2) The request for, or the use or disclosure of, information by the entity with respect to a payment described in paragraph (1)—

''(A) for transferring receivables;

''(B) for auditing;

''(C) in connection with—

''(i) a customer dispute; or

''(ii) an inquiry from, or to, a customer;

''(D) in a communication to a customer of the entity regarding the customer's transactions, payment card, account, check, or electronic funds transfer;

''(E) for reporting to consumer reporting agencies; or

''(F) for complying with—

''(i) a civil or criminal subpoena; or

''(ii) a Federal or State law regulating the entity.''.

(b) CONFORMING AMENDMENTS.—

(1) REQUIREMENT FOR MEDICARE PROVIDERS.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(A) by striking ''and'' at the end of subparagraph (P);

(B) by striking the period at the end of subparagraph (Q) and inserting ''; and''; and

(C) by inserting immediately after subparagraph (Q) the following new subparagraph:

''(R) to contract only with a health care clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under part C of title XI on or after the date on which the health care clearinghouse is required to comply with the standard or specification.''.

(2) TITLE HEADING.—Title XI (42 U.S.C. 1301 et seq.) is amended by striking the title heading and inserting the following:

''TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION''.

SEC. 263. CHANGES IN MEMBERSHIP AND DUTIES OF NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS.

Section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)) is amended—

(1) in paragraph (1), by striking ''16'' and inserting ''18'';

(2) by amending paragraph (2) to read as follows:

''(2) The members of the Committee shall be appointed from among persons who have distinguished themselves in the fields of health statistics, electronic interchange of health care information, privacy and security of electronic information, population-based public health, purchasing or financing health care services, integrated computerized health information systems, health services research, consumer interests in health information, health data standards, epidemiology, and the provision of health services. Members of the Committee shall be appointed for terms of 4 years.'';

(3) by redesignating paragraphs (3) through (5) as paragraphs (4) through (6), respectively, and inserting after paragraph (2) the following:

''(3) Of the members of the Committee—

''(A) 1 shall be appointed, not later than 60 days after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, by the Speaker of the House of Representatives after consultation with the minority leader of the House of Representatives;

''(B) 1 shall be appointed, not later than 60 days after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, by the President pro tempore of the Senate after consultation with the minority leader of the Senate; and

''(C) 16 shall be appointed by the Secretary.'';

(4) by amending paragraph (5) (as so redesignated) to read as follows:

''(5) The Committee—

''(A) shall assist and advise the Secretary—

''(i) to delineate statistical problems bearing on health and health services which are of national or international interest;

''(ii) to stimulate studies of such problems by other organizations and agencies whenever possible or to make investigations of such problems through subcommittees;

''(iii) to determine, approve, and revise the terms, definitions, classifications, and guidelines for assessing health status and health services, their distribution and costs, for use (I) within the Department of Health and Human Services, (II) by all programs administered or funded by the Secretary, including the Federal-State-local cooperative health statistics system referred to in subsection (e), and (III) to the extent possible as determined by the head of the agency involved, by the Department of Veterans Affairs, the Department of Defense, and other Federal agencies concerned with health and health services;

''(iv) with respect to the design of and approval of health statistical and health information systems concerned with the collection, processing, and tabulation of health statistics within the Department of Health and Human Services, with respect to the Cooperative Health Statistics System established under subsection (e), and with respect to the standardized means for the collection of health information and statistics to be established by the Secretary under subsection (j)(1);

''(v) to review and comment on findings and proposals developed by other organizations and agencies and to make recommendations for their adoption or implementation by local, State, national, or international agencies;

''(vi) to cooperate with national committees of other countries and with the World Health Organization and other national agencies in the studies of problems of mutual interest;

''(vii) to issue an annual report on the state of the Nation's health, its health services, their costs and distributions, and to make proposals for improvement of the Nation's health statistics and health information systems; and

''(viii) in complying with the requirements imposed on the Secretary under part C of title XI of the Social Security Act;

''(B) shall study the issues related to the adoption of uniform data standards for patient medical record information and the electronic exchange of such information;

''(C) shall report to the Secretary not later than 4 years after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996 recommendations and legislative proposals for such standards and electronic exchange; and

''(D) shall be responsible generally for advising the Secretary and the Congress on the status of the implementation of part C of title XI of the Social Security Act.''; and

(5) by adding at the end the following:

''(7) Not later than 1 year after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996, and annually thereafter, the Committee shall submit to the Congress, and make public, a report regarding the implementation of part C of title XI of the Social Security Act. Such report shall address the following subjects, to the extent that the Committee determines appropriate:

''(A) The extent to which persons required to comply with part C of title XI of the Social Security Act are cooperating in implementing the standards adopted under such part.

''(B) The extent to which such entities are meeting the security standards adopted under such part and the types of penalties assessed for noncompliance with such standards.

''(C) Whether the Federal and State Governments are receiving information of sufficient quality to meet their responsibilities under such part.

''(D) Any problems that exist with respect to implementation of such part.

''(E) The extent to which timetables under such part are being met.''.

SEC. 264. RECOMMENDATIONS WITH RESPECT TO PRIVACY OF CERTAIN HEALTH INFORMATION.

(a) IN GENERAL.—Not later than the date that is 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the Committee on Labor and Human Resources and the Committee on Finance of the Senate and the Committee on Commerce and the Committee on Ways and Means of the House of Representatives detailed recommendations on standards with respect to the privacy of individually identifiable health information.

(b) SUBJECTS FOR RECOMMENDATIONS.—The recommendations under subsection (a) shall address at least the following:

(1) The rights that an individual who is a subject of individually identifiable health information should have.

(2) The procedures that should be established for the exercise of such rights.

(3) The uses and disclosures of such information that should be authorized or required.

(c) REGULATIONS.—

(1) IN GENERAL.—If legislation governing standards with respect to the privacy of individually identifiable health information transmitted in connection with the transactions described in section 1173(a) of the Social Security Act (as added by section 262) is not enacted by the date that is 36 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall promulgate final regulations containing such standards not later than the date that is 42 months after the date of the enactment of this Act. Such regulations shall address at least the subjects described in subsection (b).

(2) PREEMPTION.—A regulation promulgated under paragraph (1) shall not supercede a contrary provision of State law, if the provision of State law imposes requirements, standards, or implementation specifications that are more stringent than the requirements, standards, or implementation specifications imposed under the regulation.

(d) CONSULTATION.—In carrying out this section, the Secretary of Health and Human Services shall consult with—

(1) the National Committee on Vital and Health Statistics established under section 306(k) of the Public Health Service Act (42 U.S.C. 242k(k)); and

(2) the Attorney General.

Subtitle G—Duplication and Coordination of Medicare-Related Plans

SEC. 271. DUPLICATION AND COORDINATION OF MEDICARE-RELATED PLANS.

(a) TREATMENT OF CERTAIN HEALTH INSURANCE POLICIES AS NONDUPLICATIVE.—Section 1882(d)(3)(A) (42 U.S.C. 1395ss(d)(3)(A)) is amended—

(1) in clause (iii), by striking ''clause (i)'' and inserting ''clause (i)(II)''; and

(2) by adding at the end the following:

''(iv) For purposes of this subparagraph, a health insurance policy (other than a medicare

supplemental policy) providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to 'duplicate' any health benefits under this title, under title XIX, or under a health insurance policy, and subclauses (I) and (III) of clause (i) do not apply to such a policy.

''(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy) is not considered to 'duplicate' health benefits under this title or under another health insurance policy if it—

''(I) provides health care benefits only for long-term care, nursing home care, home health care, or community-based care, or any combination thereof,

''(II) coordinates against or excludes items and services available or paid for under this title or under another health insurance policy, and

''(III) for policies sold or issued on or after the end of the 90-day period beginning on the date of enactment of the Health Insurance Portability and Accountability Act of 1996) discloses such coordination or exclusion in the policy's outline of coverage.

For purposes of this clause, the terms 'coordinates' and 'coordination' mean, with respect to a policy in relation to health benefits under this title or under another health insurance policy, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this title or under another health insurance policy.

''(vi)(I) An individual entitled to benefits under part A or enrolled under part B of this title who is applying for a health insurance policy (other than a policy described in subclause (III)) shall be furnished a disclosure statement described in clause (vii) for the type of policy being applied for. Such statement shall be furnished as a part of (or together with) the application for such policy.

''(II) Whoever issues or sells a health insurance policy (other than a policy described in subclause (III)) to an individual described in subclause (I) and fails to furnish the appropriate disclosure statement as required under such subclause shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $25,000 (or $15,000 in the case of a person other than the issuer of the policy) for each such violation.

''(III) A policy described in this subclause (to which subclauses (I) and (II) do not apply) is a medicare supplemental policy or a health insurance policy identified under 60 Federal Register 30880 (June 12, 1995) as a policy not required to have a disclosure statement.

''(IV) Any reference in this section to the revised NAIC model regulation (referred to in subsection (m)(1)(A)) is deemed a reference to such regulation as revised by section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified by substituting, for the disclosure required under section 16D(2), disclosure under subclause (I) of an appropriate disclosure statement under clause (vii).

''(vii) The disclosure statement described in this clause for a type of policy is the statement specified under subparagraph (D) of this paragraph (as in effect before the date of the enactment of the Health Insurance Portability and Accountability Act of 1996) for that type of policy, as revised as follows:

''(I) In each statement, amend the second line to read as follows:

'THIS IS NOT MEDICARE SUPPLEMENT INSURANCE'.

*''(II) In each statement, strike the third line and insert the following: '**Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.**'.*

*''(III) In each statement not described in subclause (V), strike the boldface matter that begins '**This insurance**' and all that follows up to the next paragraph that begins '**Medicare**'.*

*''(IV) In each statement not described in subclause (V), insert before the boxed matter (that states '**Before You Buy This Insurance**') the following: '**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**'.*

''(V) In a statement relating to policies providing both nursing home and non-institutional coverage, to policies providing nursing home benefits only, or policies providing home care benefits only, amend the sentence that begins 'Federal law' to read as follows: 'Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare.'.

''(viii)(I) Subject to subclause (II), nothing in this subparagraph shall restrict or preclude a State's ability to regulate health insurance policies, including any health insurance policy that is described in clause (iv), (v), or (vi)(III).

''(II) A State may not declare or specify, in statute, regulation, or otherwise, that a health insurance policy (other than a medicare supplemental policy) or rider to an insurance contract which is not a health insurance policy, that is described in clause (iv), (v), or (vi)(III) and that is sold, issued, or renewed to an individual entitled to benefits under part A or enrolled under part B 'duplicates' health benefits under this title or under a medicare supplemental policy.''.

(b) CONFORMING AMENDMENTS.—Section 1882(d)(3) (42 U.S.C. 1395ss(d)(3)) is amended—

(1) in subparagraph (C)—

(A) by striking ''with respect to (i)'' and inserting ''with respect to'', and

(B) by striking '', (ii) the sale'' and all that follows up to the period at the end; and

(2) by striking subparagraph (D).

(c) TRANSITIONAL PROVISION.—

(1) NO PENALTIES.—Subject to paragraph (3), no criminal or civil money penalty may be imposed under section 1882(d)(3)(A) of the Social Security Act for any act or omission that occurred during the transition period (as defined in paragraph (4)) and that relates to any health insurance policy that is described in clause (iv) or (v) of such section (as amended by subsection (a)).

(2) LIMITATION ON LEGAL ACTION.—Subject to paragraph (3), no legal action shall be brought or continued in any Federal or State court insofar as such action—

(A) includes a cause of action which arose, or which is based on or evidenced by any act or omission which occurred, during the transition period; and

(B) relates to the application of section 1882(d)(3)(A) of the Social Security Act to any act or omission with respect to the sale, issuance, or renewal of any health insurance policy that is described in clause (iv) or (v) of such section (as amended by subsection (a)).

(3) DISCLOSURE CONDITION.—In the case of a policy described in clause (iv) of section 1882(d)(3)(A) of the Social Security Act that is sold or issued on or after the effective date of statements under section 171(d)(3)(C) of the Social Security Act Amendments of 1994 and before the end of the 30-day period beginning on the date of the enactment of this Act, paragraphs (1) and (2) shall only apply if disclosure was made in accordance with section 1882(d)(3)(C)(ii) of the Social Security Act (as in effect before the date of the enactment of this Act).

(4) TRANSITION PERIOD.—In this subsection, the term ''transition period'' means the period beginning on November 5, 1991, and ending on the date of the enactment of this Act.

(d) EFFECTIVE DATE.—(1) Except as provided in this subsection, the amendment made by subsection (a) shall be effective as if included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990.

(2)(A) Clause (vi) of section 1882(d)(3)(A) of the Social Security Act, as added by subsection (a), shall only apply to individuals applying for—

(i) a health insurance policy described in section 1882(d)(3)(A)(iv) of such Act (as added by subsection (a)), after the date of the enactment of this Act, or

(ii) another health insurance policy after the end of the 30-day period beginning on the date of the enactment of this Act.

(B) A seller or issuer of a health insurance policy may substitute, for the disclosure statement described in clause (vii) of such section, the statement specified under section 1882(d)(3)(D) of the Social Security Act (as in effect before the date of the enactment of this Act), without the revision specified in such clause.

Subtitle H—Patent Extension

SEC. 281. PATENT EXTENSION.

(a) IN GENERAL.—Any owner on the date of the enactment of this Act of the right to market a non-steroidal anti-inflammatory drug that—

(1) contains a patented active agent,

(2) has been reviewed by the Federal Food and Drug Administration for a period of more than 96 months as a new drug application, and

(3) was approved as safe and effective by the Federal Food and Drug Administration on January 31, 1991,

shall be entitled, for the 2-year period beginning on February 28, 1997, to exclude others from making, using, offering for sale, selling, or importing into the United States such active agent, in accordance with section 154(a)(1) of title 35, United States Code.

(b) INFRINGEMENT.—Section 271 of title 35, United States Code, shall apply to the infringement of the entitlement provided under subsection (a) to the same extent as such section applies to infringement of a patent.

(c) NOTIFICATION.—Not later than 30 days after the date of the enactment of this Act, any owner granted an entitlement under subsection (a) shall notify the Commissioner of Patents and Trademarks and the Secretary for Health and Human Services of such entitlement. Not later than 7 days after the receipt of such notice, the Commissioner and the Secretary shall publish an appropriate notice of the receipt of such notice.

(d) OFFSET.—An owner described in subsection (a) shall pay the amount of $10,000,000 to the Secretary of Health and Human Services in each of the fiscal years 1997 and 1998 as a condition for being eligible to qualify for the entitlement under subsection (a). As a further condition for eligibility, such owner shall enter into a legally binding agreement with the Secretary of Health and Human Services which shall provide a means for ensuring that the entitlement under subsection (a) shall not create any net costs to the States under the medicaid program under title XIX of the Social Security Act.

TITLE III—TAX-RELATED HEALTH PROVISIONS

SEC. 300. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Medical Savings Accounts

SEC. 301. MEDICAL SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 (relating to additional itemized deductions for individuals) is amended by redesignating section 220 as section 221 and by inserting after section 219 the following new section:

''SEC. 220. MEDICAL SAVINGS ACCOUNTS.

''(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be

allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a medical savings account of such individual.

''(b) LIMITATIONS.—

''(1) IN GENERAL.—The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual.

''(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of—

''(A) in the case of an individual who has self-only coverage under the high deductible health plan as of the first day of such month, 65 percent of the annual deductible under such coverage, and

''(B) in the case of an individual who has family coverage under the high deductible health plan as of the first day of such month, 75 percent of the annual deductible under such coverage.

''(3) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of individuals who are married to each other, if either spouse has family coverage—

''(A) both spouses shall be treated as having only such family coverage (and if such spouses each have family coverage under different plans, as having the family coverage with the lowest annual deductible), and

''(B) the limitation under paragraph (1) (after the application of subparagraph (A) of this paragraph) shall be divided equally between them unless they agree on a different division.

''(4) DEDUCTION NOT TO EXCEED COMPENSATION.—

''(A) EMPLOYEES.—The deduction allowed under subsection (a) for contributions as an eligible individual described in subclause (I) of subsection (c)(1)(A)(iii) shall not exceed such individual's wages, salaries, tips, and other employee compensation which are attributable to such individual's employment by the employer referred to in such subclause.

''(B) SELF-EMPLOYED INDIVIDUALS.—The deduction allowed under subsection (a) for contributions as an eligible individual described in subclause (II) of subsection (c)(1)(A)(iii) shall not exceed such individual's earned income (as defined in section 401(c)(1)) derived by the taxpayer from the trade or business with respect to which the high deductible health plan is established.

''(C) COMMUNITY PROPERTY LAWS NOT TO APPLY.—The limitations under this paragraph shall be determined without regard to community property laws.

''(5) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—No deduction shall be allowed under this section for any amount paid for any taxable year to a medical savings account of an individual if—

''(A) any amount is contributed to any medical savings account of such individual for such year which is excludable from gross income under section 106(b), or

''(B) if such individual's spouse is covered under the high deductible health plan covering such individual, any amount is contributed for such year to any medical savings account of such spouse which is so excludable.

''(6) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(c) DEFINITIONS.—For purposes of this section—

''(1) ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if—

''(i) such individual is covered under a high deductible health plan as of the 1st day of such month,

''(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

''(I) which is not a high deductible health plan, and

''(II) which provides coverage for any benefit which is covered under the high deductible health plan, and

''(iii)(I) the high deductible health plan covering such individual is established and maintained by the employer of such individual or of the spouse of such individual and such employer is a small employer, or

''(II) such individual is an employee (within the meaning of section 401(c)(1)) or the spouse of such an employee and the high deductible health plan covering such individual is not established or maintained by any employer of such individual or spouse.

''(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—

''(i) coverage for any benefit provided by permitted insurance, and

''(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

''(C) CONTINUED ELIGIBILITY OF EMPLOYEE AND SPOUSE ESTABLISHING MEDICAL SAVINGS ACCOUNTS.—If, while an employer is a small employer—

''(i) any amount is contributed to a medical savings account of an individual who is an employee of such employer or the spouse of such an employee, and

''(ii) such amount is excludable from gross income under section 106(b) or allowable as a deduction under this section,

such individual shall not cease to meet the requirement of subparagraph (A)(iii)(I) by reason of such employer ceasing to be a small employer so long as such employee continues to be an employee of such employer.

''(D) LIMITATIONS ON ELIGIBILITY.—

''For limitations on number of taxpayers who are eligible to have medical savings accounts, see subsection (i).

''(2) HIGH DEDUCTIBLE HEALTH PLAN.—

''(A) IN GENERAL.—The term 'high deductible health plan' means a health plan—

''(i) in the case of self-only coverage, which has an annual deductible which is not less than $1,500 and not more than $2,250,

''(ii) in the case of family coverage, which has an annual deductible which is not less than $3,000 and not more than $4,500, and

''(iii) the annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—

''(I) $3,000 for self-only coverage, and

''(II) $5,500 for family coverage.

''(B) SPECIAL RULES.—

''(i) EXCLUSION OF CERTAIN PLANS.—Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

''(ii) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care if the absence of a deductible for such care is required by State law.

''(3) PERMITTED INSURANCE.—The term 'permitted insurance' means—

''(A) Medicare supplemental insurance,

''(B) insurance if substantially all of the coverage provided under such insurance relates to—

''(i) liabilities incurred under workers' compensation laws,

''(ii) tort liabilities,

''(iii) liabilities relating to ownership or use of property, or

''(iv) such other similar liabilities as the Secretary may specify by regulations,

''(C) insurance for a specified disease or illness, and

''(D) insurance paying a fixed amount per day (or other period) of hospitalization.

''(4) SMALL EMPLOYER.—

''(A) IN GENERAL.—The term 'small employer' means, with respect to any calendar year, any employer if such employer employed an average of 50 or fewer employees on business days during either of the 2 preceding calendar years. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer was in existence throughout such year.

''(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the 1st preceding calendar year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

''(C) CERTAIN GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—The term 'small employer' includes, with respect to any calendar year, any employer if—

''(i) such employer met the requirement of subparagraph (A) (determined without regard to subparagraph (B)) for any preceding calendar year after 1996,

''(ii) any amount was contributed to the medical savings account of any employee of such employer with respect to coverage of such employee under a high deductible health plan of such employer during such preceding calendar year and such amount was excludable from gross income under section 106(b) or allowable as a deduction under this section, and

''(iii) such employer employed an average of 200 or fewer employees on business days during each preceding calendar year after 1996.

''(D) SPECIAL RULES.—

''(i) CONTROLLED GROUPS.—For purposes of this paragraph, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

''(ii) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

''(5) FAMILY COVERAGE.—The term 'family coverage' means any coverage other than self-only coverage.

''(d) MEDICAL SAVINGS ACCOUNT.—For purposes of this section—

''(1) MEDICAL SAVINGS ACCOUNT.—The term 'medical savings account' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

''(A) Except in the case of a rollover contribution described in subsection (f)(5), no contribution will be accepted—

''(i) unless it is in cash, or

''(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds 75 percent of the highest annual limit deductible permitted under subsection (c)(2)(A)(ii) for such calendar year.

''(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

''(C) No part of the trust assets will be invested in life insurance contracts.

''(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(E) The interest of an individual in the balance in his account is nonforfeitable.

''(2) QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an account holder, amounts paid by such holder for medical

care (as defined in section 213(d)) for such individual, the spouse of such individual, and any dependent (as defined in section 152) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

''(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—

''(i) IN GENERAL.—Subparagraph (A) shall not apply to any payment for insurance.

''(ii) EXCEPTIONS.—Clause (i) shall not apply to any expense for coverage under—

''(I) a health plan during any period of continuation coverage required under any Federal law,

''(II) a qualified long-term care insurance contract (as defined in section 7702B(b)), or

''(III) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law.

''(C) MEDICAL EXPENSES OF INDIVIDUALS WHO ARE NOT ELIGIBLE INDIVIDUALS.—Subparagraph (A) shall apply to an amount paid by an account holder for medical care of an individual who is not an eligible individual for the month in which the expense for such care is incurred only if no amount is contributed (other than a rollover contribution) to any medical savings account of such account holder for the taxable year which includes such month. This subparagraph shall not apply to any expense for coverage described in subclause (I) or (III) of subparagraph (B)(ii).

''(3) ACCOUNT HOLDER.—The term 'account holder' means the individual on whose behalf the medical savings account was established.

''(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

''(A) Section 219(d)(2) (relating to no deduction for rollovers).

''(B) Section 219(f)(3) (relating to time when contributions deemed made).

''(C) Except as provided in section 106(b), section 219(f)(5) (relating to employer payments).

''(D) Section 408(g) (relating to community property laws).

''(E) Section 408(h) (relating to custodial accounts).

''(e) TAX TREATMENT OF ACCOUNTS.—

''(1) IN GENERAL.—A medical savings account is exempt from taxation under this subtitle unless such account has ceased to be a medical savings account. Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

''(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to medical savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

''(f) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a medical savings account which is used exclusively to pay qualified medical expenses of any account holder shall not be includible in gross income.

''(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a medical savings account which is not used exclusively to pay the qualified medical expenses of the account holder shall be included in the gross income of such holder.

''(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—

''(A) IN GENERAL.—If any excess contribution is contributed for a taxable year to any medical savings account of an individual, paragraph (2) shall not apply to distributions from the medical savings accounts of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if—

''(i) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

''(ii) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in clause (ii) shall be included in the gross income of the individual for the taxable year in which it is received.

''(B) EXCESS CONTRIBUTION.—For purposes of subparagraph (A), the term 'excess contribution' means any contribution (other than a rollover contribution) which is neither excludable from gross income under section 106(b) nor deductible under this section.

''(4) ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The tax imposed by this chapter on the account holder for any taxable year in which there is a payment or distribution from a medical savings account of such holder which is includible in gross income under paragraph (2) shall be increased by 15 percent of the amount which is so includible.

''(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account holder becomes disabled within the meaning of section 72(m)(7) or dies.

''(C) EXCEPTION FOR DISTRIBUTIONS AFTER MEDICARE ELIGIBILITY.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account holder attains the age specified in section 1811 of the Social Security Act.

''(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

''(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a medical savings account to the account holder to the extent the amount received is paid into a medical savings account for the benefit of such holder not later than the 60th day after the day on which the holder receives the payment or distribution.

''(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a medical savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a medical savings account which was not includible in the individual's gross income because of the application of this paragraph.

''(6) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of determining the amount of the deduction under section 213, any payment or distribution out of a medical savings account for qualified medical expenses shall not be treated as an expense paid for medical care.

''(7) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a medical savings account to an individual's spouse or former spouse under a divorce or separation instrument described in subparagraph (A) of section 71(b)(2) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a medical savings account with respect to which such spouse is the account holder.

''(8) TREATMENT AFTER DEATH OF ACCOUNT HOLDER.—

''(A) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—If the account holder's surviving spouse acquires such holder's interest in a medical savings account by reason of being the designated beneficiary of such account at the death of the account holder, such medical savings account shall be treated as if the spouse were the account holder.

''(B) OTHER CASES.—

''(i) IN GENERAL.—If, by reason of the death of the account holder, any person acquires the account holder's interest in a medical savings account in a case to which subparagraph (A) does not apply—

''(I) such account shall cease to be a medical savings account as of the date of death, and

''(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such holder, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such holder, in such holder's gross income for the last taxable year of such holder.

''(ii) SPECIAL RULES.—

''(I) REDUCTION OF INCLUSION FOR PRE-DEATH EXPENSES.—The amount includible in gross income under clause (i) by any person (other than the estate) shall be reduced by the amount of qualified medical expenses which were incurred by the decedent before the date of the decedent's death and paid by such person within 1 year after such date.

''(II) DEDUCTION FOR ESTATE TAXES.—An appropriate deduction shall be allowed under section 691(c) to any person (other than the decedent or the decedent's spouse) with respect to amounts included in gross income under clause (i) by such person.

''(g) COST-OF-LIVING ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subsection (c)(2) shall be increased by an amount equal to—

''(1) such dollar amount, multiplied by

''(2) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 1997' for 'calendar year 1992' in subparagraph (B) thereof.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

''(h) REPORTS.—The Secretary may require the trustee of a medical savings account to make such reports regarding such account to the Secretary and to the account holder with respect to contributions, distributions, and such other matters as the Secretary determines appropriate. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.

''(i) LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—

''(1) IN GENERAL.—Except as provided in paragraph (5), no individual shall be treated as an eligible individual for any taxable year beginning after the cut-off year unless—

''(A) such individual was an active MSA participant for any taxable year ending on or before the close of the cut-off year, or

''(B) such individual first became an active MSA participant for a taxable year ending after the cut-off year by reason of coverage under a high deductible health plan of an MSA–participating employer.

''(2) CUT-OFF YEAR.—For purposes of paragraph (1), the term 'cut-off year' means the earlier of—

''(A) calendar year 2000, or

''(B) the first calendar year before 2000 for which the Secretary determines under subsection (j) that the numerical limitation for such year has been exceeded.

''(3) ACTIVE MSA PARTICIPANT.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'active MSA participant' means, with respect to any taxable year, any individual who is the account holder of any medical savings account into which any contribution was made which was excludable from gross income under section 106(b), or allowable as a deduction under this section, for such taxable year.

''(B) SPECIAL RULE FOR CUT-OFF YEARS BEFORE 2000.—In the case of a cut-off year before 2000—

''(i) an individual shall not be treated as an eligible individual for any month of such year or an active MSA participant under paragraph (1)(A) unless such individual is, on or before the cut-off date, covered under a high deductible health plan, and

''(ii) an employer shall not be treated as an MSA-participating employer unless the employer, on or before the cut-off date, offered coverage under a high deductible health plan to any employee.

''(C) CUT-OFF DATE.—For purposes of subparagraph (B)—

''(i) IN GENERAL.—Except as otherwise provided in this subparagraph, the cut-off date is October 1 of the cut-off year.

''(ii) EMPLOYEES WITH ENROLLMENT PERIODS AFTER OCTOBER 1.—In the case of an individual described in subclause (I) of subsection (c)(1)(A)(iii), if the regularly scheduled enrollment period for health plans of the individual's employer occurs during the last 3 months of the cut-off year, the cut-off date is December 31 of the cut-off year.

''(iii) SELF-EMPLOYED INDIVIDUALS.—In the case of an individual described in subclause (II) of subsection (c)(1)(A)(iii), the cut-off date is November 1 of the cut-off year.

''(iv) SPECIAL RULES FOR 1997.—If 1997 is a cut-off year by reason of subsection (j)(1)(A)—

''(I) each of the cut-off dates under clauses (i) and (iii) shall be 1 month earlier than the date determined without regard to this clause, and

''(II) clause (ii) shall be applied by substituting '4 months' for '3 months'.

''(4) MSA-PARTICIPATING EMPLOYER.—For purposes of this subsection, the term 'MSA-participating employer' means any small employer if—

''(A) such employer made any contribution to the medical savings account of any employee during the cut-off year or any preceding calendar year which was excludable from gross income under section 106(b), or

''(B) at least 20 percent of the employees of such employer who are eligible individuals for any month of the cut-off year by reason of coverage under a high deductible health plan of such employer each made a contribution of at least $100 to their medical savings accounts for any taxable year ending with or within the cut-off year which was allowable as a deduction under this section.

''(5) ADDITIONAL ELIGIBILITY AFTER CUT-OFF YEAR.—If the Secretary determines under subsection (j)(2)(A) that the numerical limit for the calendar year following a cut-off year described in paragraph (2)(B) has not been exceeded—

''(A) this subsection shall not apply to any otherwise eligible individual who is covered under a high deductible health plan during the first 6 months of the second calendar year following the cut-off year (and such individual shall be treated as an active MSA participant for purposes of this subsection if a contribution is made to any medical savings account with respect to such coverage), and

''(B) any employer who offers coverage under a high deductible health plan to any employee during such 6-month period shall be treated as an MSA-participating employer for purposes of this subsection if the requirements of paragraph (4) are met with respect to such coverage.

For purposes of this paragraph, subsection (j)(2)(A) shall be applied for 1998 by substituting '750,000' for '600,000'.

''(j) DETERMINATION OF WHETHER NUMERICAL LIMITS ARE EXCEEDED.—

''(1) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR 1997.—The numerical limitation for 1997 is exceeded if, based on the reports required under paragraph (4), the number of medical savings accounts established as of—

''(A) April 30, 1997, exceeds 375,000, or

''(B) June 30, 1997, exceeds 525,000.

''(2) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR 1998 OR 1999.—

''(A) IN GENERAL.—The numerical limitation for 1998 or 1999 is exceeded if the sum of—

''(i) the number of MSA returns filed on or before April 15 of such calendar year for taxable years ending with or within the preceding calendar year, plus

''(ii) the Secretary's estimate (determined on the basis of the returns described in clause (i)) of the number of MSA returns for such taxable years which will be filed after such date,

exceeds 600,000 (750,000 in the case of 1999). For purposes of the preceding sentence, the term 'MSA return' means any return on which any exclusion is claimed under section 106(b) or any deduction is claimed under this section.

''(B) ALTERNATIVE COMPUTATION OF LIMITATION.—The numerical limitation for 1998 or 1999 is also exceeded if the sum of—

''(i) 90 percent of the sum determined under subparagraph (A) for such calendar year, plus

''(ii) the product of 2.5 and the number of medical savings accounts established during the portion of such year preceding July 1 (based on the reports required under paragraph (4)) for taxable years beginning in such year,

exceeds 750,000.

''(3) PREVIOUSLY UNINSURED INDIVIDUALS NOT INCLUDED IN DETERMINATION.—

''(A) IN GENERAL.—The determination of whether any calendar year is a cut-off year shall be made by not counting the medical savings account of any previously uninsured individual.

''(B) PREVIOUSLY UNINSURED INDIVIDUAL.—For purposes of this subsection, the term 'previously uninsured individual' means, with respect to any medical savings account, any individual who had no health plan coverage (other than coverage referred to in subsection (c)(1)(B)) at any time during the 6-month period before the date such individual's coverage under the high deductible health plan commences.

''(4) REPORTING BY MSA TRUSTEES.—

''(A) IN GENERAL.—Not later than August 1 of 1997, 1998, and 1999, each person who is the trustee of a medical savings account established before July 1 of such calendar year shall make a report to the Secretary (in such form and manner as the Secretary shall specify) which specifies—

''(i) the number of medical savings accounts established before such July 1 (for taxable years beginning in such calendar year) of which such person is the trustee,

''(ii) the name and TIN of the account holder of each such account, and

''(iii) the number of such accounts which are accounts of previously uninsured individuals.

''(B) ADDITIONAL REPORT FOR 1997.—Not later than June 1, 1997, each person who is the trustee of a medical savings account established before May 1, 1997, shall make an additional report described in subparagraph (A) but only with respect to accounts established before May 1, 1997.

''(C) PENALTY FOR FAILURE TO FILE REPORT.—The penalty provided in section 6693(a) shall apply to any report required by this paragraph, except that—

''(i) such section shall be applied by substituting '$25' for '$50', and

''(ii) the maximum penalty imposed on any trustee shall not exceed $5,000.

''(D) AGGREGATION OF ACCOUNTS.—To the extent practical, in determining the number of medical savings accounts on the basis of the reports under this paragraph, all medical savings accounts of an individual shall be treated as 1 account and all accounts of individuals who are married to each other shall be treated as 1 account.

''(5) DATE OF MAKING DETERMINATIONS.—Any determination under this subsection that a calendar year is a cut-off year shall be made by the Secretary and shall be published not later than October 1 of such year.

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 is amended by inserting after paragraph (15) the following new paragraph:

''(16) MEDICAL SAVINGS ACCOUNTS.—The deduction allowed by section 220.''

(c) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) EXCLUSION FROM INCOME TAX.—The text of section 106 (relating to contributions by employer to accident and health plans) is amended to read as follows:

''(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

''(b) CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

''(1) IN GENERAL.—In the case of an employee who is an eligible individual, amounts contributed by such employee's employer to any medical savings account of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

''(2) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

''(3) SPECIAL RULE FOR DEDUCTION OF EMPLOYER CONTRIBUTIONS.—Any employer contribution to a medical savings account, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

''(4) EMPLOYER MSA CONTRIBUTIONS REQUIRED TO BE SHOWN ON RETURN.—Every individual required to file a return under section 6012 for the taxable year shall include on such return the aggregate amount contributed by employers to the medical savings accounts of such individual or such individual's spouse for such taxable year.

''(5) MSA CONTRIBUTIONS NOT PART OF COBRA COVERAGE.—Paragraph (1) shall not apply for purposes of section 4980B.

''(6) DEFINITIONS.—For purposes of this subsection, the terms 'eligible individual' and 'medical savings account' have the respective meanings given to such terms by section 220.

''(7) CROSS REFERENCE.—

''For penalty on failure by employer to make comparable contributions to the medical savings accounts of comparable employees, see section 4980E.''.

(2) EXCLUSION FROM EMPLOYMENT TAXES.—

(A) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 is amended by adding at the end the following new paragraph:

''(10) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).''

(B) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 is amended by striking ''or'' at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting ''; or'', and by inserting after paragraph (16) the following new paragraph:

''(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).''

(C) WITHHOLDING TAX.—Subsection (a) of section 3401 is amended by striking ''or'' at the end of paragraph (19), by striking the period at the end of paragraph (20) and inserting ''; or'', and by inserting after paragraph (20) the following new paragraph:

''(21) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b).''

(3) EMPLOYER CONTRIBUTIONS REQUIRED TO BE SHOWN ON W-2.—Subsection (a) of section 6051 is amended by striking ''and'' at the end of paragraph (9), by striking the period at the end of paragraph (10) and inserting '', and'', and by inserting after paragraph (10) the following new paragraph:

''(11) the amount contributed to any medical savings account (as defined in section 220(d)) of such employee or such employee's spouse.''

(4) PENALTY FOR FAILURE OF EMPLOYER TO MAKE COMPARABLE MSA CONTRIBUTIONS.—

(A) IN GENERAL.—Chapter 43 is amended by adding after section 4980D the following new section:

''SEC. 4980E. FAILURE OF EMPLOYER TO MAKE COMPARABLE MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS.

''(a) GENERAL RULE.—In the case of an employer who makes a contribution to the medical savings account of any employee with respect to coverage under a high deductible health plan of the employer during a calendar year, there is hereby imposed a tax on the failure of such employer to meet the requirements of subsection (d) for such calendar year.

''(b) AMOUNT OF TAX.—The amount of the tax imposed by subsection (a) on any failure for any calendar year is the amount equal to 35 percent of the aggregate amount contributed by the employer to medical savings accounts of employees for taxable years of such employees ending with or within such calendar year.

''(c) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

''(d) EMPLOYER REQUIRED TO MAKE COMPARABLE MSA CONTRIBUTIONS FOR ALL PARTICIPATING EMPLOYEES.—

''(1) IN GENERAL.—An employer meets the requirements of this subsection for any calendar year if the employer makes available comparable contributions to the medical savings accounts of all comparable participating employees for each coverage period during such calendar year.

''(2) COMPARABLE CONTRIBUTIONS.—

''(A) IN GENERAL.—For purposes of paragraph (1), the term 'comparable contributions' means contributions—

''(i) which are the same amount, or

''(ii) which are the same percentage of the annual deductible limit under the high deductible health plan covering the employees.

''(B) PART-YEAR EMPLOYEES.—In the case of an employee who is employed by the employer for only a portion of the calendar year, a contribution to the medical savings account of such employee shall be treated as comparable if it is an amount which bears the same ratio to the comparable amount (determined without regard to this subparagraph) as such portion bears to the entire calendar year.

''(3) COMPARABLE PARTICIPATING EMPLOYEES.—For purposes of paragraph (1), the term 'comparable participating employees' means all employees—

''(A) who are eligible individuals covered under any high deductible health plan of the employer, and

''(B) who have the same category of coverage. For purposes of subparagraph (B), the categories of coverage are self-only and family coverage.

''(4) PART-TIME EMPLOYEES.—

''(A) IN GENERAL.—Paragraph (3) shall be applied separately with respect to part-time employees and other employees.

''(B) PART-TIME EMPLOYEE.—For purposes of subparagraph (A), the term 'part-time employee' means any employee who is customarily employed for fewer than 30 hours per week.

''(e) CONTROLLED GROUPS.—For purposes of this section, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

''(f) DEFINITIONS.—Terms used in this section which are also used in section 220 have the respective meanings given such terms in section 220.''

(B) CLERICAL AMENDMENT.—The table of sections for chapter 43 is amended by adding after the item relating to section 4980D the following new item:

''Sec. 4980E. Failure of employer to make comparable medical savings account contributions.''

(d) MEDICAL SAVINGS ACCOUNT CONTRIBUTIONS NOT AVAILABLE UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by inserting ''106(b),'' before ''117''.

(e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 (relating to tax on excess contributions to individual retirement accounts, certain section 403(b) contracts, and certain individual retirement annuities) is amended—

(1) by inserting ''medical savings accounts,'' after ''accounts,'' in the heading of such section,

(2) by striking ''or'' at the end of paragraph (1) of subsection (a),

(3) by redesignating paragraph (2) of subsection (a) as paragraph (3) and by inserting after paragraph (1) the following:

''(2) a medical savings account (within the meaning of section 220(d)), or'', and

(4) by adding at the end the following new subsection:

''(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—For purposes of this section, in the case of medical savings accounts (within the meaning of section 220(d)), the term 'excess contributions' means the sum of—

''(1) the aggregate amount contributed for the taxable year to the accounts (other than rollover contributions described in section 220(f)(5)) which is neither excludable from gross income under section 106(b) nor allowable as a deduction under section 220 for such year, and

''(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of—

''(A) the distributions out of the accounts which were included in gross income under section 220(f)(2), and

''(B) the excess (if any) of—

''(i) the maximum amount allowable as a deduction under section 220(b)(1) (determined without regard to section 106(b)) for the taxable year, over

''(ii) the amount contributed to the accounts for the taxable year.

For purposes of this subsection, any contribution which is distributed out of the medical savings account in a distribution to which section 220(f)(3) applies shall be treated as an amount not contributed.''

(f) TAX ON PROHIBITED TRANSACTIONS.—

(1) Section 4975 (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraph:

''(4) SPECIAL RULE FOR MEDICAL SAVINGS ACCOUNTS.—An individual for whose benefit a medical savings account (within the meaning of section 220(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a medical savings account by reason of the application of section 220(e)(2) to such account.''

(2) Paragraph (1) of section 4975(e) is amended to read as follows:

''(1) PLAN.—For purposes of this section, the term 'plan' means—

''(A) a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a),

''(B) an individual retirement account described in section 408(a),

''(C) an individual retirement annuity described in section 408(b),

''(D) a medical savings account described in section 220(d), or

''(E) a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be described in any preceding subparagraph of this paragraph.''

(g) FAILURE TO PROVIDE REPORTS ON MEDICAL SAVINGS ACCOUNTS.—

(1) Subsection (a) of section 6693 (relating to failure to provide reports on individual retirement accounts or annuities) is amended to read as follows:

''(a) REPORTS.—

''(1) IN GENERAL.—If a person required to file a report under a provision referred to in paragraph (2) fails to file such report at the time and in the manner required by such provision, such person shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.

''(2) PROVISIONS.—The provisions referred to in this paragraph are—

''(A) subsections (i) and (l) of section 408 (relating to individual retirement plans), and

''(B) section 220(h) (relating to medical savings accounts).''

(h) EXCEPTION FROM CAPITALIZATION OF POLICY ACQUISITION EXPENSES.—Subparagraph (B) of section 848(e)(1) (defining specified insurance contract) is amended by striking ''and'' at the end of clause (ii), by striking the period at the end of clause (iii) and inserting '', and'', and by adding at the end the following new clause:

''(iv) any contract which is a medical savings account (as defined in section 220(d)).''.

(i) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 is amended by striking the last item and inserting the following:

''Sec. 220. Medical savings accounts.

''Sec. 221. Cross reference.''.

(j) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

(k) MONITORING OF PARTICIPATION IN MEDICAL SAVINGS ACCOUNTS.—The Secretary of the Treasury or his delegate shall—

(1) during 1997, 1998, 1999, and 2000, regularly evaluate the number of individuals who are maintaining medical savings accounts and the reduction in revenues to the United States by reason of such accounts, and

(2) provide such reports of such evaluations to Congress as such Secretary determines appropriate.

(l) STUDY OF EFFECTS OF MEDICAL SAVINGS ACCOUNTS ON SMALL GROUP MARKET.—The Comptroller General of the United States shall enter into a contract with an organization with expertise in health economics, health insurance markets, and actuarial science to conduct a comprehensive study regarding the effects of medical savings accounts in the small group market on—

(1) selection, including adverse selection,

(2) health costs, including any impact on premiums of individuals with comprehensive coverage,

(3) use of preventive care,

(4) consumer choice,

(5) the scope of coverage of high deductible plans purchased in conjunction with such accounts, and

(6) other relevant items.

A report on the results of the study conducted under this subsection shall be submitted to the Congress no later than January 1, 1999.

Subtitle B—Increase in Deduction for Health Insurance Costs of Self-Employed Individuals

SEC. 311. INCREASE IN DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Paragraph (1) of section 162(l) is amended to read as follows:

''(1) ALLOWANCE OF DEDUCTION.—

''(A) IN GENERAL.—In the case of an individual who is an employee within the meaning of

section 401(c)(1), there shall be allowed as a deduction under this section an amount equal to the applicable percentage of the amount paid during the taxable year for insurance which constitutes medical care for the taxpayer, his spouse, and dependents.

''(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage shall be determined under the following table:

"For taxable years beginning in calendar year—	The applicable in percentage is—
1997	40 percent
1998 through 2002	45 percent
2003	50 percent
2004	60 percent
2005	70 percent
2006 or thereafter	80 percent.''.

(b) EXCLUSION FOR AMOUNTS RECEIVED UNDER CERTAIN SELF-INSURED PLANS.—Paragraph (3) of section 104(a) is amended by inserting ''(or through an arrangement having the effect of accident or health insurance)'' after ''health insurance''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

Subtitle C—Long-Term Care Services and Contracts

PART I—GENERAL PROVISIONS

SEC. 321. TREATMENT OF LONG-TERM CARE INSURANCE.

(a) GENERAL RULE.—Chapter 79 (relating to definitions) is amended by inserting after section 7702A the following new section:

"SEC. 7702B. TREATMENT OF QUALIFIED LONG-TERM CARE INSURANCE.

''(a) IN GENERAL.—For purposes of this title—

''(1) a qualified long-term care insurance contract shall be treated as an accident and health insurance contract,

''(2) amounts (other than policyholder dividends, as defined in section 808, or premium refunds) received under a qualified long-term care insurance contract shall be treated as amounts received for personal injuries and sickness and shall be treated as reimbursement for expenses actually incurred for medical care (as defined in section 213(d)),

''(3) any plan of an employer providing coverage under a qualified long-term care insurance contract shall be treated as an accident and health plan with respect to such coverage,

''(4) except as provided in subsection (e)(3), amounts paid for a qualified long-term care insurance contract providing the benefits described in subsection (b)(2)(A) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

''(5) a qualified long-term care insurance contract shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

''(b) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT.—For purposes of this title—

''(1) IN GENERAL.—The term 'qualified long-term care insurance contract' means any insurance contract if—

''(A) the only insurance protection provided under such contract is coverage of qualified long-term care services,

''(B) such contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount,

''(C) such contract is guaranteed renewable,

''(D) such contract does not provide for a cash surrender value or other money that can be—

''(i) paid, assigned, or pledged as collateral for a loan, or

''(ii) borrowed,

other than as provided in subparagraph (E) or paragraph (2)(C),

''(E) all refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, and

''(F) such contract meets the requirements of subsection (g).

''(2) SPECIAL RULES.—

''(A) PER DIEM, ETC. PAYMENTS PERMITTED.—A contract shall not fail to be described in subparagraph (A) or (B) of paragraph (1) by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

''(B) SPECIAL RULES RELATING TO MEDICARE.—

''(i) Paragraph (1)(B) shall not apply to expenses which are reimbursable under title XVIII of the Social Security Act only as a secondary payor.

''(ii) No provision of law shall be construed or applied so as to prohibit the offering of a qualified long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under such title.

''(C) REFUNDS OF PREMIUMS.—Paragraph (1)(E) shall not apply to any refund on the death of the insured, or on a complete surrender or cancellation of the contract, which cannot exceed the aggregate premiums paid under the contract. Any refund on a complete surrender or cancellation of the contract shall be includible in gross income to the extent that any deduction or exclusion was allowable with respect to the premiums.

''(c) QUALIFIED LONG-TERM CARE SERVICES.—For purposes of this section—

''(1) IN GENERAL.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which—

''(A) are required by a chronically ill individual, and

''(B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

''(2) CHRONICALLY ILL INDIVIDUAL.—

''(A) IN GENERAL.—The term 'chronically ill individual' means any individual who has been certified by a licensed health care practitioner as—

''(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

''(ii) having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

''(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

''(B) ACTIVITIES OF DAILY LIVING.—For purposes of subparagraph (A), each of the following is an activity of daily living:

''(i) Eating.

''(ii) Toileting.

''(iii) Transferring.

''(iv) Bathing.

''(v) Dressing.

''(vi) Continence.

A contract shall not be treated as a qualified long-term care insurance contract unless the determination of whether an individual is a chronically ill individual takes into account at least 5 of such activities.

''(3) MAINTENANCE OR PERSONAL CARE SERVICES.—The term 'maintenance or personal care services' means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

''(4) LICENSED HEALTH CARE PRACTITIONER.—The term 'licensed health care practitioner' means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

''(d) AGGREGATE PAYMENTS IN EXCESS OF LIMITS.—

''(1) IN GENERAL.—If the aggregate of—

''(A) the periodic payments received for any period under all qualified long-term care insurance contracts which are treated as made for qualified long-term care services for an insured, and

''(B) the periodic payments received for such period which are treated under section 101(g) as paid by reason of the death of such insured,

exceeds the per diem limitation for such period, such excess shall be includible in gross income without regard to section 72. A payment shall not be taken into account under subparagraph (B) if the insured is a terminally ill individual (as defined in section 101(g)) at the time the payment is received.

''(2) PER DIEM LIMITATION.—For purposes of paragraph (1), the per diem limitation for any period is an amount equal to the excess (if any) of—

''(A) the greater of—

''(i) the dollar amount in effect for such period under paragraph (4), or

''(ii) the costs incurred for qualified long-term care services provided for the insured for such period, over

''(B) the aggregate payments received as reimbursements (through insurance or otherwise) for qualified long-term care services provided for the insured during such period.

''(3) AGGREGATION RULES.—For purposes of this subsection—

''(A) all persons receiving periodic payments described in paragraph (1) with respect to the same insured shall be treated as 1 person, and

''(B) the per diem limitation determined under paragraph (2) shall be allocated first to the insured and any remaining limitation shall be allocated among the other such persons in such manner as the Secretary shall prescribe.

''(4) DOLLAR AMOUNT.—The dollar amount in effect under this subsection shall be $175 per day (or the equivalent amount in the case of payments on another periodic basis).

''(5) INFLATION ADJUSTMENT.—In the case of a calendar year after 1997, the dollar amount contained in paragraph (4) shall be increased at the same time and in the same manner as amounts are increased pursuant to section 213(d)(10).

''(6) PERIODIC PAYMENTS.—For purposes of this subsection, the term 'periodic payment' means any payment (whether on a periodic basis or otherwise) made without regard to the extent of the costs incurred by the payee for qualified long-term care services.

''(e) TREATMENT OF COVERAGE PROVIDED AS PART OF A LIFE INSURANCE CONTRACT.—Except as otherwise provided in regulations prescribed by the Secretary, in the case of any long-term care insurance coverage (whether or not qualified) provided by a rider on or as part of a life insurance contract—

''(1) IN GENERAL.—This section shall apply as if the portion of the contract providing such coverage is a separate contract.

''(2) APPLICATION OF 7702.—Section 7702(c)(2) (relating to the guideline premium limitation) shall be applied by increasing the guideline premium limitation with respect to a life insurance contract, as of any date—

''(A) by the sum of any charges (but not premium payments) against the life insurance contract's cash surrender value (within the meaning of section 7702(f)(2)(A)) for such coverage made to that date under the contract, less

''(B) any such charges the imposition of which reduces the premiums paid for the contract (within the meaning of section 7702(f)(1)).

''(3) APPLICATION OF SECTION 213.—No deduction shall be allowed under section 213(a) for charges against the life insurance contract's cash surrender value described in paragraph (2), unless such charges are includible in income as a result of the application of section 72(e)(10) and the rider is a qualified long-term care insurance contract under subsection (b).

''(4) PORTION DEFINED.—For purposes of this subsection, the term 'portion' means only the terms and benefits under a life insurance contract that are in addition to the terms and benefits under the contract without regard to long-term care insurance coverage.

''(f) TREATMENT OF CERTAIN STATE-MAINTAINED PLANS.—

''(1) IN GENERAL.—If—

(A) an individual receives coverage for qualified long-term care services under a State long-term care plan, and

''(B) the terms of such plan would satisfy the requirements of subsection (b) were such plan an insurance contract,

such plan shall be treated as a qualified long-term care insurance contract for purposes of this title.

''(2) STATE LONG-TERM CARE PLAN.—For purposes of paragraph (1), the term 'State long-term care plan' means any plan—

''(A) which is established and maintained by a State or an instrumentality of a State,

''(B) which provides coverage only for qualified long-term care services, and

''(C) under which such coverage is provided only to—

''(i) employees and former employees of a State (or any political subdivision or instrumentality of a State),

''(ii) the spouses of such employees, and

''(iii) individuals bearing a relationship to such employees or spouses which is described in any of paragraphs (1) through (8) of section 152(a).''

(b) RESERVE METHOD.—Clause (iii) of section 807(d)(3)(A) is amended by inserting ''(other than a qualified long-term care insurance contract, as defined in section 7702B(b))'' after ''insurance contract''.

(c) LONG-TERM CARE INSURANCE NOT PERMITTED UNDER CAFETERIA PLANS OR FLEXIBLE SPENDING ARRANGEMENTS.—

(1) CAFETERIA PLANS.—Section 125(f) is amended by adding at the end the following new sentence: ''Such term shall not include any product which is advertised, marketed, or offered as long-term care insurance.''

(2) FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 (relating to contributions by employer to accident and health plans), as amended by section 301(c), is amended by adding at the end the following new subsection:

''(c) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) IN GENERAL.—Effective on and after January 1, 1997, gross income of an employee shall include employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

''(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

''(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

''(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.''

(d) CONTINUATION COVERAGE RULES NOT TO APPLY.—

(1) Paragraph (2) of section 4980B(g) is amended by adding at the end the following new sentence: ''Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c)).''

(2) Paragraph (1) of section 607 of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following new sentence: ''Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of such Code).''

(3) Paragraph (1) of section 2208 of the Public Health Service Act is amended by adding at the end the following new sentence: ''Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of such Code).''

(e) CLERICAL AMENDMENT.—The table of sections for chapter 79 is amended by inserting after the item relating to section 7702A the following new item:

''Sec. 7702B. Treatment of qualified long-term care insurance.''.

(f) EFFECTIVE DATES.—

(1) GENERAL EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the amendments made by this section shall apply to contracts issued after December 31, 1996.

(B) RESERVE METHOD.—The amendment made by subsection (b) shall apply to contracts issued after December 31, 1997.

(2) CONTINUATION OF EXISTING POLICIES.—In the case of any contract issued before January 1, 1997, which met the long-term care insurance requirements of the State in which the contract was situsted at the time the contract was issued—

(A) such contract shall be treated for purposes of the Internal Revenue Code of 1986 as a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), and

(B) services provided under, or reimbursed by, such contract shall be treated for such purposes as qualified long-term care services (as defined in section 7702B(c) of such Code).

In the case of an individual who is covered on December 31, 1996, under a State long-term care plan (as defined in section 7702B(f)(2) of such Code), the terms of such plan on such date shall be treated for purposes of the preceding sentence as a contract issued on such date which met the long-term care insurance requirements of such State.

(3) EXCHANGES OF EXISTING POLICIES.—If, after the date of enactment of this Act and before January 1, 1998, a contract providing for long-term care insurance coverage is exchanged solely for a qualified long-term care insurance contract (as defined in section 7702B(b) of such Code), no gain or loss shall be recognized on the exchange. If, in addition to a qualified long-term care insurance contract, money or other property is received in the exchange, then any gain shall be recognized to the extent of the sum of the money and the fair market value of the other property received. For purposes of this paragraph, the cancellation of a contract providing for long-term care insurance coverage and reinvestment of the cancellation proceeds in a qualified long-term care insurance contract within 60 days thereafter shall be treated as an exchange.

(4) ISSUANCE OF CERTAIN RIDERS PERMITTED.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

(A) the issuance of a rider which is treated as a qualified long-term care insurance contract under section 7702B, and

(B) the addition of any provision required to conform any other long-term care rider to be so treated,

shall not be treated as a modification or material change of such contract.

(5) APPLICATION OF PER DIEM LIMITATION TO EXISTING CONTRACTS.—The amount of per diem payments made under a contract issued on or before July 31, 1996, with respect to an insured which are excludable from gross income by reason of section 7702B of the Internal Revenue Code of 1986 (as added by this section) shall not be reduced under subsection (d)(2)(B) thereof by reason of reimbursements received under a contract issued on or before such date. The preceding sentence shall cease to apply as of the date (after July 31, 1996) such contract is exchanged or there is any contract modification which results in an increase in the amount of such per diem payments or the amount of such reimbursements.

(g) LONG-TERM CARE STUDY REQUEST.—The Chairman of the Committee on Ways and Means of the House of Representatives and the Chairman of the Committee on Finance of the Senate shall jointly request the National Association of Insurance Commissioners, in consultation with representatives of the insurance industry and consumer organizations, to formulate, develop, and conduct a study to determine the marketing and other effects of per diem limits on certain types of long-term care policies. If the National Association of Insurance Commissioners agrees to the study request, the National Association of Insurance Commissioners shall report the results of its study to such committees not later than 2 years after accepting the request.

SEC. 322. QUALIFIED LONG-TERM CARE SERVICES TREATED AS MEDICAL CARE.

(a) GENERAL RULE.—Paragraph (1) of section 213(d) (defining medical care) is amended by striking ''or'' at the end of subparagraph (B), by redesignating subparagraph (C) as subparagraph (D), and by inserting after subparagraph (B) the following new subparagraph:

''(C) for qualified long-term care services (as defined in section 7702B(c)), or''.

(b) TECHNICAL AMENDMENTS.—

(1) Subparagraph (D) of section 213(d)(1) (as redesignated by subsection (a)) is amended by inserting before the period ''or for any qualified long-term care insurance contract (as defined in section 7702B(b))''.

(2)(A) Paragraph (1) of section 213(d) is amended by adding at the end the following new flush sentence:

''In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D).''

(B) Paragraph (2) of section 162(l) is amended by adding at the end the following new subparagraph:

''(C) LONG-TERM CARE PREMIUMS.—In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligible long-term care premiums (as defined in section 213(d)(10)) shall be taken into account under paragraph (1).''

(C) Subsection (d) of section 213 is amended by adding at the end the following new paragraphs:

''(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

''(A) IN GENERAL.—For purposes of this section, the term 'eligible long-term care premiums' means the amount paid during a taxable year for any qualified long-term care insurance contract (as defined in section 7702B(b)) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

''In the case of an individual with an attained age before the close of the taxable year of:	***The limitation is:***
40 or less	*$200*
More than 40 but not more than 50	*375*
More than 50 but not more than 60	*750*

"In the case of an individual with an attained age before the close of the taxable year of:	***The limitation is:***
More than 60 but not more than 70	*2,000*
More than 70	*2,500.*

''(B) INDEXING.—

''(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount contained in subparagraph (A) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

''(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

''(I) the medical care component of the Consumer Price Index (as defined in section 1(f)(5)) for August of the preceding calendar year, exceeds

''(II) such component for August of 1996.

The Secretary shall, in consultation with the Secretary of Health and Human Services, prescribe an adjustment which the Secretary determines is more appropriate for purposes of this paragraph than the adjustment described in the preceding sentence, and the adjustment so prescribed shall apply in lieu of the adjustment described in the preceding sentence.

''(11) CERTAIN PAYMENTS TO RELATIVES TREATED AS NOT PAID FOR MEDICAL CARE.—An amount paid for a qualified long-term care service (as defined in section 7702B(c)) provided to an individual shall be treated as not paid for medical care if such service is provided—

''(A) by the spouse of the individual or by a relative (directly or through a partnership, corporation, or other entity) unless the service is provided by a licensed professional with respect to such service, or

''(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term 'relative' means an individual bearing a relationship to the individual which is described in any of paragraphs (1) through (8) of section 152(a). This paragraph shall not apply for purposes of section 105(b) with respect to reimbursements through insurance.'' .

(3) Paragraph (6) of section 213(d) is amended—

(A) by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)'', and

(B) by striking ''paragraph (1)(C)'' in subparagraph (A) and inserting ''paragraph (1)(D)''.

(4) Paragraph (7) of section 213(d) is amended by striking ''subparagraphs (A) and (B)'' and inserting ''subparagraphs (A), (B), and (C)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

SEC. 323. REPORTING REQUIREMENTS.

(a) IN GENERAL.—Subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new section:

"SEC. 6050Q. CERTAIN LONG-TERM CARE BENEFITS.

''(a) REQUIREMENT OF REPORTING.—Any person who pays long-term care benefits shall make a return, according to the forms or regulations prescribed by the Secretary, setting forth—

''(1) the aggregate amount of such benefits paid by such person to any individual during any calendar year,

''(2) whether or not such benefits are paid in whole or in part on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate,

''(3) the name, address, and TIN of such individual, and

''(4) the name, address, and TIN of the chronically ill or terminally ill individual on account of whose condition such benefits are paid.

''(b) STATEMENTS TO BE FURNISHED TO PERSONS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

''(1) the name of the person making the payments, and

''(2) the aggregate amount of long-term care benefits paid to the individual which are required to be shown on such return.

The written statement required under the preceding sentence shall be furnished to the individual on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

''(c) LONG-TERM CARE BENEFITS.—For purposes of this section, the term 'long-term care benefit' means—

''(1) any payment under a product which is advertised, marketed, or offered as long-term care insurance, and

''(2) any payment which is excludable from gross income by reason of section 101(g).''.

(b) PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) is amended by redesignating clauses (ix) through (xiv) as clauses (x) through (xv), respectively, and by inserting after clause (viii) the following new clause:

''(ix) section 6050Q (relating to certain long-term care benefits),''.

(2) Paragraph (2) of section 6724(d) is amended by redesignating subparagraphs (Q) through (T) as subparagraphs (R) through (U), respectively, and by inserting after subparagraph (P) the following new subparagraph:

''(Q) section 6050Q(b) (relating to certain long-term care benefits),''.

(c) CLERICAL AMENDMENT.—The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item:

''Sec. 6050Q. Certain long-term care benefits.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits paid after December 31, 1996.

PART II—CONSUMER PROTECTION PROVISIONS

SEC. 325. POLICY REQUIREMENTS.

Section 7702B (as added by section 321) is amended by adding at the end the following new subsection:

''(g) CONSUMER PROTECTION PROVISIONS.—

''(1) IN GENERAL.—The requirements of this subsection are met with respect to any contract if the contract meets—

''(A) the requirements of the model regulation and model Act described in paragraph (2),

''(B) the disclosure requirement of paragraph (3), and

''(C) the requirements relating to nonforfeitability under paragraph (4).

''(2) REQUIREMENTS OF MODEL REGULATION AND ACT.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any contract if such contract meets—

''(i) MODEL REGULATION.—The following requirements of the model regulation:

''(I) Section 7A (relating to guaranteed renewal or noncancellability), and the requirements of section 6B of the model Act relating to such section 7A.

''(II) Section 7B (relating to prohibitions on limitations and exclusions).

''(III) Section 7C (relating to extension of benefits).

''(IV) Section 7D (relating to continuation or conversion of coverage).

''(V) Section 7E (relating to discontinuance and replacement of policies).

''(VI) Section 8 (relating to unintentional lapse).

''(VII) Section 9 (relating to disclosure), other than section 9F thereof.

''(VIII) Section 10 (relating to prohibitions against post-claims underwriting).

''(IX) Section 11 (relating to minimum standards).

''(X) Section 12 (relating to requirement to offer inflation protection), except that any requirement for a signature on a rejection of inflation protection shall permit the signature to be on an application or on a separate form.

''(XI) Section 23 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

''(ii) MODEL ACT.—The following requirements of the model Act:

''(I) Section 6C (relating to preexisting conditions).

''(II) Section 6D (relating to prior hospitalization).

''(B) DEFINITIONS.—For purposes of this paragraph—

''(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993).

''(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

''(iii) DETERMINATION.—For purposes of this section and section 4980C, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.

''(3) DISCLOSURE REQUIREMENT.—The requirement of this paragraph is met with respect to any contract if such contract meets the requirements of section 4980C(d).

''(4) NONFORFEITURE REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met with respect to any level premium contract, if the issuer of such contract offers to the policyholder, including any group policyholder, a nonforfeiture provision meeting the requirements of subparagraph (B).

''(B) REQUIREMENTS OF PROVISION.—The nonforfeiture provision required under subparagraph (A) shall meet the following requirements:

''(i) The nonforfeiture provision shall be appropriately captioned.

''(ii) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums and the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the Secretary for the same contract form.

''(iii) The nonforfeiture provision shall provide at least one of the following:

''(I) Reduced paid-up insurance.

''(II) Extended term insurance.

''(III) Shortened benefit period.

''(IV) Other similar offerings approved by the Secretary.

''(5) CROSS REFERENCE.—

"For coordination of the requirements of this subsection with State requirements, see section 4980C(f)."

SEC. 326. REQUIREMENTS FOR ISSUERS OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

(a) IN GENERAL.—Chapter 43 is amended by adding at the end the following new section:

"SEC. 4980C. REQUIREMENTS FOR ISSUERS OF QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

''(a) GENERAL RULE.—There is hereby imposed on any person failing to meet the requirements

of subsection (c) or (d) a tax in the amount determined under subsection (b).

''(b) AMOUNT.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) shall be $100 per insured for each day any requirement of subsection (c) or (d) is not met with respect to each qualified long-term care insurance contract.

''(2) WAIVER.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that payment of the tax would be excessive relative to the failure involved.

''(c) RESPONSIBILITIES.—The requirements of this subsection are as follows:

''(1) REQUIREMENTS OF MODEL PROVISIONS.—

''(A) MODEL REGULATION.—The following requirements of the model regulation must be met:

''(i) Section 13 (relating to application forms and replacement coverage).

''(ii) Section 14 (relating to reporting requirements), except that the issuer shall also report at least annually the number of claims denied during the reporting period for each class of business (expressed as a percentage of claims denied), other than claims denied for failure to meet the waiting period or because of any applicable preexisting condition.

''(iii) Section 20 (relating to filing requirements for marketing).

''(iv) Section 21 (relating to standards for marketing), including inaccurate completion of medical histories, other than sections 21C(1) and 21C(6) thereof, except that—

''(I) in addition to such requirements, no person shall, in selling or offering to sell a qualified long-term care insurance contract, misrepresent a material fact; and

''(II) no such requirements shall include a requirement to inquire or identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

''(v) Section 22 (relating to appropriateness of recommended purchase).

''(vi) Section 24 (relating to standard format outline of coverage).

''(vii) Section 25 (relating to requirement to deliver shopper's guide).

''(B) MODEL ACT.—The following requirements of the model Act must be met:

''(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

''(ii) Section 6G (relating to outline of coverage).

''(iii) Section 6H (relating to requirements for certificates under group plans).

''(iv) Section 6I (relating to policy summary).

''(v) Section 6J (relating to monthly reports on accelerated death benefits).

''(vi) Section 7 (relating to incontestability period).

''(C) DEFINITIONS.—For purposes of this paragraph, the terms 'model regulation' and 'model Act' have the meanings given such terms by section 7702B(g)(2)(B).

''(2) DELIVERY OF POLICY.—If an application for a qualified long-term care insurance contract (or for a certificate under such a contract for a group) is approved, the issuer shall deliver to the applicant (or policyholder or certificateholder) the contract (or certificate) of insurance not later than 30 days after the date of the approval.

''(3) INFORMATION ON DENIALS OF CLAIMS.—If a claim under a qualified long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificateholder (or representative)—

''(A) provide a written explanation of the reasons for the denial, and

''(B) make available all information directly relating to such denial.

''(d) DISCLOSURE.—The requirements of this subsection are met if the issuer of a long-term care insurance policy discloses in such policy and in the outline of coverage required under subsection (c)(1)(B)(ii) that the policy is intended to be a qualified long-term care insurance contract under section 7702B(b).

''(e) QUALIFIED LONG-TERM CARE INSURANCE CONTRACT DEFINED.—For purposes of this section, the term 'qualified long-term care insurance contract' has the meaning given such term by section 7702B.

''(f) COORDINATION WITH STATE REQUIREMENTS.—If a State imposes any requirement which is more stringent than the analogous requirement imposed by this section or section 7702B(g), the requirement imposed by this section or section 7702B(g) shall be treated as met if the more stringent State requirement is met.''.

(b) CONFORMING AMENDMENT.—The table of sections for chapter 43 is amended by adding at the end the following new item:

''Sec. 4980C. Requirements for issuers of qualified long-term care insurance contracts.''

SEC. 327. EFFECTIVE DATES.

(a) IN GENERAL.—The provisions of, and amendments made by, this part shall apply to contracts issued after December 31, 1996. The provisions of section 321(f) (relating to transition rule) shall apply to such contracts.

(b) ISSUERS.—The amendments made by section 326 shall apply to actions taken after December 31, 1996.

Subtitle D—Treatment of Accelerated Death Benefits

SEC. 331. TREATMENT OF ACCELERATED DEATH BENEFITS BY RECIPIENT.

(a) IN GENERAL.—Section 101 (relating to certain death benefits) is amended by adding at the end the following new subsection:

''(g) TREATMENT OF CERTAIN ACCELERATED DEATH BENEFITS.—

''(1) IN GENERAL.—For purposes of this section, the following amounts shall be treated as an amount paid by reason of the death of an insured:

''(A) Any amount received under a life insurance contract on the life of an insured who is a terminally ill individual.

''(B) Any amount received under a life insurance contract on the life of an insured who is a chronically ill individual.

''(2) TREATMENT OF VIATICAL SETTLEMENTS.—

''(A) IN GENERAL.—If any portion of the death benefit under a life insurance contract on the life of an insured described in paragraph (1) is sold or assigned to a viatical settlement provider, the amount paid for the sale or assignment of such portion shall be treated as an amount paid under the life insurance contract by reason of the death of such insured.

''(B) VIATICAL SETTLEMENT PROVIDER.—

''(i) IN GENERAL.—The term 'viatical settlement provider' means any person regularly engaged in the trade or business of purchasing, or taking assignments of, life insurance contracts on the lives of insureds described in paragraph (1) if—

''(I) such person is licensed for such purposes (with respect to insureds described in the same subparagraph of paragraph (1) as the insured) in the State in which the insured resides, or

''(II) in the case of an insured who resides in a State not requiring the licensing of such persons for such purposes with respect to such insured, such person meets the requirements of clause (ii) or (iii), whichever applies to such insured.

''(ii) TERMINALLY ILL INSUREDS.—A person meets the requirements of this clause with respect to an insured who is a terminally ill individual if such person—

''(I) meets the requirements of sections 8 and 9 of the Viatical Settlements Model Act of the National Association of Insurance Commissioners, and

''(II) meets the requirements of the Model Regulations of the National Association of Insurance Commissioners (relating to standards for evaluation of reasonable payments) in determining amounts paid by such person in connection with such purchases or assignments.

''(iii) CHRONICALLY ILL INSUREDS.—A person meets the requirements of this clause with respect to an insured who is a chronically ill individual if such person—

''(I) meets requirements similar to the requirements referred to in clause (ii)(I), and

''(II) meets the standards (if any) of the National Association of Insurance Commissioners for evaluating the reasonableness of amounts paid by such person in connection with such purchases or assignments with respect to chronically ill individuals.

''(3) SPECIAL RULES FOR CHRONICALLY ILL INSUREDS.—In the case of an insured who is a chronically ill individual—

''(A) IN GENERAL.—Paragraphs (1) and (2) shall not apply to any payment received for any period unless—

''(i) such payment is for costs incurred by the payee (not compensated for by insurance or otherwise) for qualified long-term care services provided for the insured for such period, and

''(ii) the terms of the contract giving rise to such payment satisfy—

''(I) the requirements of section 7702B(b)(1)(B), and

''(II) the requirements (if any) applicable under subparagraph (B).

For purposes of the preceding sentence, the rule of section 7702B(b)(2)(B) shall apply.

''(B) OTHER REQUIREMENTS.—The requirements applicable under this subparagraph are—

''(i) those requirements of section 7702B(g) and section 4980C which the Secretary specifies as applying to such a purchase, assignment, or other arrangement,

''(ii) standards adopted by the National Association of Insurance Commissioners which specifically apply to chronically ill individuals (and, if such standards are adopted, the analogous requirements specified under clause (i) shall cease to apply), and

''(iii) standards adopted by the State in which the policyholder resides (and if such standards are adopted, the analogous requirements specified under clause (i) and (subject to section 4980C(f)) standards under clause (ii), shall cease to apply).

''(C) PER DIEM PAYMENTS.—A payment shall not fail to be described in subparagraph (A) by reason of being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payment relates.

''(D) LIMITATION ON EXCLUSION FOR PERIODIC PAYMENTS.—

''For limitation on amount of periodic payments which are treated as described in paragraph (1), see section 7702B(d).''

''(4) DEFINITIONS.—For purposes of this subsection—

''(A) TERMINALLY ILL INDIVIDUAL.—The term 'terminally ill individual' means an individual who has been certified by a physician as having an illness or physical condition which can reasonably be expected to result in death in 24 months or less after the date of the certification.

''(B) CHRONICALLY ILL INDIVIDUAL.—The term 'chronically ill individual' has the meaning given such term by section 7702B(c)(2); except that such term shall not include a terminally ill individual.

''(C) QUALIFIED LONG-TERM CARE SERVICES.—The term 'qualified long-term care services' has the meaning given such term by section 7702B(c).

''(D) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1)).

''(5) EXCEPTION FOR BUSINESS-RELATED POLICIES.—This subsection shall not apply in the case of any amount paid to any taxpayer other

than the insured if such taxpayer has an insurable interest with respect to the life of the insured by reason of the insured being a director, officer, or employee of the taxpayer or by reason of the insured being financially interested in any trade or business carried on by the taxpayer.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts received after December 31, 1996.

SEC. 332. TAX TREATMENT OF COMPANIES ISSUING QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.

(a) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—Section 818 (relating to other definitions and special rules) is amended by adding at the end the following new subsection:

''(g) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS TREATED AS LIFE INSURANCE.—For purposes of this part—

''(1) IN GENERAL.—Any reference to a life insurance contract shall be treated as including a reference to a qualified accelerated death benefit rider on such contract.

''(2) QUALIFIED ACCELERATED DEATH BENEFIT RIDERS.—For purposes of this subsection, the term 'qualified accelerated death benefit rider' means any rider on a life insurance contract if the only payments under the rider are payments meeting the requirements of section 101(g).

''(3) EXCEPTION FOR LONG-TERM CARE RIDERS.—Paragraph (1) shall not apply to any rider which is treated as a long-term care insurance contract under section 7702B.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall take effect on January 1, 1997.

(2) ISSUANCE OF RIDER NOT TREATED AS MATERIAL CHANGE.—For purposes of applying sections 101(f), 7702, and 7702A of the Internal Revenue Code of 1986 to any contract—

(A) the issuance of a qualified accelerated death benefit rider (as defined in section 818(g) of such Code (as added by this Act)), and

(B) the addition of any provision required to conform an accelerated death benefit rider to the requirements of such section 818(g),

shall not be treated as a modification or material change of such contract.

Subtitle E—State Insurance Pools

SEC. 341. EXEMPTION FROM INCOME TAX FOR STATE-SPONSORED ORGANIZATIONS PROVIDING HEALTH COVERAGE FOR HIGH-RISK INDIVIDUALS.

(a) IN GENERAL.—Subsection (c) of section 501 (relating to list of exempt organizations) is amended by adding at the end the following new paragraph:

''(26) Any membership organization if—

''(A) such organization is established by a State exclusively to provide coverage for medical care (as defined in section 213(d)) on a not-for-profit basis to individuals described in subparagraph (B) through—

''(i) insurance issued by the organization, or

''(ii) a health maintenance organization under an arrangement with the organization,

''(B) the only individuals receiving such coverage through the organization are individuals—

''(i) who are residents of such State, and

''(ii) who, by reason of the existence or history of a medical condition—

''(I) are unable to acquire medical care coverage for such condition through insurance or from a health maintenance organization, or

''(II) are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization,

''(C) the composition of the membership in such organization is specified by such State, and

''(D) no part of the net earnings of the organization inures to the benefit of any private shareholder or individual.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 1996.

SEC. 342. EXEMPTION FROM INCOME TAX FOR STATE-SPONSORED WORKMEN'S COMPENSATION REINSURANCE ORGANIZATIONS.

(a) IN GENERAL.—Subsection (c) of section 501 (relating to list of exempt organizations), as amended by section 341, is amended by adding at the end the following new paragraph:

''(27) Any membership organization if—

''(A) such organization is established before June 1, 1996, by a State exclusively to reimburse its members for losses arising under workmen's compensation acts,

''(B) such State requires that the membership of such organization consist of—

''(i) all persons who issue insurance covering workmen's compensation losses in such State, and

''(ii) all persons and governmental entities who self-insure against such losses, and

''(C) such organization operates as a nonprofit organization by—

''(i) returning surplus income to its members or workmen's compensation policyholders on a periodic basis, and

''(ii) reducing initial premiums in anticipation of investment income.''

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years ending after the date of the enactment of this Act.

Subtitle F—Organizations Subject to Section 833

SEC. 351. ORGANIZATIONS SUBJECT TO SECTION 833.

(a) IN GENERAL.—Section 833(c) (relating to organization to which section applies) is amended by adding at the end the following new paragraph:

''(4) TREATMENT AS EXISTING BLUE CROSS OR BLUE SHIELD ORGANIZATION.—

''(A) IN GENERAL.—Paragraph (2) shall be applied to an organization described in subparagraph (B) as if it were a Blue Cross or Blue Shield organization.

''(B) APPLICABLE ORGANIZATION.—An organization is described in this subparagraph if it—

''(i) is organized under, and governed by, State laws which are specifically and exclusively applicable to not-for-profit health insurance or health service type organizations, and

''(ii) is not a Blue Cross or Blue Shield organization or health maintenance organization.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years ending after December 31, 1996.

Subtitle G—IRA Distributions to the Unemployed

SEC. 361. DISTRIBUTIONS FROM CERTAIN PLANS MAY BE USED WITHOUT ADDITIONAL TAX TO PAY FINANCIALLY DEVASTATING MEDICAL EXPENSES.

(a) IN GENERAL.—Section 72(t)(3)(A) is amended by striking ''(B),''.

(b) DISTRIBUTIONS FOR PAYMENT OF HEALTH INSURANCE PREMIUMS OF CERTAIN UNEMPLOYED INDIVIDUALS.—Paragraph (2) of section 72(t) is amended by adding at the end the following new subparagraph:

''(D) DISTRIBUTIONS TO UNEMPLOYED INDIVIDUALS FOR HEALTH INSURANCE PREMIUMS.—

''(i) IN GENERAL.—Distributions from an individual retirement plan to an individual after separation from employment—

''(I) if such individual has received unemployment compensation for 12 consecutive weeks under any Federal or State unemployment compensation law by reason of such separation,

''(II) if such distributions are made during any taxable year during which such unemployment compensation is paid or the succeeding taxable year, and

''(III) to the extent such distributions do not exceed the amount paid during the taxable year for insurance described in section 213(d)(1)(D) with respect to the individual and the individual's spouse and dependents (as defined in section 152).

''(ii) DISTRIBUTIONS AFTER REEMPLOYMENT.—Clause (i) shall not apply to any distribution made after the individual has been employed for at least 60 days after the separation from employment to which clause (i) applies.

''(iii) SELF-EMPLOYED INDIVIDUALS.—To the extent provided in regulations, a self-employed individual shall be treated as meeting the requirements of clause (i)(I) if, under Federal or State law, the individual would have received unemployment compensation but for the fact the individual was self-employed.''.

(c) CONFORMING AMENDMENT.—Subparagraph (B) of section 72(t)(2) is amended by striking ''or (C)'' and inserting '', (C), or (D)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions after December 31, 1996.

Subtitle H—Organ and Tissue Donation Information Included With Income Tax Refund Payments

SEC. 371. ORGAN AND TISSUE DONATION INFORMATION INCLUDED WITH INCOME TAX REFUND PAYMENTS.

(a) IN GENERAL.—The Secretary of the Treasury shall, to the extent practicable, include with the mailing of any payment of a refund of individual income tax made during the period beginning on February 1, 1997, and ending on June 30, 1997, a copy of the document described in subsection (b).

(b) TEXT OF DOCUMENT.—The Secretary of the Treasury shall, after consultation with the Secretary of Health and Human Services and organizations promoting organ and tissue (including eye) donation, prepare a document suitable for inclusion with individual income tax refund payments which—

(1) encourages organ and tissue donation;

(2) includes a detachable organ and tissue donor card; and

(3) urges recipients to—

(A) sign the organ and tissue donor card;

(B) discuss organ and tissue donation with family members and tell family members about the recipient's desire to be an organ and tissue donor if the occasion arises; and

(C) encourage family members to request or authorize organ and tissue donation if the occasion arises.

TITLE IV—APPLICATION AND ENFORCEMENT OF GROUP HEALTH PLAN REQUIREMENTS

Subtitle A—Application and Enforcement of Group Health Plan Requirements

SEC. 401. GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS.

(a) IN GENERAL.—The Internal Revenue Code of 1986 is amended by adding at the end the following new subtitle:

''Subtitle K—Group Health Plan Portability, Access, and Renewability Requirements

''Chapter 100. Group health plan portability, access, and renewability requirements.

''CHAPTER 100—GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

''Sec. 9801. Increased portability through limitation on preexisting condition exclusions.

''Sec. 9802. Prohibiting discrimination against individual participants and beneficiaries based on health status.

''Sec. 9803. Guaranteed renewability in multiemployer plans and certain multiple employer welfare arrangements.

''Sec. 9804. General exceptions.

''Sec. 9805. Definitions.

''Sec. 9806. Regulations.

"SEC. 9801. INCREASED PORTABILITY THROUGH LIMITATION ON PREEXISTING CONDITION EXCLUSIONS.

"(a) LIMITATION ON PREEXISTING CONDITION EXCLUSION PERIOD; CREDITING FOR PERIODS OF PREVIOUS COVERAGE.—Subject to subsection (d), a group health plan may, with respect to a participant or beneficiary, impose a preexisting condition exclusion only if—

"(1) such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date;

"(2) such exclusion extends for a period of not more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

"(3) the period of any such preexisting condition exclusion is reduced by the length of the aggregate of the periods of creditable coverage (if any) applicable to the participant or beneficiary as of the enrollment date.

"(b) DEFINITIONS.—For purposes of this section—

"(1) PREEXISTING CONDITION EXCLUSION.—

"(A) IN GENERAL.—The term 'preexisting condition exclusion' means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

"(B) TREATMENT OF GENETIC INFORMATION.—For purposes of this section, genetic information shall not be treated as a condition described in subsection (a)(1) in the absence of a diagnosis of the condition related to such information.

"(2) ENROLLMENT DATE.—The term 'enrollment date' means, with respect to an individual covered under a group health plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the waiting period for such enrollment.

"(3) LATE ENROLLEE.—The term 'late enrollee' means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

"(A) the first period in which the individual is eligible to enroll under the plan, or

"(B) a special enrollment period under subsection (f).

"(4) WAITING PERIOD.—The term 'waiting period' means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

"(c) RULES RELATING TO CREDITING PREVIOUS COVERAGE.—

"(1) CREDITABLE COVERAGE DEFINED.—For purposes of this part, the term 'creditable coverage' means, with respect to an individual, coverage of the individual under any of the following:

"(A) A group health plan.

"(B) Health insurance coverage.

"(C) Part A or part B of title XVIII of the Social Security Act.

"(D) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.

"(E) Chapter 55 of title 10, United States Code.

"(F) A medical care program of the Indian Health Service or of a tribal organization.

"(G) A State health benefits risk pool.

"(H) A health plan offered under chapter 89 of title 5, United States Code.

"(I) A public health plan (as defined in regulations).

"(J) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e).

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 9805(c)).

"(2) NOT COUNTING PERIODS BEFORE SIGNIFICANT BREAKS IN COVERAGE.—

"(A) IN GENERAL.—A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

"(B) WAITING PERIOD NOT TREATED AS A BREAK IN COVERAGE.—For purposes of subparagraph (A) and subsection (d)(4), any period that an individual is in a waiting period for any coverage under a group health plan or is in an affiliation period shall not be taken into account in determining the continuous period under subparagraph (A).

"(C) AFFILIATION PERIOD.—

"(i) IN GENERAL.—For purposes of this section, the term 'affiliation period' means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. During such an affiliation period, the organization is not required to provide health care services or benefits and no premium shall be charged to the participant or beneficiary.

"(ii) BEGINNING.—Such period shall begin on the enrollment date.

"(iii) RUNS CONCURRENTLY WITH WAITING PERIODS.—Any such affiliation period shall run concurrently with any waiting period under the plan.

"(3) METHOD OF CREDITING COVERAGE.—

"(A) STANDARD METHOD.—Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3), a group health plan shall count a period of creditable coverage without regard to the specific benefits for which coverage is offered during the period.

"(B) ELECTION OF ALTERNATIVE METHOD.—A group health plan may elect to apply subsection (a)(3) based on coverage of any benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

"(C) PLAN NOTICE.—In the case of an election with respect to a group health plan under subparagraph (B), the plan shall—

"(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

"(ii) include in such statements a description of the effect of this election.

"(4) ESTABLISHMENT OF PERIOD.—Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) or in such other manner as may be specified in regulations.

"(d) EXCEPTIONS.—

"(1) EXCLUSION NOT APPLICABLE TO CERTAIN NEWBORNS.—Subject to paragraph (4), a group health plan may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

"(2) EXCLUSION NOT APPLICABLE TO CERTAIN ADOPTED CHILDREN.—Subject to paragraph (4), a group health plan may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

"(3) EXCLUSION NOT APPLICABLE TO PREGNANCY.—For purposes of this section, a group health plan may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

"(4) LOSS IF BREAK IN COVERAGE.—Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

"(e) CERTIFICATIONS AND DISCLOSURE OF COVERAGE.—

"(1) REQUIREMENT FOR CERTIFICATION OF PERIOD OF CREDITABLE COVERAGE.—

"(A) IN GENERAL.—A group health plan shall provide the certification described in subparagraph (B)—

"(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

"(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

"(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

"(B) CERTIFICATION.—The certification described in this subparagraph is a written certification of—

"(i) the period of creditable coverage of the individual under such plan and the coverage under such COBRA continuation provision, and

"(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

"(C) ISSUER COMPLIANCE.—To the extent that medical care under a group health plan consists of health insurance coverage offered in connection with the plan, the plan is deemed to have satisfied the certification requirement under this paragraph if the issuer provides for such certification in accordance with this paragraph.

"(2) DISCLOSURE OF INFORMATION ON PREVIOUS BENEFITS.—

"(A) IN GENERAL.—In the case of an election described in subsection (c)(3)(B) by a group health plan, if the plan enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

"(i) upon request of such plan, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan information on coverage of classes and categories of health benefits available under such entity's plan, and

"(ii) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

"(3) REGULATIONS.—The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

"(f) SPECIAL ENROLLMENT PERIODS.—

"(1) INDIVIDUALS LOSING OTHER COVERAGE.—A group health plan shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

"(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or individual.

"(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor (or the health insurance issuer offering

health insurance coverage in connection with the plan) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

''(C) The employee's or dependent's coverage described in subparagraph (A)—

''(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

''(ii) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.

''(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

''(2) FOR DEPENDENT BENEFICIARIES.—

''(A) IN GENERAL.—If—

''(i) a group health plan makes coverage available with respect to a dependent of an individual,

''(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

''(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not otherwise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

''(B) DEPENDENT SPECIAL ENROLLMENT PERIOD.—The dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

''(i) the date dependent coverage is made available, or

''(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

''(C) NO WAITING PERIOD.—If an individual seeks coverage of a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

''(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

''(ii) in the case of a dependent's birth, as of the date of such birth; or

''(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

''SEC. 9802. PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS.

''(a) IN ELIGIBILITY TO ENROLL.—

''(1) IN GENERAL.—Subject to paragraph (2), a group health plan may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following factors in relation to the individual or a dependent of the individual:

''(A) Health status.

''(B) Medical condition (including both physical and mental illnesses).

''(C) Claims experience.

''(D) Receipt of health care.

''(E) Medical history.

''(F) Genetic information.

''(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

''(H) Disability.

''(2) NO APPLICATION TO BENEFITS OR EXCLUSIONS.—To the extent consistent with section 9801, paragraph (1) shall not be construed—

''(A) to require a group health plan to provide particular benefits (or benefits with respect to a specific procedure, treatment, or service) other than those provided under the terms of such plan; or

''(B) to prevent such a plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

''(3) CONSTRUCTION.—For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

''(b) IN PREMIUM CONTRIBUTIONS.—

''(1) IN GENERAL.—A group health plan may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any factor described in subsection (a)(1) in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

''(A) to restrict the amount that an employer may be charged for coverage under a group health plan; or

''(B) to prevent a group health plan from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

''SEC. 9803. GUARANTEED RENEWABILITY IN MULTIEMPLOYER PLANS AND CERTAIN MULTIPLE EMPLOYER WELFARE ARRANGEMENTS.

''(a) IN GENERAL.—A group health plan which is a multiemployer plan (as defined in section 414(f)) or which is a multiple employer welfare arrangement may not deny an employer continued access to the same or different coverage under such plan, other than—

''(1) for nonpayment of contributions;

''(2) for fraud or other intentional misrepresentation of material fact by the employer;

''(3) for noncompliance with material plan provisions;

''(4) because the plan is ceasing to offer any coverage in a geographic area;

''(5) in the case of a plan that offers benefits through a network plan, because there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan applies this paragraph uniformly without regard to the claims experience of employers or a factor described in section 9802(a)(1) in relation to such individuals or their dependents; or

''(6) for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

''(b) MULTIPLE EMPLOYER WELFARE ARRANGEMENT.—For purposes of subsection (a), the term 'multiple employer welfare arrangement' has the meaning given such term by section 3(40) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section.

''SEC. 9804. GENERAL EXCEPTIONS.

''(a) EXCEPTION FOR CERTAIN PLANS.—The requirements of this chapter shall not apply to—

''(1) any governmental plan, and

''(2) any group health plan for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

''(b) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(1).

''(c) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—

''(1) LIMITED, EXCEPTED BENEFITS.—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(2) if the benefits—

''(A) are provided under a separate policy, certificate, or contract of insurance; or

''(B) are otherwise not an integral part of the plan.

''(2) NONCOORDINATED, EXCEPTED BENEFITS.—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(3) if all of the following conditions are met:

''(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

''(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

''(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

''(3) SUPPLEMENTAL EXCEPTED BENEFITS.—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9805(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

''SEC. 9805. DEFINITIONS.

''(a) GROUP HEALTH PLAN.—For purposes of this chapter, the term 'group health plan' has the meaning given to such term by section 5000(b)(1).

''(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—For purposes of this chapter—

''(1) HEALTH INSURANCE COVERAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'health insurance coverage' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

''(B) NO APPLICATION TO CERTAIN EXCEPTED BENEFITS.—In applying subparagraph (A), excepted benefits described in subsection (c)(1) shall not be treated as benefits consisting of medical care.

''(2) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974, as in effect on the date of the enactment of this section). Such term does not include a group health plan.

''(3) HEALTH MAINTENANCE ORGANIZATION.—The term 'health maintenance organization' means—

''(A) a Federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

''(B) an organization recognized under State law as a health maintenance organization, or

''(C) a similar organization regulated under State law for solvency in the same manner and

to the same extent as such a health maintenance organization.

''(c) EXCEPTED BENEFITS.—For purposes of this chapter, the term 'excepted benefits' means benefits under one or more (or any combination thereof) of the following:

''(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

''(A) Coverage only for accident, or disability income insurance, or any combination thereof.

''(B) Coverage issued as a supplement to liability insurance.

''(C) Liability insurance, including general liability insurance and automobile liability insurance.

''(D) Workers' compensation or similar insurance.

''(E) Automobile medical payment insurance.

''(F) Credit-only insurance.

''(G) Coverage for on-site medical clinics.

''(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

''(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

''(A) Limited scope dental or vision benefits.

''(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

''(C) Such other similar, limited benefits as are specified in regulations.

''(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

''(A) Coverage only for a specified disease or illness.

''(B) Hospital indemnity or other fixed indemnity insurance.

''(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

''(d) OTHER DEFINITIONS.—For purposes of this chapter—

''(1) COBRA CONTINUATION PROVISION.—The term 'COBRA continuation provision' means any of the following:

''(A) Section 4980B, other than subsection (f)(1) thereof insofar as it relates to pediatric vaccines.

''(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.), other than section 609 of such Act.

''(C) Title XXII of the Public Health Service Act.

''(2) GOVERNMENTAL PLAN.—The term 'governmental plan' has the meaning given such term by section 414(d).

''(3) MEDICAL CARE.—The term 'medical care' has the meaning given such term by section 213(d) determined without regard to—

''(A) paragraph (1)(C) thereof, and

''(B) so much of paragraph (1)(D) thereof as relates to qualified long-term care insurance.

''(4) NETWORK PLAN.—The term 'network plan' means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care are provided, in whole or in part, through a defined set of providers under contract with the issuer.

''(5) PLACED FOR ADOPTION DEFINED.—The term 'placement', or being 'placed', for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

SEC. 9806. REGULATIONS.

''The Secretary, consistent with section 104 of the Health Care Portability and Accountability Act of 1996, may promulgate such regulations as may be necessary or appropriate to carry out the provisions of this chapter. The Secretary may promulgate any interim final rules as the Secretary determines are appropriate to carry out this chapter.''

(b) CLERICAL AMENDMENT.—The table of subtitles of such Code is amended by adding at the end the following new item:

''Subtitle K. Group health plan portability, access, and renewability requirements.''

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to plan years beginning after June 30, 1997.

(2) DETERMINATION OF CREDITABLE COVERAGE.—

(A) PERIOD OF COVERAGE.—

(i) IN GENERAL.—Subject to clause (ii), no period before July 1, 1996, shall be taken into account under chapter 100 of the Internal Revenue Code of 1986 (as added by this section) in determining creditable coverage.

(ii) SPECIAL RULE FOR CERTAIN PERIODS.—The Secretary of the Treasury, consistent with section 104, shall provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996, and who would have such coverage credited but for clause (i) may be given credit for creditable coverage for such periods through the presentation of documents or other means.

(B) CERTIFICATIONS, ETC.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii), subsection (e) of section 9801 of the Internal Revenue Code of 1986 (as added by this section) shall apply to events occurring after June 30, 1996.

(ii) NO CERTIFICATION REQUIRED TO BE PROVIDED BEFORE JUNE 1, 1997.—In no case is a certification required to be provided under such subsection before June 1, 1997.

(iii) CERTIFICATION ONLY ON WRITTEN REQUEST FOR EVENTS OCCURRING BEFORE OCTOBER 1, 1996.—In the case of an event occurring after June 30, 1996, and before October 1, 1996, a certification is not required to be provided under such subsection unless an individual (with respect to whom the certification is otherwise required to be made) requests such certification in writing.

(C) TRANSITIONAL RULE.—In the case of an individual who seeks to establish creditable coverage for any period for which certification is not required because it relates to an event occurring before June 30, 1996—

(i) the individual may present other credible evidence of such coverage in order to establish the period of creditable coverage; and

(ii) a group health plan and a health insurance issuer shall not be subject to any penalty or enforcement action with respect to the plan's or issuer's crediting (or not crediting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under the amendments made by this section.

(3) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—Except as provided in paragraph (2), in the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the later of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) July 1, 1997.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

(4) TIMELY REGULATIONS.—The Secretary of the Treasury, consistent with section 104, shall first issue by not later than April 1, 1997, such regulations as may be necessary to carry out the amendments made by this section.

(5) LIMITATION ON ACTIONS.—No enforcement action shall be taken, pursuant to the amendments made by this section, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by such amendments before January 1, 1998, or, if later, the date of issuance of regulations referred to in paragraph (4), if the plan or issuer has sought to comply in good faith with such requirements.

SEC. 402. PENALTY ON FAILURE TO MEET CERTAIN GROUP HEALTH PLAN REQUIREMENTS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 (relating to qualified pension, etc., plans) is amended by adding after section 4980C the following new section:

''SEC. 4980D. FAILURE TO MEET CERTAIN GROUP HEALTH PLAN REQUIREMENTS.

''(a) GENERAL RULE.—There is hereby imposed a tax on any failure of a group health plan to meet the requirements of chapter 100 (relating to group health plan portability, access, and renewability requirements).

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The amount of the tax imposed by subsection (a) on any failure shall be $100 for each day in the noncompliance period with respect to each individual to whom such failure relates.

''(2) NONCOMPLIANCE PERIOD.—For purposes of this section, the term 'noncompliance period' means, with respect to any failure, the period—

''(A) beginning on the date such failure first occurs, and

''(B) ending on the date such failure is corrected.

''(3) MINIMUM TAX FOR NONCOMPLIANCE PERIOD WHERE FAILURE DISCOVERED AFTER NOTICE OF EXAMINATION.—Notwithstanding paragraphs (1) and (2) of subsection (c)—

''(A) IN GENERAL.—In the case of 1 or more failures with respect to an individual—

''(i) which are not corrected before the date a notice of examination of income tax liability is sent to the employer, and

''(ii) which occurred or continued during the period under examination,

the amount of tax imposed by subsection (a) by reason of such failures with respect to such individual shall not be less than the lesser of $2,500 or the amount of tax which would be imposed by subsection (a) without regard to such paragraphs.

''(B) HIGHER MINIMUM TAX WHERE VIOLATIONS ARE MORE THAN DE MINIMIS.—To the extent violations for which any person is liable under subsection (e) for any year are more than de minimis, subparagraph (A) shall be applied by substituting '$15,000' for '$2,500' with respect to such person.

''(C) EXCEPTION FOR CHURCH PLANS.—This paragraph shall not apply to any failure under a church plan (as defined in section 414(e)).

''(c) LIMITATIONS ON AMOUNT OF TAX.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) on any failure during any period for which it is established to the satisfaction of the Secretary that the person otherwise liable for such tax did not know, and exercising reasonable diligence would not have known, that such failure existed.

''(2) TAX NOT TO APPLY TO FAILURES CORRECTED WITHIN CERTAIN PERIODS.—No tax shall be imposed by subsection (a) on any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B)(i) in the case of a plan other than a church plan (as defined in section 414(e)), such

failure is corrected during the 30-day period beginning on the 1st date the person otherwise liable for such tax knew, or exercising reasonable diligence would have known, that such failure existed, and

''(ii) in the case of a church plan (as so defined), such failure is corrected before the close of the correction period (determined under the rules of section 414(e)(4)(C)).

''(3) OVERALL LIMITATION FOR UNINTENTIONAL FAILURES.—In the case of failures which are due to reasonable cause and not to willful neglect—

''(A) SINGLE EMPLOYER PLANS.—

''(i) IN GENERAL.—In the case of failures with respect to plans other than specified multiple employer health plans, the tax imposed by subsection (a) for failures during the taxable year of the employer shall not exceed the amount equal to the lesser of—

''(I) 10 percent of the aggregate amount paid or incurred by the employer (or predecessor employer) during the preceding taxable year for group health plans, or

''(II) $500,000.

''(ii) TAXABLE YEARS IN THE CASE OF CERTAIN CONTROLLED GROUPS.—For purposes of this subparagraph, if not all persons who are treated as a single employer for purposes of this section have the same taxable year, the taxable years taken into account shall be determined under principles similar to the principles of section 1561.

''(B) SPECIFIED MULTIPLE EMPLOYER HEALTH PLANS.—

''(i) IN GENERAL.—In the case of failures with respect to a specified multiple employer health plan, the tax imposed by subsection (a) for failures during the taxable year of the trust forming part of such plan shall not exceed the amount equal to the lesser of—

''(I) 10 percent of the amount paid or incurred by such trust during such taxable year to provide medical care (as defined in section 9805(d)(3)) directly or through insurance, reimbursement, or otherwise, or

''(II) $500,000.

For purposes of the preceding sentence, all plans of which the same trust forms a part shall be treated as 1 plan.

''(ii) SPECIAL RULE FOR EMPLOYERS REQUIRED TO PAY TAX.—If an employer is assessed a tax imposed by subsection (a) by reason of a failure with respect to a specified multiple employer health plan, the limit shall be determined under subparagraph (A) (and not under this subparagraph) and as if such plan were not a specified multiple employer health plan.

''(4) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by subsection (a) to the extent that the payment of such tax would be excessive relative to the failure involved.

''(d) TAX NOT TO APPLY TO CERTAIN INSURED SMALL EMPLOYER PLANS.—

''(1) IN GENERAL.—In the case of a group health plan of a small employer which provides health insurance coverage solely through a contract with a health insurance issuer, no tax shall be imposed by this section on the employer on any failure which is solely because of the health insurance coverage offered by such issuer.

''(2) SMALL EMPLOYER.—

''(A) IN GENERAL.—For purposes of paragraph (1), the term 'small employer' means, with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year. For purposes of the preceding sentence, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

''(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

''(C) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

''(3) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—For purposes of paragraph (1), the terms 'health insurance coverage' and 'health insurance issuer' have the respective meanings given such terms by section 9805.

''(e) LIABILITY FOR TAX.—The following shall be liable for the tax imposed by subsection (a) on a failure:

''(1) Except as otherwise provided in this subsection, the employer.

''(2) In the case of a multiemployer plan, the plan.

''(3) In the case of a failure under section 9803 (relating to guaranteed renewability) with respect to a plan described in subsection (f)(2)(B), the plan.

''(f) DEFINITIONS.—For purposes of this section—

''(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 9805(a).

''(2) SPECIFIED MULTIPLE EMPLOYER HEALTH PLAN.—The term 'specified multiple employer health plan' means a group health plan which is—

''(A) any multiemployer plan, or

''(B) any multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Secrurity Act of 1974, as in effect on the date of the enactment of this section).

''(3) CORRECTION.—A failure of a group health plan shall be treated as corrected if—

''(A) such failure is retroactively undone to the extent possible, and

''(B) the person to whom the failure relates is placed in a financial position which is as good as such person would have been in had such failure not occurred.''

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding after the item relating to section 4980C the following new item:

''Sec. 4980D. Failure to meet certain group health plan requirements.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to failures under chapter 100 of the Internal Revenue Code of 1986 (as added by section 401 of this Act).

Subtitle B—Clarification of Certain Continuation Coverage Requirements

SEC. 421. COBRA CLARIFICATIONS.

(a) PUBLIC HEALTH SERVICE ACT.—

(1) PERIOD OF COVERAGE.—Section 2202(2) of the Public Health Service Act (42 U.S.C. 300bb–2(2)) is amended—

(A) in subparagraph (A)—

(i) by transferring the sentence immediately preceding clause (iv) so as to appear immediately following such clause (iv); and

(ii) in the last sentence (as so transferred)—

(I) by striking ''an individual'' and inserting ''a qualified beneficiary'';

(II) by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the first 60 days of continuation coverage under this title'';

(III) by striking ''with respect to such event,''; and

(IV) by inserting ''(with respect to all qualified beneficiaries)'' after ''29 months'';

(B) in subparagraph (D)(i), by inserting before '', or'' the following: ''(other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of the Internal Revenue Code of 1986, part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or title XXVII of this Act)''; and

(C) in subparagraph (E), by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the first 60 days of continuation coverage under this title''.

(2) NOTICES.—Section 2206(3) of the Public Health Service Act (42 U.S.C. 300bb–6(3)) is amended by striking ''at the time of a qualifying event described in section 2203(2)'' and inserting ''at any time during the first 60 days of continuation coverage under this title''.

(3) BIRTH OR ADOPTION OF A CHILD.—Section 2208(3)(A) of the Public Health Service Act (42 U.S.C. 300bb–8(3)(A)) is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this title.''.

(b) EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) PERIOD OF COVERAGE.—Section 602(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1162(2)) is amended—

(A) in the last sentence of subparagraph (A)—

(i) by striking ''an individual'' and inserting ''a qualified beneficiary'';

(ii) by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the first 60 days of continuation coverage under this part'';

(iii) by striking ''with respect to such event''; and

(iv) by inserting ''(with respect to all qualified beneficiaries)'' after ''29 months'';

(B) in subparagraph (D)(i), by inserting before '', or'' the following: ''(other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of the Internal Revenue Code of 1986, part 7 of this subtitle, or title XXVII of the Public Health Service Act)''; and

(C) in subparagraph (E), by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the first 60 days of continuation coverage under this part''.

(2) NOTICES.—Section 606(a)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1166(a)(3)) is amended by striking ''at the time of a qualifying event described in section 603(2)'' and inserting ''at any time during the first 60 days of continuation coverage under this part''.

(3) BIRTH OR ADOPTION OF A CHILD.—Section 607(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1167(3)) is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this part.''.

(c) INTERNAL REVENUE CODE OF 1986.—

(1) PERIOD OF COVERAGE.—Section 4980B(f)(2)(B) of the Internal Revenue Code of 1986 is amended—

(A) in the last sentence of clause (i)—

(i) by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the first 60 days of continuation coverage under this section'';

(ii) by striking ''with respect to such event''; and

(iii) by inserting ''(with respect to all qualified beneficiaries)'' after ''29 months'';

(B) in clause (iv)(I), by inserting before '', or'' the following: ''(other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of chapter 100 of this title, part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, or title XXVII of the Public Health Service Act)''; and

(C) in clause (v), by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the first 60

days of continuation coverage under this section''.

(2) NOTICES.—Section 4980B(f)(6)(C) of the Internal Revenue Code of 1986 is amended by striking ''at the time of a qualifying event described in paragraph (3)(B)'' and inserting ''at any time during the first 60 days of continuation coverage under this section''.

(3) BIRTH OR ADOPTION OF A CHILD.—Section 4980B(g)(1)(A) of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new flush sentence:

''Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this section.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall become effective on January 1, 1997, regardless of whether the qualifying event occurred before, on, or after such date.

(e) NOTIFICATION OF CHANGES.—Not later than November 1, 1996, each group health plan (covered under title XXII of the Public Health Service Act, part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, and section 4980B(f) of the Internal Revenue Code of 1986) shall notify each qualified beneficiary who has elected continuation coverage under such title, part or section of the amendments made by this section.

TITLE V—REVENUE OFFSETS

SEC. 500. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

Subtitle A—Company-Owned Life Insurance

SEC. 501. DENIAL OF DEDUCTION FOR INTEREST ON LOANS WITH RESPECT TO COMPANY-OWNED LIFE INSURANCE.

(a) IN GENERAL.—Paragraph (4) of section 264(a) is amended—

(1) by inserting '', or any endowment or annuity contracts owned by the taxpayer covering any individual,'' after ''the life of any individual'', and

(2) by striking all that follows ''carried on by the taxpayer'' and inserting a period.

(b) EXCEPTION FOR CONTRACTS RELATING TO KEY PERSONS; PERMISSIBLE INTEREST RATES.—Section 264 is amended—

(1) by striking ''Any'' in subsection (a)(4) and inserting ''Except as provided in subsection (d), any'', and

(2) by adding at the end the following new subsection:

''(d) SPECIAL RULES FOR APPLICATION OF SUBSECTION (a)(4).—

''(1) EXCEPTION FOR KEY PERSONS.—Subsection (a)(4) shall not apply to any interest paid or accrued on any indebtedness with respect to policies or contracts covering an individual who is a key person to the extent that the aggregate amount of such indebtedness with respect to policies and contracts covering such individual does not exceed $50,000.

''(2) INTEREST RATE CAP ON KEY PERSONS AND PRE-1986 CONTRACTS.—

''(A) IN GENERAL.—No deduction shall be allowed by reason of paragraph (1) or the last sentence of subsection (a) with respect to interest paid or accrued for any month beginning after December 31, 1995, to the extent the amount of such interest exceeds the amount which would have been determined if the applicable rate of interest were used for such month.

''(B) APPLICABLE RATE OF INTEREST.—For purposes of subparagraph (A)—

''(i) IN GENERAL.—The applicable rate of interest for any month is the rate of interest described as Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto, for such month.

''(ii) PRE-1986 CONTRACTS.—In the case of indebtedness on a contract purchased on or before June 20, 1986—

''(I) which is a contract providing a fixed rate of interest, the applicable rate of interest for any month shall be the Moody's rate described in clause (i) for the month in which the contract was purchased, or

''(II) which is a contract providing a variable rate of interest, the applicable rate of interest for any month in an applicable period shall be such Moody's rate for the third month preceding the first month in such period.

For purposes of subclause (II), the taxpayer shall elect an applicable period for such contract on its return of tax imposed by this chapter for its first taxable year ending on or after October 13, 1995. Such applicable period shall be for any number of months (not greater than 12) specified in the election and may not be changed by the taxpayer without the consent of the Secretary.

''(3) KEY PERSON.—For purposes of paragraph (1), the term 'key person' means an officer or 20-percent owner, except that the number of individuals who may be treated as key persons with respect to any taxpayer shall not exceed the greater of—

''(A) 5 individuals, or

''(B) the lesser of 5 percent of the total officers and employees of the taxpayer or 20 individuals.

''(4) 20-PERCENT OWNER.—For purposes of this subsection, the term '20-percent owner' means—

''(A) if the taxpayer is a corporation, any person who owns directly 20 percent or more of the outstanding stock of the corporation or stock possessing 20 percent or more of the total combined voting power of all stock of the corporation, or

''(B) if the taxpayer is not a corporation, any person who owns 20 percent or more of the capital or profits interest in the employer.

''(5) AGGREGATION RULES.—

''(A) IN GENERAL.—For purposes of paragraph (4)(A) and applying the $50,000 limitation in paragraph (1)—

''(i) all members of a controlled group shall be treated as 1 taxpayer, and

''(ii) such limitation shall be allocated among the members of such group in such manner as the Secretary may prescribe.

''(B) CONTROLLED GROUP.—For purposes of this paragraph, all persons treated as a single employer under subsection (a) or (b) of section 52 or subsection (m) or (o) of section 414 shall be treated as members of a controlled group.''.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to interest paid or accrued after October 13, 1995.

(2) TRANSITION RULE FOR EXISTING INDEBTEDNESS.—

(A) IN GENERAL.—In the case of—

(i) indebtedness incurred before January 1, 1996, or

(ii) indebtedness incurred before January 1, 1997 with respect to any contract or policy entered into in 1994 or 1995,

the amendments made by this section shall not apply to qualified interest paid or accrued on such indebtedness after October 13, 1995, and before January 1, 1999.

(B) QUALIFIED INTEREST.—For purposes of subparagraph (A), the qualified interest with respect to any indebtedness for any month is the amount of interest (otherwise deductible) which would be paid or accrued for such month on such indebtedness if—

(i) in the case of any interest paid or accrued after December 31, 1995, indebtedness with respect to no more than 20,000 insured individuals were taken into account, and

(ii) the lesser of the following rates of interest were used for such month:

(I) The rate of interest specified under the terms of the indebtedness as in effect on October 13, 1995 (and without regard to modification of such terms after such date).

(II) The applicable percentage of the rate of interest described as Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto, for such month.

For purposes of clause (i), all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as 1 person. Subclause (II) of clause (ii) shall not apply to any month before January 1, 1996.

(C) APPLICABLE PERCENTAGE.—For purposes of subparagraph (B), the applicable percentage is as follows:

For calendar year:	The percentage is:
1996	100 percent
1997	90 percent
1998	80 percent.

(3) SPECIAL RULE FOR GRANDFATHERED CONTRACTS.—This section shall not apply to any contract purchased on or before June 20, 1986, except that section 264(d)(2) of the Internal Revenue Code of 1986 shall apply to interest paid or accrued after October 13, 1995.

(d) SPREAD OF INCOME INCLUSION ON SURRENDER, ETC. OF CONTRACTS.—

(1) IN GENERAL.—If any amount is received under any life insurance policy or endowment or annuity contract described in paragraph (4) of section 264(a) of the Internal Revenue Code of 1986—

(A) on the complete surrender, redemption, or maturity of such policy or contract during calendar year 1996, 1997, or 1998, or

(B) in full discharge during any such calendar year of the obligation under the policy or contract which is in the nature of a refund of the consideration paid for the policy or contract,

then (in lieu of any other inclusion in gross income) such amount shall be includible in gross income ratably over the 4-taxable year period beginning with the taxable year such amount would (but for this paragraph) be includible. The preceding sentence shall only apply to the extent the amount is includible in gross income for the taxable year in which the event described in subparagraph (A) or (B) occurs.

(2) SPECIAL RULES FOR APPLYING SECTION 264.—A contract shall not be treated as—

(A) failing to meet the requirement of section 264(c)(1) of the Internal Revenue Code of 1986, or

(B) a single premium contract under section 264(b)(1) of such Code,

solely by reason of an occurrence described in subparagraph (A) or (B) of paragraph (1) of this subsection or solely by reason of no additional premiums being received under the contract by reason of a lapse occurring after October 13, 1995.

(3) SPECIAL RULE FOR DEFERRED ACQUISITION COSTS.—In the case of the occurrence of any event described in subparagraph (A) or (B) of paragraph (1) of this subsection with respect to any policy or contract—

(A) section 848 of the Internal Revenue Code of 1986 shall not apply to the unamortized balance (if any) of the specified policy acquisition expenses attributable to such policy or contract immediately before the insurance company's taxable year in which such event occurs, and

(B) there shall be allowed as a deduction to such company for such taxable year under chapter 1 of such Code an amount equal to such unamortized balance.

Subtitle B—Treatment of Individuals Who Lose United States Citizenship

SEC. 511. REVISION OF INCOME, ESTATE, AND GIFT TAXES ON INDIVIDUALS WHO LOSE UNITED STATES CITIZENSHIP.

(a) IN GENERAL.—Subsection (a) of section 877 is amended to read as follows:

''(a) TREATMENT OF EXPATRIATES.—

''(1) IN GENERAL.—Every nonresident alien individual who, within the 10-year period immediately preceding the close of the taxable year,

lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle B, shall be taxable for such taxable year in the manner provided in subsection (b) if the tax imposed pursuant to such subsection exceeds the tax which, without regard to this section, is imposed pursuant to section 871.

''(2) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—For purposes of paragraph (1), an individual shall be treated as having a principal purpose to avoid such taxes if—

''(A) the average annual net income tax (as defined in section 38(c)(1)) of such individual for the period of 5 taxable years ending before the date of the loss of United States citizenship is greater than $100,000, or

''(B) the net worth of the individual as of such date is $500,000 or more.

In the case of the loss of United States citizenship in any calendar year after 1996, such $100,000 and $500,000 amounts shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for such calendar year by substituting '1994' for '1992' in subparagraph (B) thereof. Any increase under the preceding sentence shall be rounded to the nearest multiple of $1,000.''.

(b) EXCEPTIONS.—

(1) IN GENERAL.—Section 877 is amended by striking subsection (d), by redesignating subsection (c) as subsection (d), and by inserting after subsection (b) the following new subsection:

''(c) TAX AVOIDANCE NOT PRESUMED IN CERTAIN CASES.—

''(1) IN GENERAL.—Subsection (a)(2) shall not apply to an individual if—

''(A) such individual is described in a subparagraph of paragraph (2) of this subsection, and

''(B) within the 1-year period beginning on the date of the loss of United States citizenship, such individual submits a ruling request for the Secretary's determination as to whether such loss has for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle B.

''(2) INDIVIDUALS DESCRIBED.—

''(A) DUAL CITIZENSHIP, ETC.—An individual is described in this subparagraph if—

''(i) the individual became at birth a citizen of the United States and a citizen of another country and continues to be a citizen of such other country, or

''(ii) the individual becomes (not later than the close of a reasonable period after loss of United States citizenship) a citizen of the country in which—

''(I) such individual was born,

''(II) if such individual is married, such individual's spouse was born, or

''(III) either of such individual's parents were born.

''(B) LONG-TERM FOREIGN RESIDENTS.—An individual is described in this subparagraph if, for each year in the 10-year period ending on the date of loss of United States citizenship, the individual was present in the United States for 30 days or less. The rule of section 7701(b)(3)(D)(ii) shall apply for purposes of this subparagraph.

''(C) RENUNCIATION UPON REACHING AGE OF MAJORITY.—An individual is described in this subparagraph if the individual's loss of United States citizenship occurs before such individual attains age 18½.

''(D) INDIVIDUALS SPECIFIED IN REGULATIONS.—An individual is described in this subparagraph if the individual is described in a category of individuals prescribed by regulation by the Secretary.''

(2) TECHNICAL AMENDMENT.—Paragraph (1) of section 877(b) of such Code is amended by striking ''subsection (c)'' and inserting ''subsection (d)''.

(c) TREATMENT OF PROPERTY DISPOSED OF IN NONRECOGNITION TRANSACTIONS; TREATMENT OF DISTRIBUTIONS FROM CERTAIN CONTROLLED FOREIGN CORPORATIONS.—Subsection (d) of section 877, as redesignated by subsection (b), is amended to read as follows:

''(d) SPECIAL RULES FOR SOURCE, ETC.—For purposes of subsection (b)—

''(1) SOURCE RULES.—The following items of gross income shall be treated as income from sources within the United States:

''(A) SALE OF PROPERTY.—Gains on the sale or exchange of property (other than stock or debt obligations) located in the United States.

''(B) STOCK OR DEBT OBLIGATIONS.—Gains on the sale or exchange of stock issued by a domestic corporation or debt obligations of United States persons or of the United States, a State or political subdivision thereof, or the District of Columbia.

''(C) INCOME OR GAIN DERIVED FROM CONTROLLED FOREIGN CORPORATION.—Any income or gain derived from stock in a foreign corporation but only—

''(i) if the individual losing United States citizenship owned (within the meaning of section 958(a)), or is considered as owning (by applying the ownership rules of section 958(b)), at any time during the 2-year period ending on the date of the loss of United States citizenship, more than 50 percent of—

''(I) the total combined voting power of all classes of stock entitled to vote of such corporation, or

''(II) the total value of the stock of such corporation, and

''(ii) to the extent such income or gain does not exceed the earnings and profits attributable to such stock which were earned or accumulated before the loss of citizenship and during periods that the ownership requirements of clause (i) are met.

''(2) GAIN RECOGNITION ON CERTAIN EXCHANGES.—

''(A) IN GENERAL.—In the case of any exchange of property to which this paragraph applies, notwithstanding any other provision of this title, such property shall be treated as sold for its fair market value on the date of such exchange, and any gain shall be recognized for the taxable year which includes such date.

''(B) EXCHANGES TO WHICH PARAGRAPH APPLIES.—This paragraph shall apply to any exchange during the 10-year period described in subsection (a) if—

''(i) gain would not (but for this paragraph) be recognized on such exchange in whole or in part for purposes of this subtitle,

''(ii) income derived from such property was from sources within the United States (or, if no income was so derived, would have been from such sources), and

''(iii) income derived from the property acquired in the exchange would be from sources outside the United States.

''(C) EXCEPTION.—Subparagraph (A) shall not apply if the individual enters into an agreement with the Secretary which specifies that any income or gain derived from the property acquired in the exchange (or any other property which has a basis determined in whole or part by reference to such property) during such 10-year period shall be treated as from sources within the United States. If the property transferred in the exchange is disposed of by the person acquiring such property, such agreement shall terminate and any gain which was not recognized by reason of such agreement shall be recognized as of the date of such disposition.

''(D) SECRETARY MAY EXTEND PERIOD.—To the extent provided in regulations prescribed by the Secretary, subparagraph (B) shall be applied by substituting the 15-year period beginning 5 years before the loss of United States citizenship for the 10-year period referred to therein.

''(E) SECRETARY MAY REQUIRE RECOGNITION OF GAIN IN CERTAIN CASES.—To the extent provided in regulations prescribed by the Secretary—

''(i) the removal of appreciated tangible personal property from the United States, and

''(ii) any other occurrence which (without recognition of gain) results in a change in the source of the income or gain from property from sources within the United States to sources outside the United States,

shall be treated as an exchange to which this paragraph applies.

''(3) SUBSTANTIAL DIMINISHING OF RISKS OF OWNERSHIP.—For purposes of determining whether this section applies to any gain on the sale or exchange of any property, the running of the 10-year period described in subsection (a) shall be suspended for any period during which the individual's risk of loss with respect to the property is substantially diminished by—

''(A) the holding of a put with respect to such property (or similar property),

''(B) the holding by another person of a right to acquire the property, or

''(C) a short sale or any other transaction.

''(4) TREATMENT OF PROPERTY CONTRIBUTED TO CONTROLLED FOREIGN CORPORATIONS.—

''(A) IN GENERAL.—If—

''(i) an individual losing United States citizenship contributes property to any corporation which, at the time of the contribution, is described in subparagraph (B), and

''(ii) income derived from such property was from sources within the United States (or, if no income was so derived, would have been from such sources),

during the 10-year period referred to in subsection (a), any income or gain on such property (or any other property which has a basis determined in whole or part by reference to such property) received or accrued by the corporation shall be treated as received or accrued directly by such individual and not by such corporation. The preceding sentence shall not apply to the extent the property has been treated under subparagraph (C) as having been sold by such corporation.

''(B) CORPORATION DESCRIBED.—A corporation is described in this subparagraph with respect to an individual if, were such individual a United States citizen—

''(i) such corporation would be a controlled foreign corporation (as defined in 957), and

''(ii) such individual would be a United States shareholder (as defined in section 951(b)) with respect to such corporation.

''(C) DISPOSITION OF STOCK IN CORPORATION.—If stock in the corporation referred to in subparagraph (A) (or any other stock which has a basis determined in whole or part by reference to such stock) is disposed of during the 10-year period referred to in subsection (a) and while the property referred to in subparagraph (A) is held by such corporation, a pro rata share of such property (determined on the basis of the value of such stock) shall be treated as sold by the corporation immediately before such disposition.

''(D) ANTI-ABUSE RULES.—The Secretary shall prescribe such regulations as may be necessary to prevent the avoidance of the purposes of this paragraph, including where—

''(i) the property is sold to the corporation, and

''(ii) the property taken into account under subparagraph (A) is sold by the corporation.

''(E) INFORMATION REPORTING.—The Secretary shall require such information reporting as is necessary to carry out the purposes of this paragraph.''

(d) CREDIT FOR FOREIGN TAXES IMPOSED ON UNITED STATES SOURCE INCOME.—

(1) Subsection (b) of section 877 is amended by adding at the end the following new sentence: ''The tax imposed solely by reason of this section shall be reduced (but not below zero) by the amount of any income, war profits, and excess profits taxes (within the meaning of section 903) paid to any foreign country or possession of the United States on any income of the taxpayer on which tax is imposed solely by reason of this section.''

(2) Subsection (a) of section 877, as amended by subsection (a), is amended by inserting ''(after any reduction in such tax under the last sentence of such subsection)'' after ''such subsection''.

(e) COMPARABLE ESTATE AND GIFT TAX TREATMENT.—

(1) ESTATE TAX.—

(A) IN GENERAL.—Subsection (a) of section 2107 is amended to read as follows:

''(a) TREATMENT OF EXPATRIATES.—

''(1) RATE OF TAX.—A tax computed in accordance with the table contained in section 2001 is hereby imposed on the transfer of the taxable estate, determined as provided in section 2106, of every decedent nonresident not a citizen of the United States if, within the 10-year period ending with the date of death, such decedent lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle A.

''(2) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—

''(A) IN GENERAL.—For purposes of paragraph (1), an individual shall be treated as having a principal purpose to avoid such taxes if such individual is so treated under section 877(a)(2).

''(B) EXCEPTION.—Subparagraph (A) shall not apply to a decedent meeting the requirements of section 877(c)(1).''.

(B) CREDIT FOR FOREIGN DEATH TAXES.—Subsection (c) of section 2107 is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

''(2) CREDIT FOR FOREIGN DEATH TAXES.—

''(A) IN GENERAL.—The tax imposed by subsection (a) shall be credited with the amount of any estate, inheritance, legacy, or succession taxes actually paid to any foreign country in respect of any property which is included in the gross estate solely by reason of subsection (b).

''(B) LIMITATION ON CREDIT.—The credit allowed by subparagraph (A) for such taxes paid to a foreign country shall not exceed the lesser of—

''(i) the amount which bears the same ratio to the amount of such taxes actually paid to such foreign country in respect of property included in the gross estate as the value of the property included in the gross estate solely by reason of subsection (b) bears to the value of all property subjected to such taxes by such foreign country, or

''(ii) such property's proportionate share of the excess of—

''(I) the tax imposed by subsection (a), over

''(II) the tax which would be imposed by section 2101 but for this section.

''(C) PROPORTIONATE SHARE.—For purposes of subparagraph (B), a property's proportionate share is the percentage of the value of the property which is included in the gross estate solely by reason of subsection (b) bears to the total value of the gross estate.''.

(C) EXPANSION OF INCLUSION IN GROSS ESTATE OF STOCK OF FOREIGN CORPORATIONS.—Paragraph (2) of section 2107(b) is amended by striking ''more than 50 percent of'' and all that follows and inserting ''more than 50 percent of—

''(A) the total combined voting power of all classes of stock entitled to vote of such corporation, or

''(B) the total value of the stock of such corporation,''.

(2) GIFT TAX.—

(A) IN GENERAL.—Paragraph (3) of section 2501(a) is amended to read as follows:

''(3) EXCEPTION.—

''(A) CERTAIN INDIVIDUALS.—Paragraph (2) shall not apply in the case of a donor who, within the 10-year period ending with the date of transfer, lost United States citizenship, unless such loss did not have for 1 of its principal purposes the avoidance of taxes under this subtitle or subtitle A.

''(B) CERTAIN INDIVIDUALS TREATED AS HAVING TAX AVOIDANCE PURPOSE.—For purposes of subparagraph (A), an individual shall be treated as having a principal purpose to avoid such taxes if such individual is so treated under section 877(a)(2).

''(C) EXCEPTION FOR CERTAIN INDIVIDUALS.—Subparagraph (B) shall not apply to a decedent meeting the requirements of section 877(c)(1).

''(D) CREDIT FOR FOREIGN GIFT TAXES.—The tax imposed by this section solely by reason of this paragraph shall be credited with the amount of any gift tax actually paid to any foreign country in respect of any gift which is taxable under this section solely by reason of this paragraph.''.

(f) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—

(1) IN GENERAL.—Section 877 is amended by redesignating subsection (e) as subsection (f) and by inserting after subsection (d) the following new subsection:

''(e) COMPARABLE TREATMENT OF LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—

''(1) IN GENERAL.—Any long-term resident of the United States who—

''(A) ceases to be a lawful permanent resident of the United States (within the meaning of section 7701(b)(6)), or

''(B) commences to be treated as a resident of a foreign country under the provisions of a tax treaty between the United States and the foreign country and who does not waive the benefits of such treaty applicable to residents of the foreign country,

shall be treated for purposes of this section and sections 2107, 2501, and 6039F in the same manner as if such resident were a citizen of the United States who lost United States citizenship on the date of such cessation or commencement.

''(2) LONG-TERM RESIDENT.—For purposes of this subsection, the term 'long-term resident' means any individual (other than a citizen of the United States) who is a lawful permanent resident of the United States in at least 8 taxable years during the period of 15 taxable years ending with the taxable year during which the event described in subparagraph (A) or (B) of paragraph (1) occurs. For purposes of the preceding sentence, an individual shall not be treated as a lawful permanent resident for any taxable year if such individual is treated as a resident of a foreign country for the taxable year under the provisions of a tax treaty between the United States and the foreign country and does not waive the benefits of such treaty applicable to residents of the foreign country.

''(3) SPECIAL RULES.—

''(A) EXCEPTIONS NOT TO APPLY.—Subsection (c) shall not apply to an individual who is treated as provided in paragraph (1).

''(B) STEP-UP IN BASIS.—Solely for purposes of determining any tax imposed by reason of this subsection, property which was held by the long-term resident on the date the individual first became a resident of the United States shall be treated as having a basis on such date of not less than the fair market value of such property on such date. The preceding sentence shall not apply if the individual elects not to have such sentence apply. Such an election, once made, shall be irrevocable.

''(4) AUTHORITY TO EXEMPT INDIVIDUALS.—This subsection shall not apply to an individual who is described in a category of individuals prescribed by regulation by the Secretary.

''(5) REGULATIONS.—The Secretary shall prescribe such regulations as may be appropriate to carry out this subsection, including regulations providing for the application of this subsection in cases where an alien individual becomes a resident of the United States during the 10-year period after being treated as provided in paragraph (1).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 2107 is amended by striking subsection (d), by redesignating subsection (e) as subsection (d), and by inserting after subsection (d) (as so redesignated) the following new subsection:

''(e) CROSS REFERENCE.—

''For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).''.

(B) Paragraph (3) of section 2501(a) (as amended by subsection (e)) is amended by adding at the end the following new subparagraph:

''(E) CROSS REFERENCE.—

''For comparable treatment of long-term lawful permanent residents who ceased to be taxed as residents, see section 877(e).''.

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to—

(A) individuals losing United States citizenship (within the meaning of section 877 of the Internal Revenue Code of 1986) on or after February 6, 1995, and

(B) long-term residents of the United States with respect to whom an event described in subparagraph (A) or (B) of section 877(e)(1) of such Code occurs on or after February 6, 1995.

(2) RULING REQUESTS.—In no event shall the 1-year period referred to in section 877(c)(1)(B) of such Code, as amended by this section, expire before the date which is 90 days after the date of the enactment of this Act.

(3) SPECIAL RULE.—

(A) IN GENERAL.—In the case of an individual who performed an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)–(4)) before February 6, 1995, but who did not, on or before such date, furnish to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of such act, the amendments made by this section and section 512 shall apply to such individual except that the 10-year period described in section 877(a) of such Code shall not expire before the end of the 10-year period beginning on the date such statement is so furnished.

(B) EXCEPTION.—Subparagraph (A) shall not apply if the individual establishes to the satisfaction of the Secretary of the Treasury that such loss of United States citizenship occurred before February 6, 1994.

SEC. 512. INFORMATION ON INDIVIDUALS LOSING UNITED STATES CITIZENSHIP.

(a) IN GENERAL.—Subpart A of part III of subchapter A of chapter 61 is amended by inserting after section 6039E the following new section:

''SEC. 6039F. INFORMATION ON INDIVIDUALS LOSING UNITED STATES CITIZENSHIP.

''(a) IN GENERAL.—Notwithstanding any other provision of law, any individual who loses United States citizenship (within the meaning of section 877(a)) shall provide a statement which includes the information described in subsection (b). Such statement shall be—

''(1) provided not later than the earliest date of any act referred to in subsection (c), and

''(2) provided to the person or court referred to in subsection (c) with respect to such act.

''(b) INFORMATION TO BE PROVIDED.—Information required under subsection (a) shall include—

''(1) the taxpayer's TIN,

''(2) the mailing address of such individual's principal foreign residence,

''(3) the foreign country in which such individual is residing,

''(4) the foreign country of which such individual is a citizen,

''(5) in the case of an individual having a net worth of at least the dollar amount applicable under section 877(a)(2)(B), information detailing the assets and liabilities of such individual, and

''(6) such other information as the Secretary may prescribe.

''(c) ACTS DESCRIBED.—For purposes of this section, the acts referred to in this subsection are—

''(1) the individual's renunciation of his United States nationality before a diplomatic or consular officer of the United States pursuant to paragraph (5) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(5)),

''(2) the individual's furnishing to the United States Department of State a signed statement of voluntary relinquishment of United States nationality confirming the performance of an act of expatriation specified in paragraph (1), (2), (3), or (4) of section 349(a) of the Immigration and Nationality Act (8 U.S.C. 1481(a)(1)–(4)),

''(3) the issuance by the United States Department of State of a certificate of loss of nationality to the individual, or

''(4) the cancellation by a court of the United States of a naturalized citizen's certificate of naturalization.

''(d) PENALTY.—Any individual failing to provide a statement required under subsection (a) shall be subject to a penalty for each year (of the 10-year period beginning on the date of loss of United States citizenship) during any portion of which such failure continues in an amount equal to the greater of—

''(1) 5 percent of the tax required to be paid under section 877 for the taxable year ending during such year, or

''(2) $1,000,

unless it is shown that such failure is due to reasonable cause and not to willful neglect.

''(e) INFORMATION TO BE PROVIDED TO SECRETARY.—Notwithstanding any other provision of law—

''(1) any Federal agency or court which collects (or is required to collect) the statement under subsection (a) shall provide to the Secretary—

''(A) a copy of any such statement, and

''(B) the name (and any other identifying information) of any individual refusing to comply with the provisions of subsection (a),

''(2) the Secretary of State shall provide to the Secretary a copy of each certificate as to the loss of American nationality under section 358 of the Immigration and Nationality Act which is approved by the Secretary of State, and

''(3) the Federal agency primarily responsible for administering the immigration laws shall provide to the Secretary the name of each lawful permanent resident of the United States (within the meaning of section 7701(b)(6)) whose status as such has been revoked or has been administratively or judicially determined to have been abandoned.

Notwithstanding any other provision of law, not later than 30 days after the close of each calendar quarter, the Secretary shall publish in the Federal Register the name of each individual losing United States citizenship (within the meaning of section 877(a)) with respect to whom the Secretary receives information under the preceding sentence during such quarter.

''(f) REPORTING BY LONG-TERM LAWFUL PERMANENT RESIDENTS WHO CEASE TO BE TAXED AS RESIDENTS.—In lieu of applying the last sentence of subsection (a), any individual who is required to provide a statement under this section by reason of section 877(e)(1) shall provide such statement with the return of tax imposed by chapter 1 for the taxable year during which the event described in such section occurs.

''(g) EXEMPTION.—The Secretary may by regulations exempt any class of individuals from the requirements of this section if he determines that applying this section to such individuals is not necessary to carry out the purposes of this section.''.

(b) CLERICAL AMENDMENT.—The table of sections for such subpart A is amended by inserting after the item relating to section 6039E the following new item:

''Sec. 6039F. Information on individuals losing United States citizenship.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to—

(1) individuals losing United States citizenship (within the meaning of section 877 of the Internal Revenue Code of 1986) on or after February 6, 1995, and

(2) long-term residents of the United States with respect to whom an event described in subparagraph (A) or (B) of section 877(e)(1) of such Code occurs on or after such date.

In no event shall any statement required by such amendments be due before the 90th day after the date of the enactment of this Act.

SEC. 513. REPORT ON TAX COMPLIANCE BY UNITED STATES CITIZENS AND RESIDENTS LIVING ABROAD.

Not later than 90 days after the date of the enactment of this Act, the Secretary of the Treasury shall prepare and submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report—

(1) describing the compliance with subtitle A of the Internal Revenue Code of 1986 by citizens and lawful permanent residents of the United States (within the meaning of section 7701(b)(6) of such Code) residing outside the United States, and

(2) recommending measures to improve such compliance (including improved coordination between executive branch agencies).

Subtitle C—Repeal of Financial Institution Transition Rule to Interest Allocation Rules

SEC. 521. REPEAL OF FINANCIAL INSTITUTION TRANSITION RULE TO INTEREST ALLOCATION RULES.

(a) IN GENERAL.—Paragraph (5) of section 1215(c) of the Tax Reform Act of 1986 (Public Law 99–514, 100 Stat. 2548) is hereby repealed.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by this section shall apply to taxable years beginning after December 31, 1995.

(2) SPECIAL RULE.—In the case of the first taxable year beginning after December 31, 1995, the pre-effective date portion of the interest expense of the corporation referred to in such paragraph (5) of such section 1215(c) for such taxable year shall be allocated and apportioned without regard to such amendment. For purposes of the preceding sentence, the pre-effective date portion is the amount which bears the same ratio to the interest expense for such taxable year as the number of days during such taxable year before the date of the enactment of this Act bears to 366.

And the Senate agree to the same.

BILL ARCHER,
BILL THOMAS,
TOM BLILEY,
MICHAEL BILIRAKIS,
WILLIAM F. GOODLING,
H.W. FAWELL,
HENRY HYDE,
BILL MCCOLLUM,
J. DENNIS HASTERT,
Managers on the Part of the House.

BILL ROTH,
NANCY LANDON KASSEBAUM,
TRENT LOTT,
TED KENNEDY,
Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3103) to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment that is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clerical changes.

TITLE I.—HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

I. STRUCTURE

House bill

The House bill would amend the Internal Revenue Code (IRC) and the Employee Retirement Income Security Act of 1974 (ERISA), and includes free-standing provisions.

Senate amendment

The Senate amendment includes free-standing provisions.

Conference agreement

The conference agreement adds new provisions to the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Services (PHS) Act, and the Internal Revenue Code (IRC).

II. AVAILABILITY AND PORTABILITY OF GROUP HEALTH PLANS

Current law

Current federal law does not impose any requirements on employers to provide or contribute toward the health insurance coverage of their employees or their employees' dependents. However, specific federal requirements do apply to existing employer-sponsored health plans (e.g., fiduciary, notification and disclosure requirements under ERISA and COBRA continuation coverage, non-discrimination requirements under ERISA and the Internal Revenue Code.)

House bill

The House bill would provide for federal requirements on group health plans (and insurers and health maintenance organizations (HMOs) selling to such plans) relating to portability, the use of preexisting medical condition, and discrimination based on health status.

Senate amendment

The Senate amendment would provide for federal requirements on group health plans, health plan issuers (entities licensed by the state to offer a group or individual health plan) and employee health benefit plans, relating to portability, the use of preexisting medical conditions, and discrimination based on health status.

Conference agreement

The conference agreement provides for federal requirements on group health and health insurance issuers offering group health insurance coverage relating to portability, access, and renewability.

A. DEFINITIONS

(Also see item IX below.)

Current law

Section 5000(b)(1) of the Internal Revenue Code (IRC) defines a group health plan as a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees,

the employer, others associated or formerly associated with the employer in a business relationship, or their families.

Section 607(1) of ERISA defines a group health plan as an employee welfare benefit plan providing medical care to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.

Church plans are excluded from federal requirements on existing employer plans such as ERISA's requirements on employee health benefit plans and COBRA continuation coverage requirements under the IRC and ERISA.

House bill

Group health plan means an employee welfare benefit plan to the extent that the plan provides medical care employees and their dependent directly or through insurance, reimbursement, or otherwise, and includes a group health plan within the meaning of section 5000(b)(1) of the IRC.

The provisions of this subtitle (other than those relating to individual coverage) apply to group health plans with 2 or more participants as current employees on the first day of the plan year.

The requirements would not apply to church plans unless such plans met the exemption for multiple employer health plans under subtitle c (see item V). For purposes of applying the provisions related to qualified prior coverage (II(B) below), a group health plan could elect to disregard periods of coverage of an individual under a church plan that is not subject to this subtitle.

Governmental plans could elect not to be a group health plan covered under the subtitle. For purposes of applying the provisions related to qualified prior coverage, a group health plan could elect not to include coverage under a governmental plan that elected to be excluded from this subtitle's requirements.

Senate amendment

Employee health benefit plan means any employee welfare benefit plan, governmental plan, or church plan, or any health benefit plan under section 5(e) of the Peace Corps Act, that provides or pays for health benefit for participants or beneficiaries whether directly, through a group health plan offered by a health plan issuer (see item III(A) below), or otherwise.

Conference agreement

The conference agreement defines a group health plan as an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents directly or through insurance, reimbursement, or otherwise. Both governmental and church plans are included, but certain plans with limited coverage are excluded.

The portability and guaranteed availability provisions (other than those relating to individual coverage) apply to group health plans with 2 or more participants who are active employees on the first day of the plan year. These provisions would apply to nonfederal governmental plans, unless they elected to be excluded as described below, and to church and governmental plans. (See section III(B)(3) below for exceptions from availability, renewability, and portability requirements for group health plans and group health insurance coverage for certain benefits.)

Nonfederal governmental plans could elect not to be a group health plan covered under the amendments to the PHS. An election would apply for a single specified plan year, or, in the case of a plan provided pursuant to a collective bargaining agreement, for the term of such agreement. If a nonfederal governmental plan makes this election, it must notify enrollees of the fact and consequences of the election. The plan must still provide certification and disclosure of creditable coverage under the plan to enrollees who leave the plan, for purposes of portability.

Upon request, Medicare, Medicaid, a program of the Indian Health Service or a tribal organization, and military-sponsored health care programs must also provide notice of previous creditable coverage to individuals who leave such coverage.

B. PORTABILITY OF COVERAGE FOR PREVIOUSLY COVERED INDIVIDUALS

Current law

No provision.

House bill

The House bill would provide that in general, a group health plan and an insurer or HMO offering health insurance coverage in connection with a group health plan would have to reduce any preexisting condition limitation period by the length of the aggregate period of prior coverage. Prior coverage would not qualify under this provision if there was more than a 60-day break in coverage under a group health plan. (Waiting periods would not be considered a break in coverage.) Qualified coverage would include coverage of the individual under a group health plan, health insurance coverage, Medicare, Medicaid, Tricare, a program of the Indian Health Service, and State health insurance coverage or risk pool, and coverage under the Federal Employees Health Benefit Program (FEHBP).

Senate amendment

The Senate Amendment is similar. An employee benefit plan or a health plan issuer offering a group health plan would have to reduce any preexisting condition limitation period by 1 month for each month for which the person was in a period of previous qualifying coverage. This provision would not apply if there was a break of more than 30 days. (Waiting periods would not be considered a break in coverage.) Previous qualifying coverage includes enrollment under an employee health benefit plan, group health plan, individual health plan, or under a public or private health plan established under federal or state law.

Conference agreement

The conference agreement provides that in general, group health plans, and health insurance issuers offering group health insurance coverage, would have to reduce any preexisting condition limitation period by the length of the aggregate period of prior creditable coverage. Prior coverage would not qualify under this provision if there was a break in coverage under a group health plan that was longer than a 63-day period. (Waiting periods and affiliation periods would not be considered a break in coverage.) Creditable coverage includes coverage of the individual under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual insurance), Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a State health benefits risk pool, the FEHBP, a public health plan as defined in regulations, and any health benefit plan under section 5(e) of the Peace Corps Act. An individual would establish a creditable coverage period through presentation of certifications describing previous coverage, or through other procedures specified in regulations to carry out this provision. The conferees intend that creditable coverage includes short-term, limited coverage.

1. Method for establishing qualified coverage periods

Current law

No provision.

House bill

The House bill would provide that a group health plan or insurer or HMO offering health insurance coverage in connection with a group health plan could determine qualified coverage periods without regard to the specific benefits offered, referred to as the standard method. Alternatively, it could make such determination on a benefit-specific basis and not include as a qualified coverage period a specific benefit that had not been included at the end of the most recent period of coverage. If this alternative method were to be used, the group plan or insurer would be required to state prominently in any disclosure statements and to each enrollee at the time of enrollment that such a method of determining qualifying coverage was being used, and include a description of the effect of this method. The plan, insurer, or HMO would request a certification from prior plan administrators, insurers, or HMOs which discloses the plan statement related to health benefits under the plan or other detailed benefit information on the benefits available under the previous plan or coverage. The entity providing the certification could charge the reasonable cost for providing the benefit information to the requesting plan or insurer.

Senate bill

The Senate Amendment would provide that an employee health benefit plan or health plan issuer offering a group plan could impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition only to the extent that such service or benefit was not previously covered under the plan in which the participant or beneficiary was enrolled immediately prior to enrollment in the plan involved.

Conference agreement

The conference agreement provides that a group health plan, and issuer offering group health insurance coverage, could determine creditable coverage periods without regard to the specific benefits covered during the period. Alternatively, it could make such determination based on several classes or categories of benefits, as specified in regulations. A group health plan and issuer would be required to count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is provided. This alternative would have to be used uniformity for all participants and beneficiaries.

It is the intent of the conferees that the alternate method be available to account for significant differences in benefits. For example, the inclusion versus exclusion of a category of benefits such as pharmaceuticals could be considered a difference in classes of benefits. Similarly, significant differentials in deductibles could be considered differences in classes of benefits, but the alternative method would not apply to small differences in deductibles, such as $250 versus $200. The alternative method would not apply for differences in specific services or treatments.

If the alternate method were to be used, the group health plan and issuer would be required to state prominently in any disclosure statements that such a method of determining qualifying coverage was being used, and would be required to include a description of the effect of this election. A group health plan using the alternate method would be required to notify each enrollee at the time of enrollment that the plan had made such an election, and describe the effect. An issuer would be required to notify each employer at the time of offer or sale of the coverage.

2. Certification of prior coverage

Current law

No provision.

House bill

The House bill would require the plan administrator of a group health plan, or the insurer or HMO offering health insurance coverage to a group plan, on request made on behalf of an individual covered or previously covered within the past 18 months under the plan or coverage, to provide for a certification of the period of coverage of the individual under the plan and of the waiting period (if any) imposed.

Senate amendment

The Senate Amendment would require an employee health plan to provide documentation of coverage to participants and beneficiaries whose coverage was terminated under the plan. As specified by regulation, the duty of an employee health benefit plan to verify previous qualifying coverage would be discharged when such plan provided documentation to the participant or beneficiary including the following information: (1) the dates that the person was covered under the plan; and (2) the benefits and costs-sharing arrangement available to the person under the plan.

Conference agreement

The conference agreement requires the group health plan, and health insurance issuer offering group health insurance coverage, to provide a certification of the period of creditable coverage under the plan, the coverage under any applicable COBRA continuation provision, and waiting period (if any) (and affiliation period if applicable) imposed on the individual. This certification would have to be provided when the individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision, after any COBRA continuation coverage ceases, and on the request of an individual not later than 24 months after coverage ceased. The certification may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision. A group health plan offering medical care through health insurance coverage would not be required to provide certification if the health insurance issuer provides certification.

If a group health plan or health insurance issuer elects the alternative method of crediting coverage, the plan or issuer would request, from prior entities providing coverage, information on coverage of classes and categories of benefits available under the previous plan or coverage. The entity providing the certification could charge the reasonable cost for providing such information to the requesting plan or insurer. The Secretary is required to establish rules to prevent an entity's failure to provide information on health benefits under previous coverage from adversely affecting any subsequent coverage under another group health plan or health insurance coverage.

C. RESTRICTIONS ON USE OF PRE-EXISTING CONDITION LIMITATION PERIOD

Current law

No provision.

House bill

The House bill would restrict the use of preexisting condition limitation periods in group health plans and in plans offered by insurers and HMOs to group health plans.

Senate amendment

The Senate Amendment is similar but would apply to employee health benefit plans and group plans offered by health plan issuers.

Conference agreement

The conference agreement restricts the use of preexisting conditions limitation exclusions by group health plans and health insurance issuers offering group health insurance coverage.

1. Definition of preexisting condition

Current law

No provision.

House bill

The House bill would define a preexisting condition to be a condition, regardless of the cause of condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-months ending on the day before the effective date of the coverage or the earliest date upon which such coverage would have been effective if no waiting period was applicable, whichever was earlier. Genetic information would not be considered a preexisting condition, so long as the treatment of the condition to which the information was applicable had not been sought in the 6-month period just described.

Senate amendment

The Senate Amendment provides a similar definition of preexisting condition. It does not include the genetic information language.

Conference agreement

The conference agreement defines a preexisting condition exclusion to be a limitation or exclusion of benefits relating to a condition, whether physical or mental, based on the fact that the condition was present before the enrollment date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information would not be considered a condition in the absence of a diagnosis of the condition related to such information.

2. Restrictions on limitation period

Current law

No provision.

House bill

The House bill would prohibit a group health plan, and an insurer or HMO offering health insurance coverage in connection with a group health plan from imposing a preexisting condition limitation period in excess of 12 months, or 18 months in the event of a late enrollment. A preexisting condition limitation period could not be applied to a newborn, adopted child, or child placed for adoption, so long as the individual became covered within 30 days of birth or adoption or placement for adoption. Preexisting condition limitation periods would not apply to pregnancies. An HMO could impose an eligibility period as an alternative to a preexisting condition limitation period but only if it did not exceed 60 days for timely enrollment and 90 days for late enrollment. An HMO could use alternative methods to address adverse selection as approved by state regulators.

Senate amendment

The Senate Amendment includes a similar provision, but with respect to affiliation periods of an HMO, would specify that during such a period the plan could not be required to provide health care services or benefits and no premium could be charged to the participant or beneficiary.

Conference agreement

The conference agreement permits a group health plan and health insurance issuers to impose a preexisting condition exclusion if the exclusion relates to a condition (whether physical or mental), regardless of the cause of condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date. The exclusion could extend to not more than 12 months (18 months for late enrollees) after the enrollment date. The exclusion would be reduced by the aggregate of the periods of creditable coverage. Enrollment date is defined as the date of enrollment in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

Any waiting period or affiliation period would run concurrently with any preexisting condition exclusion period. A preexisting condition limitation period could not be applied to a newborn, an adopted child or child placed for adoption under age 18, so long as the individual becomes covered under creditable coverage within 30 days of birth or adoption or placement for adoption. These exceptions for newborns and certain adopted children would not apply if the individual had a break in coverage longer than a 63-day period. Preexisting condition exclusions could not apply to pregnancies.

A group health plan offering health insurance coverage through an HMO, or an HMO which offers health insurance coverage in connection with a group health plan, may impose an affiliation period only if no preexisting condition exclusion is imposed, the period is imposed uniformly without regard to health status, and does not exceed 2 months for timely enrollment and 3 months for late enrollment. It is the intent of the conferees that any affiliation period would apply to all new enrollees and beneficiaries. During the affiliation period, the HMO could not be required to provide health care services or benefits and no premium could be charged to the participant or beneficiary. The affiliation period would begin on the enrollment date and would run concurrently with any other applicable waiting period under the plan. An HMO could use alternative methods to address adverse selection as approved by state regulators.

D. PROHIBITING EXCLUSIONS BASED ON HEALTH STATUS (ACCESS)

Current law

Under section 510 of ERISA, an employee benefit plan may not discriminate against a particular beneficiary for exercising any right to which he or she is entitled under the provisions of an employee benefit plan. Section 105(h) of the IRC prohibits discrimination in favor of highly compensated individuals by self-insured employer health plans.

House bill

Except as specified below, a group health plan, and an insurer or HMO offering coverage in connection with a plan, cannot exclude an employee or his or her beneficiary from being (or continuing to be enrolled) as a participant or beneficiary under the plan based on health status. Health status includes, with respect to an individual, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), or disability. A group health plan and an insurer or HMO offering coverage in connection with a group health plan cannot require a premium or contribution which is greater than such premium or contribution for a similarly situated participant or beneficiary solely on the basis of health status. It can, however, very the premium or contribution based on factors that are not directly related to health status (such as scope of benefits, geographic area of resident, or wage levels).

The House bill provides that nothing is intended to affect the premium rates an insurer or HMO could charge an employer for health insurance coverage provided in connection with a group health plan.

A group health plan (or insurer or HMO providing coverage in connection to a group plan) could establish premium discounts or

modify otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Senate amendment

Except as specified below, a health plan issuer offering a group health plan may not decline to offer whole group coverage to a group purchaser desiring to purchase the coverage. An employee health benefit plan or a health plan issuer offering a group health plan could not condition eligibility, enrollment, or premium contribution requirements based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability (including conditions arising out of domestic violence), genetic information, or disability.

The bill does not include a specific rule of construction relating to premium rates charged to group health plans other than a prohibition of premium contribution requirements based on health status.

A group health plan (or insurer of HMO providing coverage in connection to a group plan) could establish premium discounts or modify otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Conference agreement

Except as specified below, a group health plan, and a health insurance issuer offering group health insurance coverage, cannot establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on any of the following health-related factors in relation to the individual or a dependent of the individual: health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence), or disability.

The inclusion of evidence of insurability in the definition of health status is intended to ensure, among other things, that individuals are not excluded from health care coverage due to their participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities.

It is the intent of the conferees that a plan cannot knowingly be designed to exclude individuals and their dependents on the basis of health status. However, generally applicable terms of the plan may have a disparate impact on individual enrollees. For example, a plan may exclude all coverage of a specific condition, or may include a lifetime cap on all benefits, or a lifetime cap on specific benefits. Although individuals with the specific condition would be adversely affected by an exclusion of coverage for that condition, and individuals with serious illnesses may be adversely affected by a lifetime cap on all or specific benefits, such plan characteristics would be permitted as long as they are not directed at individual sick employees or dependents.

The Conference agreement does not require a group health plan or health insurance coverage to provide particular benefits other than those provided under the terms of the plan or coverage. Nor does it prevent any plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage. Rules defining any applicable waiting periods for enrollment may not be established based on health status related factors.

It is the intent of the conferees that a plan or coverage cannot single out an individual based on the health status or health status related factors of that individual for denial of a benefit otherwise provided other individuals covered under the plan or coverage. For example, the plan or coverage may not deny coverage for prescription drugs to a particular beneficiary or dependent if such coverage is available to other similarly situated individual covered under the plan or coverage. However, the plan or coverage could deny coverage for prescription drugs to all beneficiaries and dependents. The term ''similarly situated'' means that a plan or coverage would be permitted to vary benefits available to different groups of employees, such as full-time versus part-time employees or employees in different geographic locations. In addition, a plan or coverage could have different benefit schedules for different collective bargaining units.

The conference agreement provides that a group health plan and an issuer offering group coverage cannot require a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor relating to the individual or to any individual enrolled under the plan as a dependent of the individual. It does not restrict the amount that an employer may be charged for coverage under a group health plan. The group health plan and health insurance issuer may establish premium discounts or rebates, or modify otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

The conferees intend that these provisions preclude insurance companies from denying coverage to employers based on health status and related factors that they have traditionally used. In addition, this provision is meant to prohibit insurers or employers from excluding employees in a group from coverage or charging them higher premiums based on their health status and other related factors that could lead to higher health costs. This does not mean that an entire group cannot be charged more. But it does preclude health plans from singling out individuals in the group for higher premiums or dropping them from coverage altogether.

1. Exceptions to the non-discrimination requirement

Current law

No provision.

House bill

No provision for group health plans (i.e., the plans of the employer). See item III(B) below on requirements on insurers and HMOs.

Senate amendment

Exceptions are provided to health plan issuers with respect to enrollment in the event that: (1) the health plan ceases to offer coverage to any additional group purchasers; or (2) the issuer can demonstrate to the state insurance regulator that to enroll new people would impair its financial or provider capacity. See item III–B(3) below.

Conference agreement

See item III(B) below on requirements for health plan issuers offering group health insurance coverage.

E. ENROLLMENT OF ELIGIBLE INDIVIDUALS WHO LOSE OTHER COVERAGE

Current law

No provision.

House bill

The House bill would require group health plans to permit an uncovered employee (or uncovered dependent) otherwise eligible for coverage to enroll under at least one benefit option if certain conditions are met: (1) the person was already covered when the plan was previously offered; (2) the person stated in writing at such time that another source of coverage was the reason for declining enrollment; (3) the person lost coverage as a result of a loss of eligibility or termination from or reduction in hours of employment; and (4) the person requested enrollment within 30 days after the date of the coverage's termination.

If a group health plan offered dependent coverage, it could not require, as a condition of coverage as a dependent, a waiting period applicable to: (1) a newborn, (2) adopted child or child placed for adoption, or (3) a spouse, at the time of marriage if the person had met any applicable waiting period.

Enrollment of a participant's beneficiary would be considered to be timely if a request for enrollment were made within 30 days of the date family coverage was first made available or, in the case of a newborn or adoption or placement for adoption, within 30 days of that event; and in the case of marriage, within 30 days of the date of the marriage, if family coverage was available.

Senate amendment

The Senate Amendment would require employee health benefit plans to provide for special enrollment periods extending for a reasonable time after certain qualifying events to permit the participant to change individual or family basis of coverage or to enroll in the plan if coverage would have otherwise been available. The qualifying events would be: (1) changes in family status affecting eligibility under a plan including marriage, separation, divorce, death, birth, or placement of a child for adoption; (2) changes in employment status that would otherwise cause the loss of eligibility for coverage (other than COBRA continuation coverage); or (3) changes in employment status of a family member that results in a loss of eligibility under a group, individual, or employee health benefit plan.

The special enrollment period would have to ensure that a child born or placed for adoption was deemed covered as of the date of birth or placement so long as the child was enrolled within 30 days.

Conference agreement

The conference agreement requires special enrollment periods for certain individuals losing other coverage and for certain dependent beneficiaries. It requires group health plans, and health insurance issuers offering group health insurance coverage, to permit eligible employees or dependents who lose other coverage to enroll under the terms of the plan if each of the following conditions is met: (1) the employee or dependent was already covered when the plan was previously offered; (2) the employee stated in writing at such time that another source of coverage was the reason for declining enrollment, but only if the plan sponsor or issuer required such a statement and provided the employee with notice of this requirement; (3) the person was covered under COBRA continuation coverage which was exhausted, or coverage was not under a COBRA continuation provision and was terminated as a result of a loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in hours of employment) or termination of employer contributions towards such coverage; and (4) the person requested enrollment not later than 30 days after the loss of other coverage.

If a group health plan offers dependent coverage, it must offer a dependent special enrollment period for persons becoming a dependent through marriage, birth, or adoption or placement for adoption. The dependent

special enrollment period must last for not less than 30 days. The dependent may be enrolled as a dependent of the individual. If the individual is eligible for enrollment, but not enrolled, the individual may also enroll at this time. Moreover, in the case of the birth or adoption of a child, the spouse of the individual also may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage but not already enrolled. If an individual seeks to enroll a dependent during the first 30 days of a dependent special enrollment period, the coverage would become effective as of the date of birth, of adoption or placement for adoption, or, in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment was received.

F. APPLICABILITY OF RENEWAL REQUIREMENTS TO MULTIPLE EMPLOYER ARRANGEMENTS

Current law

Under section 3(37) of ERISA, a multiemployer plan is one in which more than one employer contributes and which is established through a collective bargaining agreement. (Such plans are commonly found in unionized sectors of the building and construction, publishing, and entertainment trades, and the lumber, maritime, retail, food, hotel, and restaurant industries.) Under section 3(40) of ERISA, a multiple employer welfare arrangement (MEWA) is an employee welfare benefit plan or any other arrangement which offers or provides health benefits and meets additional criteria, (e.g., it must offer such benefits to the employees of 2 or more employers). There is no provision or definition under current law for ''multiple employer health plans.''

House bill

Such plans could not deny an employer who employees are covered under the plan or arrangement continued access to the same or different coverage except: (1) for cause (e.g., nonpayment of premiums, fraud, and noncompliance with plan provisions); (2) because the plan is not offering coverage in a geographic area; or (3) due to a failure to meet the terms of an applicable collective bargaining agreement. Certain collectively bargained arrangements and ''multiple employer health plans'' (MEHPs) would be required to meet specific requirements relating to the nondiscrimination requirements. (MEHPs are established under this bill (see item V below) and are generally non-fully-insured MEWAs that meet certain requirements excepting them from state regulation.)

Senate amendment

No provision. (Note that the rules regarding group and individual health plans (e.g., guaranteed renewal, nondiscrimination, and portability) or state laws not preempted by the Senate Amendment also apply to health plans offered by health plan issuers to a purchasing cooperative. See item VIII below).

Conference agreement

The conference agreement provides that a group health plan which is a multiemployer plan or a multiple employer welfare arrangement may not deny an employer continued access to the same or different coverage under the terms of such plan except: (1) for nonpayment of contributions; (2) for fraud; (3) for noncompliance with plan provisions; (4) because the plan is ceasing to offer any coverage in a geographic area; (5) in the case of a network plan, there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan, and the plan applies this provision uniformly without regard to claims experience or health status-related factors; or (6) due to a failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining agreement or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

G. ENFORCEMENT OF GROUP HEALTH PLAN REQUIREMENTS

Current law

Federal requirements on existing group health plans are enforced through various laws, including ERISA, the Public Health Service (PHS) Act, the IRC, and Medicare.

House bill

The House bill would provide for enforcement of the federal group health plan availability and portability requirements through the IRC, ERISA, and through civil monetary penalties imposed through the Secretary of Health and Human Services

Senate amendment

The Senate Amendment would provide for enforcement of the federal group health plan availability and portability requirements through the Secretary of Labor, in consultation with the Secretary of Health and Human Services using ERISA civil enforcement provisions.

Conference agreement

The conference agreement provides for enforcement of the federal group health plan availability and portability requirements through the IRC, ERISA, and through civil monetary penalties imposed through the Secretary of Health and Human Services (HHS).

1. Enforcement through COBRA provisions of IRC

Current law

Plans that fail to comply with the IRC COBRA provision are subject to an excise tax of $100 per day per violation. The tax is not applied where the failure was determined to be unintentional or if the failure was corrected within 30 days. An overall limitation on the tax applies in the event of an unintentional failure.

House bill

The House bill would provide that noncomplying plans and insurers and HMOs selling to group health plans would be subject to an excise tax of $100 per day per violation enforced through the COBRA provisions of the IRC. Penalties would not be assessed if the failure was determined to be unintentional or a correction was made within 30 days. No tax could be imposed on a noncomplying insurer or HMO subject to state insurance regulation if the Secretary of Health and Human Services (HHS) determined that the state had an effective enforcement mechanism. In the case of a group health plan of a small employer that provided coverage solely through a contract with an insurer or HMO, no tax would be imposed upon the employer if the failure was solely because of the product offered by the insurer or HMO. No tax penalty would be assessed for a failure under this provision if a sanction had been imposed under ERISA or by the Secretary of HHS.

Senate amendment

No provision.

Conference agreement

See Title IV.

2. Enforcement through ERISA

Current law

Under section 502 of ERISA, employee benefit plans that fail to comply with applicable requirements can be sued for relief and be subject to civil money penalties, and can be sued to recover any benefits due under the plan. Section 504 of ERISA provides the Secretary of Labor with investigative authority to determine whether any person is out of compliance with the law's requirements. Section 506 provides for coordination and responsibility of agencies in enforcement. Section 510 prohibits a health plan from discriminating against a participant or beneficiary for exercising any right under the plan.

House bill

The House bill would provide that ERISA sanctions apply to group health plans by deeming the provisions of subtitle A and subtitle D (insofar as it is applicable to this subtitle) to be provisions of title I of ERISA. Such sanctions also would apply to an insurer or HMO that was subject to state law in the event that the Secretary of Labor determined that the state had not provided for enforcement of the above provisions of this Act. Sanctions would not apply in the event that the Secretary of Labor established that none of the persons against whom the liability would be imposed knew, or exercising reasonable diligence, would have known that a failure existed, or if the noncomplying entity acted within 30 days to correct the failure. In no case would a civil money penalty be imposed under ERISA for a violation for which an excise tax under the COBRA enforcement provisions was imposed or for which a civil money penalty was imposed by the Secretary of HHS.

Senate amendment

The Senate Amendment would provide that for employee health benefit plans, the Secretary would be required to enforce the reform standards established by the bill in the same manner as provided under sections 502, 504, 506, and 510 of ERISA. (See item IV(I) below for enforcement provisions relating to health plan issuers and group health plans sold to employers and others.)

Conference agreement

The conference agreement provides that provisions with respect to group health plans would be enforced under Title I of ERISA as under current law. The Secretary of Labor would not enforce the provisions of Title I applicable to health insurance issuers. However, private right of action under part V of ERISA would apply to such issuers. Enforcement of provisions with respect to health insurance issuers generally would be limited to civil remedies established under the PHS Act amendments (as described in the following subsection).

The conference agreement provides that a state may enter into an agreement with the Secretary for delegation to the state of some or all of the Secretary's authority under sections 502 and 504 of ERISA to enforce the requirements of this part in connection with MEWAs providing medical care which are not group health plans.

3. Enforcement through civil money penalties

Current law

No provision.

House bill

The House bill would provide that a group health plan, insurer, or HMO that failed to meet the above requirements would be subject to a civil money penalty. Rules similar to those imposed under the COBRA penalties would apply. The maximum amount of penalty would be $100 for each day for each individual with respect to which a failure occurred. In determining the penalty amount, the Secretary of HHS would have to take into account the previous record of compliance of the person being assessed with the applicable requirements of this subtitle, the gravity of the violation, and the overall limitations for unintentional failures provided

under the IRC COBRA provisions. No penalty could be assessed if the failure was not intentional or if the failure was corrected within 30 days. A procedure would be available for administrative and judicial review of a penalty assessment. Collected penalties would be paid to the Secretary of HHS and would be available for the purpose of enforcing the provisions with respect to which the penalty was imposed.

The authority for the Secretary of HHS to impose civil money penalties would not apply to enforcement with respect to any entity which offered health insurance coverage and which was an insurer or HMO subject to state regulation by an applicable state authority if the Secretary of HHS determined that the state had established an effective enforcement plan. In no case would a civil money penalty be imposed under this provision for a violation for which an excise tax under COBRA or civil money penalty under ERISA was assessed.

Senate amendment

No provision.

Conference agreement

The conference agreement provides that each state may require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the state in the small or large group markets meet the Act's requirements. In the case of a determination by the Secretary of HHS that a state has failed to substantially enforce a provision or provisions of part A with respect to health insurance issuers in the state, the Secretary would enforce such provision or provisions insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans in the state. Secretarial enforcement would apply only in the absence of state enforcement and with respect to group health plans that are nonfederal governmental plans.

In the case of a failure by a health insurance issuer, the issuer is liable for any penalty. In the case of failure by a group health plan that is a nonfederal governmental plan, the plan is liable if it is sponsored by 2 or more employers; otherwise the employer is liable. Rules similar to those imposed under the COBRA penalties would apply. The maximum amount of penalty for noncompliance would be $100 per day per individual. In determining the penalty amount, the Secretary of HHS would have to take into account the previous record of compliance and the gravity of the violation. No penalty could be assessed if the failure was not intentional or if the failure was corrected within 30 days. A procedure would be available for administrative and judicial review of a penalty assessment. Collected penalties would be paid to the Secretary of HHS and would be available for the purpose of enforcing the provisions with respect to which the penalty was imposed.

4. Coordination in administration

Current law

Section 506 of ERISA provides for coordination of other federal agencies (e.g., the Internal Revenue Service) with the Department of Labor in enforcing ERISA.

House bill

The House bill would require the Secretaries of Treasury, Labor, and HHS to issue regulations that are not duplicative to carry out this subtitle. The bill would require these regulations to be issued in a manner that assures coordination and nonduplication in their activities under this subtitle.

Senate amendment

No provision.

Conference agreement

The conference agreement provides that the Secretaries of Treasury, Labor, and HHS would ensure, through execution of an interagency memorandum of understanding, that regulations, rulings, and interpretations are administered so as to have the same effect at all times. It requires the Secretaries to coordinate enforcement policies for the same requirements to avoid duplication of enforcement efforts and assign priorities in enforcement.

It is the intent of the conferees that the committees of jurisdiction should work together to assure the coordination of policies under this Act. Such coordination is considered necessary to maintain consistency in the IRC, ERISA, and the PHS Act.

III. AVAILABILITY, PORTABILITY, AND RENEWABILITY REQUIREMENTS ON INSURERS, HMOS, AND ISSUERS OF HEALTH PLANS IN THE GROUP MARKET

Current law

The McCarran Ferguson Act of 1945 (P.L. 79–15) exempts the business of insurance from federal antitrust regulation to the extent that it is regulated by the states and indicates that no federal law should be interpreted as overriding state insurance regulation unless it does so explicitly. Section 514(b)(2)(A) of ERISA leaves to the states the regulation of insurance. (Employee benefit plans are not insurance and are regulated by the federal government.)

House bill

The House bill would establish federal requirements on insurers and HMOs selling in the group market to provide for guaranteed availability of health insurance coverage.

Senate amendment

The Senate Amendment is similar but would apply requirements to health plan issuers offering plans in the group market.

Conference agreement

The conference agreement establishes federal requirements on health insurance issuers offering group health insurance coverage to provide for guaranteed availability of health insurance coverage.

A. DEFINITIONS

Current law

No provision.

House bill

The House bill would define insurer to mean an insurance company, insurance service, or insurance organization which is licensed to engage in the business of insurance in a state and which (except for the purposes of individual health insurance availability provisions of this subtitle) is subject to state law which regulates insurance within the meaning of section 514(b)(2)(A) of ERISA.

The House bill would define a health maintenance organization to mean (a) a federally qualified HMO, (b) an organization recognized under state law as an HMO, or (c) a similar organization regulated under state law for solvency in the same manner and extent as an HMO, if (other than for the purposes of individual health insurance availability provisions of the bill) it is subject to state law which regulates insurance within the meaning of section 514(b)(2) of ERISA.

Under the House bill, a bona fide association would be defined as an association which (a) has been actively in existence for at least 5 years; (b) has been formed and maintained in good faith for purposes other than obtaining insurance; (c) does not condition membership in the association on health status; (d) makes health insurance coverage offered through the association available to any individual who is a member (or dependent of a member) of the association at the time the coverage is initially issued; (e) does not make health insurance coverage offered through the association available to any member who is not a member (or dependent of a member) of the association at the time coverage is initially issued; (f) does not impose preexisting condition exclusions consistent with the requirements of this bill relating to group health plans; and (g) provides for renewal and continuation of coverage consistent with the requirements of this bill.

Senate amendment

The Senate Amendment would define health plan issuer as any entity that is licensed (prior to or after the date of enactment of this Act) by a state to offer a group health plan or an individual health plan.

The Senate Amendment does not use the terms health maintenance organization, or bona fide association.

Conference agreement

The conference agreement defines a health insurance issuer as an insurance company, insurance service, or insurance organization, including an HMO, which is licensed to engage in the business of insurance in a state and which is subject to state law which regulates insurance within the meaning of section 514(b)(2) of ERISA. A group health plan is not a health insurance issuer.

An HMO is: (a) a federally qualified HMO, (b) an organization recognized under state law as an HMO, or (c) a similar organization regulated under state law for solvency in the same manner and extent as an HMO.

A bona fide association is an association which: (a) has been actively in existence for at least 5 years; (b) has been formed and maintained in good faith for purposes other than obtaining insurance; (c) does not condition membership in the association on any health status-related factor; (d) makes health insurance coverage offered through the association available to any member, or individuals eligible for coverage through such member, regardless of any health status-related factor; (e) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and (f) meets additional requirements as may be imposed under state law.

B. GUARANTEED AVAILABILITY OF COVERAGE

Current law

No provision.

House bill

The House bill would require each insurer or HMO offering health insurance coverage in the small group market to accept every small employer in the state that applied for coverage and to accept for enrollment under such coverage every eligible individual who applied for enrollment during the initial enrollment period in which the individual first became eligible for the group coverage. No restriction could be imposed on an eligible individual based on his or her health status. An eligible individual is determined in accordance with the terms of the plan consistent with all applicable state laws.

Senate amendment

The Senate Amendment would require a health plan issuer offering a group health plan to accept the whole group desiring to purchase the coverage. A health plan issuer offering a group health plan could not condition eligibility, continuation of eligibility, enrollment, or premium contribution requirements based on health status. (Health status is defined the same as under the House bill.)

Conference agreement

The conference agreement requires each health insurance issuer that offers health insurance coverage in the small group market in a state to accept every small employer in

the state that applies for coverage, and to accept for enrollment under such coverage every eligible individual who applies for enrollment during the period in which the individual first became eligible to enroll under the terms of the group health plan. The health plan issuer may not impose restrictions on any eligible individual being a participant or beneficiary based on his or her health status, or the health status of dependents. An eligible individual is determined in accordance with the terms of the plan, as provided by the health insurance issuer under the rules of the issuer which are uniformly applicable in a state to small employers in the small group market, and consistent with all applicable state laws governing the issuer and market.

1. Scope of requirement

Current law

No provision.

House bill

The House bill provides that the guaranteed availability requirement apply to the small group market only. Small groups are those with 2 to 50 employees.

Senate amendment

The Senate Amendment provides that the guaranteed availability requirement apply to all health plan issuers and group health plans.

Conference agreement

The conference agreement provides that the guaranteed availability requirement applies to the small group market only. Small groups are those with 2 to 50 employees on a typical business day.

To assure access in the large group market, the conference agreement provides that the Secretary of HHS request that the chief executive officer of each state submit a report on the access of large employers to health insurance coverage and the circumstances for lack of access to coverage, if any, of large employers, and classes of employers. The Secretary shall request the reports not later than December 31, 2000 and every 3 years thereafter. Based on the state reports and other information, the Secretary would be required to prepare a report for Congress, every 3 years, describing the access to health insurance for large employers, and classes of employers in each state. The Secretary may include recommendations to assure access.

In addition, the Comptroller General will submit to Congress not later than 18 months after the date of enactment of this act, a report on access of classes of large employers to health insurance coverage in the different states, and the circumstances for lack of access, if any.

2. Restrictions on preexisting condition limitation periods

Current law

No provision.

House bill

The House bill would provide for the same restrictions on the use of preexisting condition limitations by each insurer and HMO that offers health insurance coverage in connection with a group health plan as those described in above item II–(C).

Senate amendment

The Senate amendment would provide for the same restrictions on the use of preexisting condition limitations by health plan issuers as described in above item II–(C).

Conference agreement

The conference agreement provides us for the same restrictions on the use of preexisting condition limitations by each health insurance issuer that offers group health insurance coverage as those described in above item II–(C).

3. Exceptions to guaranteed availability

Current law

No provision.

House bill

The House bill would provide that an HMO or an insurer offering coverage in the small group market through a network plan could: (1) limit employers for such coverage to those with eligible individuals whose place of employment or residence was in the plan's or HMO's service area; (2) limit the individuals who might be enrolled to those whose place of residence or employment was within the service area; (3) within the service area, deny coverage if the plan or HMO demonstrated lack of capacity to deliver services adequately, but only if it was applying the capacity limit to all employers without regard to the group's claims experience or the health status of its participants and beneficiaries. Those denying coverage on the basis of capacity could not offer small groups coverage in the service area for 180 days. Similar exceptions would apply in the event of financial capacity limits.

Senate amendment

The Senate amendment would provide that a health plan issuer offering a group health plan could cease offering coverage to group purchasers if (1) the plan ceased to offer coverage to any additional group purchasers, and (2) the issuer could demonstrate to the applicable certifying authority that its financial or provider capacity would be impaired if the issuer were required to offer coverage to additional group purchasers. Such an issuer would be prohibited from offering coverage for 6 months or until the issuer could demonstrate that the capacity was adequate, whichever was later. An issuer would only be eligible for this exception if it offered coverage on a first-come-first-served basis or other basis established by a state to ensure a fair opportunity to enroll and avoid risk selection.

Conference agreement

The conference agreement provides that a health insurance issuer offering coverage in the small group market through a network plan could: (1) limit employers for such coverage to those with eligible individuals who live, work, or reside in the service area for the network plan; (2) within the service area, deny coverage to small employers if the issuer has demonstrated, if required, to the applicable state authority, the lack of capacity to deliver services adequately to additional groups, but only if it was applying the capacity limit to all employers uniformly without regard to claims experience or any health status-related factor. An issuer denying coverage on the basis of capacity could not offer coverage in the small group market in the service area for 180 days.

A health insurance issuer may deny coverage in the small group market if the issuer has demonstrated, if required, to the applicable state authority, that it does not have the financial reserves necessary to underwrite additional coverage. The issuer would be required to apply the financial capacity limit to all employers in the small group market in the state, consistent with applicable state law, and without regard to claims experience or health status-related factors. An issuer denying coverage on the basis of financial capacity could not offer coverage in the small group market in the service area for 180 days or until the issuer has demonstrated, if required, to the applicable state authority, that it has adequate capacity, whichever is later. A State may provide for determination of adequate capacity on a service-area-specific basis. It is the intent of the conferees that an issuer denying coverage on the basis of capacity limitations may demonstrate compliance if enrollment is provided on a first-come first-serve basis, or other state approved method.

The conference agreement imposes requirements for renewal and continuation on issuers offering health insurance plans to bona fide associations, but does not require these issuers to guarantee issue of the coverage offered to bona fide associations. The conferees do not intend the provision to mean that issuers of coverage to an association have to offer a particular association plan to any other employer. Thus issuers offering coverage to associations are not required to guarantee issue the association's plan to other small employers. Nondiscrimination rules would apply to these association plans, and no employee or dependent could be excluded from coverage on the basis of any health status-related factor.

The conference agreement provides exceptions to the availability, renewability and portability requirements for group health plans and group health insurance coverage for certain benefits, sometimes under certain conditions. First, these requirements would not apply to provision of certain excepted benefits including: coverage only for accident, or disability insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and, other similar coverage, as specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

Second, if the following benefits are (a) provided under a separate policy, certificate, or contract or insurance, or (b) if the benefits are otherwise not an integral part of the plan, the requirements would not apply to: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or, similar limited benefits as specified in regulations.

Third, if the following benefits: (a) are provided under a separate policy, certificate, or contract of insurance; (b) there is no coordination between the provision of these benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and (c) such benefits are paid with respect to an event without regard to whether benefits are provided for that event under any group health plan maintained by the same plan sponsor, the requirements would not apply to: coverage only for a specified disease or illness, or hospital indemnity or other fixed indemnity insurance.

Fourth, if the following benefits are provided under a separate policy, certificate, or contract of insurance, the requirements would not apply to: Medicare supplemental health insurance; coverage supplemental to coverage provided under military health care; and, similar supplemental coverage provided to coverage under a group health plan.

4. Exceptions for failure to meet participation or contribution rules

Current law

No provision.

House bill

The House bill would provide that an exception to the guaranteed availability requirement would apply in the case of any group health plan which failed to meet the participation or contribution rules of the insurer or HMO. Such participation and contribution rules would have to be uniformly applicable and in accordance with state law.

Senate amendment

No provision.

Conference agreement

The conference agreement provides that an exception to the guaranteed availability requirement would apply in the case of any group health plan which failed to meet the participation or contribution rules of the health insurance issuer. Such participation and contribution rules would have to be in accordance with state law.

C. GUARANTEED RENEWABILITY

Current law

No provision.

House bill

The House bill would provide that regardless of the size of the group, insurers and HMOs would be required to renew or continue in force coverage at the option of the covered employer with certain exceptions.

Senate amendment

The Senate provision is similar but at the option of the group purchaser.

Conference agreement

The conference agreement provides that a health insurance issuer offering group health insurance coverage in the small or large group market would be required to renew or continue in force coverage at the option of the plan sponsor of the plan.

1. Exceptions to guaranteed renewability of group coverage

Current law

No provision.

House bill

The House bill would provide exceptions to the guaranteed renewability requirement for: nonpayment of premiums, fraud, violation of participation and contribution rules, termination of the plan in a state or geographic area, or the employer moved outside the service area (but only if this last provision was applied uniformly without regard to health status). Exceptions to guaranteed renewability would also apply in the event that the insurer or plan no longer offered a particular type of coverage but only if prior notice was provided, the employer was given the chance to buy another plan offered by the insurer or HMO, and the termination was applied uniformly without regard to health status or insurability. An exception would also apply in the event of discontinuance of all coverage, but only if certain conditions were met. In this instance, the insurer or HMO could not market small and/or large group coverage for 5 years.

Senate amendment

The Senate Amendment is similar. It would include as exceptions to the guaranteed renewability requirement the loss of eligibility of COBRA continuation coverage, and failure of a participant or beneficiary to meet requirements for eligibility for coverage under the group health plan that are not prohibited by this subtitle.

A network plan could deny continued participation under the plan to participant or beneficiaries who did not live, reside, or work in an area in which the plan was offered, but only if the denial was applied uniformly, without regard to health status or insurability.

The provisions relating to discontinuation of a plan or of coverage in general are similar to the House bill.

Conference agreement

The conference agreement provides exceptions to the guaranteed renewability requirement for one or more of the following: (1) nonpayment of premiums; (2) fraud; (3) violation of participation or contribution rules; (4) termination of coverage in the market in accordance with applicable state law, as outlined below; (5) for network plans, no enrollees connected to the plan live, reside, or work in the service area of the issuer, or area for which the issuer is authorized to do business, and, in the case of the small group market only if the issuer would deny enrollment to the plan under regulations governing guaranteed availability of coverage; (6) for coverage made available to bona fide associations, if membership in the association ceases, but only if coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

Exceptions to guaranteed renewability would also apply if the issuer or plan no longer offered a particular type of group coverage in the small or large group market so long as the issuer, in accordance with applicable state law: (1) provided prior notice to each plan sponsor and participants and beneficiaries; (2) gave the plan sponsor the chance to purchase all (or, in the case of the large group market, any) other plans offered by the issuer in such market; and (3) applied the termination uniformly without regard to the claims experience of the sponsors or any health status-related factor to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

An exception would also apply in the event of discontinuance of all coverage, but only if certain conditions were met. In this instance, the issuer could not offer coverage in the market and state involved for 5 years.

Issuers would be permitted to modify the health insurance coverage for a product offered to a group health plan in the large group market, and in the small group market if the modification was effective on a uniform basis among group health plans with that product.

For example, the conferees intend that issuers could uniformly modify the terms of treatment for particular conditions among group health plans within a type of coverage. An exception would apply to coverage available in the small group market only through 1 or more bona fide associations. Issuers could modify a product offered to a group plan in the large group market.

See section B(3) above for exceptions from availability, renewability, and portability requirements for certain benefits.

D. DISCLOSURE OF INFORMATION BY HEALTH PLAN ISSUERS

Current law

Section 101 of ERISA requires covered plans to furnish summary plan descriptions and other information and notices to plan participants and the Secretary of Labor. Section 104 of ERISA requires covered plans to file certain information with the Secretary of Labor and to furnish certain information to plan participants.

House bill

The House bill does not include a provision.

Senate amendment

The Senate Amendment would require that in connection with the offering of any group health plan to a small employer (defined under state law or, if not so defined, one with not more than 50 employees), that a health plan issuer make a reasonable disclosure as part of its solicitation and sales materials of certain information, such as the provisions of the plan concerning the right of the issuer to change premium rates and the factors that could affect such changes, the provision of the plan relating to renewability and any preexisting condition provisions, and descriptive information about the plan's benefits and premiums. The information would have to be understandable by the average small employer and sufficiently accurate and comprehensive to reasonably inform employers, participants, and beneficiaries of their rights and obligations under the plan. These requirements would not apply to proprietary and trade secret information under applicable law and do not preempt state reporting and disclosure requirements.

The Senate Amendment would amend section 104(b)(1) of ERISA relating to the summary plan description to provide that if there is a modification or change described in the summary plan description that is a material reduction in covered services or benefits provided, a summary of such changes would have to be furnished to participants within 60 days after the date of its adoption. Alternatively, plans sponsors could provide such a description at regular intervals of not more than 90 days. The bill requires the Secretary of Labor to issue regulations providing alternative mechanisms to delivering by mail through which employee benefit plans may notify participants of material reductions in covered services. It further amends the summary plan description provisions of ERISA to require the inclusion of certain information.

Conference agreement

The conference agreement requires a health plan issuer offering any health insurance coverage to a small employer to make a reasonable disclosure of the availability of information as part of its solicitation and sales materials. At the small employer's request, the issuer must provide the provisions of the plan concerning the right of the issuer to change premium rates and the factors that could affect such changes, the provisions of the plan relating to renewability and any preexisting condition provisions, and the benefits and premiums under all health insurance coverage for which the employer is qualified. The information would have to be understandable by the average small employer and sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage. These requirements would not apply to proprietary and trade secret information under applicable law.

The conference agreement would amend section 104(b)(1) of ERISA relating to the summary plan description to provide that if there is a material reduction in covered services or benefits, a summary of such changes would have to be furnished to participants within 60 days after the date of its adoption. Alternatively, plan sponsors could provide a description at regular intervals of not more than 90 days. The conference agreement requires the Secretary of Labor to issue regulations within 180 days of enactment of this Act which would provide for alternative mechanisms, besides delivery by mail, through which employee benefit plans may notify participants of material reductions in covered services. It further amends the summary plan description provisions of ERISA to require the inclusion of certain information.

The conference agreement would amend section 101 of ERISA to permit the Secretary, in accordance with regulations prescribed by the Secretary, to require MEWAs that provide medical care benefits, but are not group health plans, to report, not more frequently than annually, in such form and manner as the Secretary may require to determine the extent to which the requirements of this part are being carried out.

E. STATE FLEXIBILITY

Current law

The McCarran Ferguson Act of 1945 (P.L. 79–15) exempts the business of insurance

from federal antitrust regulation to the extent that it is regulated by the states and indicates that no federal law should be interpreted as overriding state insurance regulation unless it does so explicitly. Section 514 of ERISA leaves to the states the regulation of insurance. (Employee benefit plans are not insurance and are regulated by the federal government.)

House bill

The House bill would provide that unless preempted by section 514 of ERISA, state laws would not be preempted that (1) related to matters not specifically addressed in subtitles A and B, or (2) that required insurers or HMOs to: (a) impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition for periods shorter than specified in the bill, (b) allowed persons to be considered to be in a period of previous qualifying coverage if they experienced a lapse in coverage greater than 60 days, or (c) had a look-back provision shorter than 6 months.

Senate amendment

The Senate Amendment does not include ''related to matters not specifically addressed in subtitles A and B.'' The Senate Amendment would provide that unless preempted by section 514 of ERISA, state laws would not be preempted that (1) required health plan issuers to impose a limitation or exclusion of benefits relating to the treatment of a preexisting condition for periods that are shorter than specified in the bill; (2) allowed individuals, participants, and beneficiaries to be considered in a period of previous qualifying coverage if such person experienced a lapse in coverage that was greater than the 30-days provided under this bill; or (3) required issuers to have a lookback period shorter than provided for under this subtitle.

Conference agreement

The conference agreement provides that any provision of state law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with health insurance coverage would not be superseded unless the state standard or requirement prevents the application of a federal requirement of this part. Nothing in this part of the Act would affect or modify the provisions of section 514 of ERISA with respect to group health plans.

The conferees intend the narrowest preemption. State laws which are broader than federal requirements would not prevent the application of federal requirements. For example, states may require guaranteed availability of coverage for groups of more than 50 employees, or for groups of 1.

The conference agreement provides special rules in the case of portability requirements. State laws applicable to a preexisting condition exclusion which differ from the standards or requirements specified in this part would be superseded except if they: (1) shorten the lookback period in determination of a preexisting condition limitation (from 6 months to any shorter period of time); (2) shorter the length of a preexisting condition limitation exclusion (from 12 months, or 18 months for late enrollees, to any shorter period); (3) lengthen the break in coverage time from 63 days to any greater number; (4) lengthen the time for enrollment of newborns, or certain children adopted or placed for adoption, from 30 days to any greater number; (5) prohibit the imposition of any preexisting condition exclusions in cases not described, or expand the exclusions described; (6) require additional special enrollment periods; (7) reduce the maximum period permitted in an affiliation period.

A group health plan or health insurance coverage is not required to provide specific benefits other than those provided under the terms of such plan or coverage.

IV. Individual Market Rules

Current law

The individual health insurance market is currently regulated by the states. As of December, 1995, 11 states required that individual insurers write policies on a guaranteed issue basis; 16 states required guaranteed renewal; and 22 states limited the use of preexisting condition limitation periods.

House bill

The House bill would provide for federal requirements to guarantee availability of individual health insurance coverage to certain qualified individuals with prior group coverage, without limitation or exclusion of benefits, and to guarantee renewability of individual health insurance coverage.

Senate amendment

Similar.

Conference agreement

The conference agreement provides for federal requirements to guarantee availability of individual health insurance coverage to certain qualified individuals with prior group coverage, without limitation or exclusion of benefits, and to guarantee renewability of individual health insurance coverage.

A. GUARANTEED AVAILABILITY OF INDIVIDUAL HEALTH INSURANCE COVERAGE

Current law

No provision.

House bill

The House bill would include goals that any qualifying individual would be able to obtain qualifying coverage and that qualifying individuals would receive credit for prior coverage toward the new coverage's preexisting condition exclusion period, if any. If states fail to implement programs meeting these goals, a federal fall back requirement would take effect requiring that each individual insurer enroll all eligible individuals and that such persons receive credit for their prior coverage toward any preexisting condition limitation period. (See item IV(D) below on exceptions for network plans and HMOs.)

The House bill would require that any preexisting condition exclusion period be reduced by the length of the aggregate period of qualified prior coverage. To determine qualified coverage, the plan could choose one of two alternatives: (1) it could disregard specific benefits covered and include all periods of coverage from qualified sources; or (2) it could examine prior coverage on a benefit-specific basis, and exclude from qualified coverage any specific benefits not covered under the most recent prior plan. If the second method were chosen, plans would be required to disclose this procedure at the time of enrollment or sale of the plan.

Senate amendment

The Senate Amendment would provide that all health plan issuers that issue or renew individual health plans must enroll all eligible individuals except if the insurer demonstrates that it would have financial problems, or, that its ability to service individuals already enrolled in the plan would diminish if new enrollees were allowed to join the plan. In these cases, the insurer would be prohibited from enrolling new individuals for a period of 6 months, or, if later, when the insurer could demonstrate that they could properly service new entrants. An insurer would have to enroll individuals on a first-come-first-served basis, or other basis determined by the state, to be eligible for this limitation. States implementing guaranteed availability programs meeting certain requirements would be excepted from the federal requirements.

The Senate amendment would provide that a health plan issuer may not impose a limitation or exclusion of benefits on benefits that were covered under prior health plans.

Conference agreement

The conference agreement provides that each health insurance issuer that offers health insurance coverage in the individual market in a state may not decline to offer coverage to, or deny enrollment of an eligible individual and may not impose any preexisting condition exclusions with respect to such coverage. This requirement will not apply in States with acceptable alternative mechanisms as described in section IV(E) below. In addition, in States without an acceptable alternative mechanism, a health insurance issuer may limit the coverage offered as described in section IV(C).

B. QUALIFYING/ELIGIBLE INDIVIDUALS

Current law

No provision.

House bill

The House bill would provide that qualifying individuals are individuals: with 18 or more months of qualified coverage periods; with most recent prior coverage from a group health plan, governmental plan, or church plan; ineligible for group health coverage, Medicare Parts A or B, Medicaid, and without individual coverage; not terminated from most recent prior coverage for nonpayment of premiums or fraud; who, if eligible for continuation coverage under COBRA or similar state program, elected and exhausted this coverage; and who applied for individual coverage not more than 60 days after the last day of coverage under a group plan, or the termination date of COBRA benefits.

Senate amendment

Similar, but individual would have to apply for individual coverage not more than 30 days after the last day of coverage under a group plan.

Conference agreement

The conference agreement defines eligible individuals as individuals: with 18 or more months of aggregate creditable coverage; with most recent prior coverage from a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan); ineligible for group health coverage, Medicare Parts A or B, Medicaid (or any successor program), and without any other health insurance coverage; not terminated from their most recent prior coverage for nonpayment of premiums or fraud; and who, if eligible for continuation coverage under COBRA or a similar state program, elected and exhausted this coverage.

C. QUALIFYING COVERAGE

Current law

No provision.

House bill

The House bill would require coverage with an actuarial value of benefits not less than the weighted average actuarial value of the benefits provided by all the individual health insurance coverage (excluding coverage issued under this section) during the previous year, issued by: (1) the insurer or HMO in the state; or (2) all insurers and HMOs in the state. Requires that the actuarial value of benefits be calculated based on a standardized population and a set of standardized utilization and cost factors.

Senate amendment

No provision.

Conference agreement

The conference agreement requires individual health insurance issuers to offer coverage to eligible individuals under all policy

forms with exceptions. First, a health insurance issuer may not offer coverage under all policy forms if the state is implementing an acceptable alternative mechanism (see section IV(E) below). If a state is not implementing an acceptable alternative mechanism, the health insurance issuer may elect to limit the policy forms offered to eligible individuals so long as it offers at least two different policy forms of health insurance coverage both of which are designed for, made generally available and actively marketed to, and enroll both eligible and other individuals by the issuer. In addition, the 2 policy forms must meet one of the following: (1) the 2 policy forms have the largest and next to the largest premium volume; or (2) the 2 policy forms are representative of individual health insurance coverage by the issuer. An issuer must apply the election uniformly to all eligible individuals in the state for that issuer, and the election will be effective for policies offered for not less than 2 years.

The 2 representative policy forms would include a lower and higher-level of coverage, each of which has benefits substantially similar to other individual health insurance coverage offered by the issuer in the state. The lower-level policy form would have benefits with an actuarial value at least 85 percent, but not greater than 100 percent of a weighted average benefit. The higher-level policy form would have benefits with an actuarial value: (1) at least 15 percent greater than the actuarial value of the lower-level policy form; and (2) between 100 and 120 percent of the weighted average benefit. Both products must include benefits substantially similar to other individual health insurance coverage offered by the issuer in the state. The weighted average may be either: (1) the average actuarial value of the benefits from individual coverage provided by the issuer; or (2) the average actuarial value of the benefits from individual coverage provided by all issuers in the state. The weighted average will be based on coverage provided during the previous year and exclude coverage of eligible individuals. Actuarial values will be calculated based on a standardized population and a set of standardize utilization and cost factors.

Network plans may limit coverage to those who live, reside, or work within the service area for the network plan. Within the service area for the plan, the issuer may deny coverage to individuals if the issuer has demonstrated, if required, to the applicable state authority that it will not have the capacity to deliver services adequately to additional individual enrollees. Denial must be made uniformly to individuals without regard to any health status-related factor and without regard to whether the individuals are eligible individuals. Upon denial, the issuer may not offer coverage in the individual market within the service area for 180 days. Similar rules apply for financial capacity limits.

D. GUARANTEED RENEWAL

Current law

No provision.

House bill

The House bill would require that individual coverage is renewable at the option of the individual except for: nonpayment; fraud; termination of all individual coverage by the insurer or HMO, or termination of coverage in a geographic area in the case of network or HMO plan; movement of the individual outside the insurer's service area; termination of the particular type of coverage by the insurer or HMO, after the insurer has provided 90 day notice, offered the option to purchase any other coverage, and acted without regard to health status or insurability; discontinuation of all individual coverage by the insurer or HMO, after 180 days notice; uniform modification of all health plans within the individual's type of coverage.

Senate amendment

The Senate Amendment would require that individual coverage is renewable at the option of the individual except for: nonpayment; fraud; termination of the particular type of coverage by the insurer or HMO, which has provided 90 day notice, offered the option to purchase any other coverage, and acted without regard to health status or insurability; termination of all individual coverage by the insurer or HMO, after 180 days notice, and prohibition against market reentry for 5 years; change such that the individual lives or works outside the insurer's service area but only if denial of coverage is applied uniformly without regard to the health status or insurability of the individual.

Conference agreement

The conference agreement provides that a health insurance issuer that provides individual health insurance coverage to an individual must renew or continue in force such coverage at the option of the individual. It provides exceptions to the guaranteed renewability requirement for one or more of the following: (1) nonpayment of premiums or untimely payment; (2) fraud; (3) termination of coverage in the market (as outlined below) in accordance with applicable state law; (4) for network plans, the individual no longer lives, resides, or works in the service area of the issuer, or area for which the issuer is authorized to do business but only if coverage is terminated uniformly without regard to any health status-related factor; (5) for coverage made available to bona fide associations, if membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor.

An issuer may discontinue a particular type of coverage in the individual market only if the issuer: (1) provides prior notice to each covered individual; (2) offers each individual the option to purchase any other individual health insurance coverage offered by the issuer for individuals; and (3) acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage. An issuer may elect to discontinue offering all health insurance coverage in the individual market in a state only if certain conditions are met. In this case, the issuer could not issue coverage in the market and state involved for 5 years. Issuers could modify the health insurance coverage for a policy form offered to individuals in the individual market so long as the modification was consistent with state law and was effective on a uniform basis among all individuals with that policy form.

In the case of health insurance coverage that is made available by a health insurance issuer in the individual market to individuals only through one or more associations, the issuer would be required to meet the Act's requirements related to individuals.

Health insurance issuers in the individual market must provide certifications of coverage in the same manner as health insurance issuers in the small group market.

E. OPTIONAL STATE PROGRAMS/STATE FLEXIBILITY

1. In general

Current law

No provision.

House bill.

The House bill would provide that a state may establish public or private mechanisms to meet the goals of guaranteed availability of coverage. The chief executive officer of the state must notify the Secretary of HHS if the state elects to use state mechanisms. Under a state mechanism, a state may define qualified coverage as coverage with benefits not less than the weighted average actuarial value of the benefits provided by all the individual health insurance coverage (excluding coverage issued under this section) during the previous year, issued by: the insurer or HMO in the state; or all insurers and HMOs in the state. The state may elect to establish qualified coverage for all insurers and HMOs in the state after it has established qualified coverage for each insurer or HMO.

State mechanisms could include one or more, or a combination of: health insurance coverage pools or programs authorized or established by the state; mandatory group conversion policies; guaranteed issue of one or more plans; or open enrollment by one or more insurers or HMOs. This list is not exclusive.

A state with a health insurance coverage pool or risk pool in effect on March 12, 1996, which offers qualified coverage, would automatically be considered to have met the Federal access objectives.

In general, states would have until July 1, 1997 to implement a state program. States without a regular legislative session between January 1, 1997 and June 30, 1997 would have a deadline of July 1, 1998.

Senate amendment

Similar. The Senate Amendment would provide that a state may adopt alternative public or private mechanisms to provide access to affordable health benefits for eligible individuals. The Governor of the state must notify the Secretary of Health and Human Services that the state has adopted an alternative mechanism which achieves the goals of portability and renewability, and that the state intends to implement this mechanism.

State mechanisms could include guaranteed issue, open enrollment by one or more health plan issuers, high-risk pools, mandatory conversion policies, or any combination of these mechanisms. A state high risk pool would meet the portability and renewability requirements if it is: (a) open to eligible individuals; (b) limits preexisting condition waiting periods; and (c) is consistent with premium rates and covered benefits in the National Association of Insurance Commissioners (NAIC) Model Health Plan for Uninsurable Individuals Act. States which adopt a NAIC model act, including group to individual market portability provisions that meet the Federal portability and renewability goals, would not be subject to federal rules.

A state may notify the Secretary, within 6 months after enactment of this Act, that state alternate mechanism(s) would meet portability and renewability goals. The Secretary would not determine if the state mechanism meets the goals until 12 months after the initial state notification, or January 1, 1998, whichever is later. The Secretary would not make a determination until January 1, 1999 for states without legislative sessions within the 12 months after enactment of this Act.

Conference agreement

The conference agreement provides that a state may implement an acceptable alternative mechanism that is designed to provide access to health benefits for individuals. This mechanism must: (1) provide a choice of health insurance coverage to all eligible individuals; (2) not impose any preexisting condition exclusions; and (3) include at least one policy form of coverage that is comparable to either comprehensive health insurance coverage offered in the individual market in

the state or a standard option of coverage available under the group or individual health insurance laws in the state. If a state elects to implement the following mechanisms, the state must also meet the preceding requirements. These mechanisms are: (1) the NAIC Small Employer and Individual Health Insurance Availability Model Act (as it applies to individual health insurance coverage) or the Individual Health Insurance Portability Model Act; (2) a qualified high risk pool that meets certain specified requirements; or (3) other mechanisms that provide for risk adjustment, risk spreading, or a risk spreading mechanism (by an issuer or among issuers or policies of an issuer), or otherwise provide some financial subsidies for participating insurers or eligible individuals, or, alternatively, a mechanism under which each eligible individual is provided a choice of all individual health insurance coverage otherwise available.

Examples of potential alternative mechanisms include health insurance coverage pools or programs, mandatory group conversion policies, guaranteed issue of one or more plans of individual health insurance coverage, or open enrollment by one or more health insurance issuers, or a combination of such mechanisms.

A state is presumed to be implementing an acceptable alternative mechanism as of January 1, 1998, by not later than July 1, 1997, the chief executive officer of the state notifies the Secretary that the state has enacted any necessary legislation as of January 1, 1998 and provides the Secretary with information needed to review the mechanism and its implementation, or proposed implementation. The state must provide this information to the Secretary every 3 years to continue to be presumed to have an acceptable alternative mechanism. If a state submits notice and information after July 1, 1997, and the Secretary makes no determination within 90 days, the mechanism will be considered acceptable after 90 days.

F. CONSTRUCTION/PREEMPTION

Current law

No provision.

House bill

The House bill would provide that states are not prevented from: (1) implementing guaranteed availability mechanisms before the deadline; (2) continuing state mechanisms that were in effect before the enactment of this act; (3) offering guaranteed availability of coverage that is not qualifying coverage; or (4) offering guaranteed availability of coverage to individuals who are not qualifying individuals

Senate amendment

The Senate Amendment would provide that states are not required to replace or dissolve high risk pools or other similar state mechanisms which are designed to provide individuals in those states with access to health benefits.

Conference agreement

The conference agreement provides that nothing in this part would prevent a state from establishing, implementing, or continuing in effect standards and requirements unless they prevent the application of a requirement in this part. Nothing in this part would affect or modify the provisions of section 514 of ERISA.

G. FEDERAL RULES (FALLBACK OR IN ABSENCE OF STATE ALTERNATIVE)

Current law

No provision.

House bill

The House bill would provide that the Secretary of HHS notify a state that federal rules would apply if: (1) the state has not elected to use a state mechanism; or (2) if the Secretary finds, after consultation with state officials, that the state mechanism would not meet the federal availability goals, and the state has had reasonable opportunity to change or implement a state mechanism to meet the goals.

Federal rules would provide that each insurer or HMO which issues individual health insurance coverage in the state would have to offer qualifying coverage to qualifying individuals, and credit prior coverage toward any preexisting condition exclusion periods. In addition, no individual could be refused coverage based on health status. Network plans or HMOs could refuse coverage to individuals who did not reside or work in the plan's service area, or if network or financial capacity limits would be exceeded. Federal rules would cease to apply if the state implements a mechanism designed to meet the federal goals of availability.

Senate amendment

The Senate Amendment would provide that federal standards would apply if the state does not notify the Secretary of HHS of its intent to implement state mechanisms, or if the Secretary finds that the state mechanism fails to: (1) offer coverage to eligible individuals; (2) prohibit preexisting condition limitations or exclusions for benefits covered under previous health plans; (3) offer eligible individuals a choice of individual health plans, including at least one comprehensive plan, or a plan comparable to a standard option plan available under the group or individual health insurance laws of the state; or (4) implement a risk spreading mechanism, cross subsidy mechanism, risk adjustment mechanism, rating limitation or other mechanism designed to reduce the variation in costs of coverage for eligible individuals and other plans offered by the carrier or available in the state.

The bill would waive the requirement for a risk spreading mechanism if all individual health plans available in the market are also available to eligible individuals.

It would provide that if the Secretary determines that the state alternative mechanism fails to meet the above criteria, or if the state mechanism is no longer being implemented, the Secretary would have to notify the Governor of the failure to meet the goals of portability and renewability, and permit the state to come into compliance. Federal individual health plan portability rules would apply if the state still does not meet these criteria. Under these rules, a plan issuer could not, with respect to an eligible individual, decline to offer coverage to or deny enrollment of the individual or impose a limitation or exclusion of benefits, otherwise available under the plan, for which coverage was available under the group health plan or employee health benefit plan in which the person was previously enrolled. (This would not prevent a health plan issuer from establishing premium discounts or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion or disease prevention.)

Future adoptions of a state mechanism would be subject to the same procedures of: (1) notification of the Secretary; and (2) determination of satisfaction of criteria for compliance, except in the cases of adoption of the NAIC model or high risk pool.

Conference agreement

The conference agreement provides that if the Secretary finds that the state mechanism is not acceptable or is no longer being implemented, the Secretary must notify the state of the preliminary determination and consequences of failure to implement an acceptable mechanism. The state will have a reasonable opportunity to modify the mechanism, or adopt a new mechanism. If the Secretary finds that the state mechanism is not acceptable, or is not being implemented, the Secretary must notify the state of the effective date of federal requirements for guaranteed availability. Each issuer would then be required to guarantee issue health insurance coverage to any individual, but could limit coverage to 2 policy forms as outlined in section IV(C) above. Secretarial authority would be limited to determinations based only on whether a state mechanism is not an acceptable alternative mechanism or is not being implemented. It is the intent of Congress that the risk adjustment, risk spreading, risk spreading mechanism and financial subsidization standards provide meaningful financial protection and assistance for eligible individuals, both in the case of a state alternative system and alternative coverage provided under section 2741(c).

H. CONSTRUCTION (PREMIUMS, MARKET REQUIREMENTS, ASSOCIATION COVERAGE AND MARKETING)

Current law

No provision.

House bill

The House bill would provide that insurers or HMOs are free to determine the premiums for individual health insurance coverage under applicable state law. Insurers or HMOs which only insure groups or associations would not be required to offer individual health insurance coverage. Insurers or HMOs that offer conversion policies in connection with a group health plan would not be required to offer individual coverage. Insurers or HMOs that offer coverage only in connection with a group health plan or in connection with individuals based on affiliation with one or more bona fide associations would not be considered to be offering individual coverage.

A state could require that insurers or HMOs offering individual coverage actively market this coverage.

Senate bill

The Senate Amendment is similar but did not include a provision relating to associations.

Conference agreement

Premiums that an issuer may charge an individual for individual health insurance coverage are not restricted by the conference agreement, but must comply with state law. The health insurance issuer may establish premium discounts or rebates, or modify otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Under the conference agreement, health insurance issuers offering health insurance coverage in connection with group health plans, or through one or more bona fide associations, or both, are not required to offer health insurance coverage in the individual market. A health insurance issuer offering group health coverage is not considered to be a health insurance issuer offering individual health insurance coverage solely because the issuer offers a conversion policy.

I. ENFORCEMENT OF REQUIREMENTS ON INDIVIDUAL INSURERS, HMO'S, AND HEALTH PLAN ISSUERS

Current law

Under section 502 of ERISA, employee benefit plans that fail to comply with applicable requirements can be sued for relief and be subject to civil money penalties, and can be sued to recover any benefits due under the plan. Section 504 of ERISA provides the Secretary of Labor with investigative authority

to determine whether any person is out of compliance with the law's requirements. Section 506 provides for coordination and responsibility of agencies in enforcement. Section 510 prohibits a health plan from discriminating against a participant or beneficiary for exercising any right under the plan.

House bill

Noncomplying insurers and HMOs would be subject to enforcement through federal civil money penalties (in the same manner as imposed above (see item II(G)) but only in the event that the Secretary of HHS has determined that the state in which the insurer or HMO is selling coverage is not providing for enforcement.

Senate amendment

Noncomplying individual health plans offered by a health plan issuer would be subject to state enforcement. Each state would require each individual health plan issued, sold, renewed, or offered for sale or operated in the state by a health plan issuer to meet the Act's standards pursuant to an enforcement plan filed with the Secretary of Labor. The state would be required to submit such information as required by the Secretary demonstrating effective implementation of the enforcement plan. In the event that the state failed to substantially enforce the Act's standards and requirements, the Secretary of Labor, in consultation with the Secretary of HHS, would implement an enforcement plan. Issuers would then be subject to civil enforcement as provided under sections 502, 504, 506 and 510 of ERISA. The Secretary of Labor could issue such regulations as needed to carry out this Act.

Conference agreement

Each state may require health insurance issuers that issue, sell, renew, or offer health insurance coverage in the individual market to meet the requirements under this part with respect to such issuers. If a state fails to substantially enforce the federal requirements, the Secretary will provide enforcement in the same manner as in the small group market (see section II(G) above).

V. MULTIPLE EMPLOYER POOLING ARRANGEMENTS

A. CLARIFICATION OF DUTY OF THE SECRETARY OF LABOR TO IMPLEMENT CURRENT LAW PROVIDING FOR EXEMPTIONS FROM STATE REGULATION OF MULTIPLE EMPLOYER HEALTH PLANS (MEHPS)

Current law

Section 3(40) of ERISA defines a multiple employer welfare benefit plan, or any other arrangement which offers or provides health benefits and meets additional criteria, (e.g., it must offer such benefits to the employees or 2 or more employers and cannot be a plan established under a collective bargaining agreement, a rural electric cooperative, or rural telephone cooperative association). Two or more trades or businesses, whether or not incorporated, are deemed a single employer and thus not a MEWA if such trades or businesses are within the same control group.

Section 514 of ERISA treats fully-insured MEWAs differently from those that are not fully-insured (i.e., that are partly or fully-insured). With respect to a fully-insured MEWA, a state may apply and enforce its insurance laws (section 514(b)(6)(A)(i)). With respect to a not-fully-insured MEWA, a state may apply and enforce its insurance laws so long as such laws or regulations are not inconsistent with ERISA (section 514(b)(6)(A)(ii). Section 514(b)(6)(B) provides that the Department of Labor (DOL) may issue an exemption from state law with respect to non-fully-insured MEWAs. (No such exemptions have been issued.)

House bill

The House bill would add a new Part 7 (Rules Governing State Regulation of Multiple Employer Health Plans) to Title I of ERISA.

It would define the following terms: insurer, fully-insured, HMO, participating employer, sponsor, and state insurance comissioner. The House bill would define a multiple employer health plan as a MEWA which provides medical care and which is or has been exempt under section 514(b)(6)(B) of ERISA.

The bill clarifies the conditions under which multiple employer health plans (MEHPs)—non-fully-insured multiple employer arrangements providing medical care—may apply for an exemption from certain state laws. In provides that only certain legitimate association health plans and other arrangements (described below) which are not fully insured are eligible for an exemption. This is accomplished by clarifying the duty of the Secretary of Labor to implement the provisions of current law section 514(b)(6)(B) to provide exemption from state law for MEHPS.

The bill would establish criteria which a not fully-insured arrangement must meet to qualify for an exemption and thus become a MEHP. The Secretary could grant an exemption to an arrangement only if: (1) a complete application has been filed, accompanied by the filing fee of $5,000; (2) the application demonstrates compliance with requirements established in new sections 703 and 704 described below; (3) the Secretary finds that the exemption is administratively feasible, not adverse to the interests of the individuals covered under it, and protective of the rights and benefits of the individuals covered under the arrangement, and (4) all other terms of the exemption are met (including financial, actuarial, reporting, participation, and such other requirements as may be specified as a condition of the exemption). The application must include: (1) identifying information about the arrangement and the states in which it will operate; (2) evidence that ERISA's bonding requirements will be met; (3) copies of all plan documents and agreements with service providers; (4) a funding report indicating that the reserve requirements of new section 705 will be met, that contribution rates will be adequate to cover obligations, and that a qualified actuary (a member in good standing of the American Academy of Actuaries or an actuary meeting such other standards the Secretary considers adequate) has issued an opinion with respect to the arrangement's assets, liabilities, and projected costs; and (5) any other information prescribed by the Secretary. Exempt arrangements must notify the Secretary of any material changes in this information at any time, must file annual reports with the Secretary, and must engage a qualified actuary.

In addition, the bill would provide for a class exemption from section 514(b)(6)(B)(ii) of ERISA for large MEHPs that have been in operation for at least five years on the date of enactment. An arrangement would qualify for this class exemption if, in addition to all other requirements: (1) at the time of application for exemption; the arrangement covers at least 1,000 participants and beneficiaries, or has at least 2,000 employees of eligible participating employers ; (2) a complete application has been filed and is pending; and (3) the application meets requirements established by the Secretary with respect to class exemptions. Class exemptions would be treated as having been granted with respect to the arrangement unless the Secretary provide appropriate notice that the exemption has been denied.

1. Requirements relating to MEHP sponsors, board of trustees, plan operations, and covered persons

The House bill would establish eligibility requirements for MEHPs. Applications must comply with requirements established by the Secretary. They must demonstrate that the arrangement's sponsor has been in existence for a continuous period of at least 5 years and is organized and maintained in good faith, with a constitution and by laws specifically starting its purpose and providing for at least annual meetings, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group, including a corporation or similar organization that operates on a cooperative basis within the meaning of section 1381 of the IRC) for purposes other than that of obtaining or providing medical care. Also, the applicant must demonstrate that the sponsor is established as a permanent entity, has the active support of its members, and collects dues from its members without conditioning such on the basis of the health status or claims experience of plan participants or beneficiaries or on the basis of the member's participation in the MEHP.

The bill would require that the arrangement be operated, pursuant to a trust agreement, by a ''board of trustees'' which has complete fiscal control and which is responsible for all operations of the arrangement. The board of trustees must develop rules of operation and financial control based on a three-year plan of operation which is adequate to carry out the terms of the arrangement and to meet all applicable requirements of the exemption and Title I of ERISA.

With respect to covered persons, the bill would require that all employers who are association members be eligible for participation under the terms of the plan. Eligible individuals of such participating employers cannot be excluded from enrolling in the plan because of health status (as required under section 103 of the Act as described in item I-(B) above). The rules also stipulate that premium rates established under the plan with respect to any particular participating employer cannot be based on the claims experience of the particular employer.

2. Additional entities eligible to be MEHPs

In addition to the associations described above, certain other entities would be provided eligibility to seek an exemption as MEHPs under section 514(b)(6)(B). These include (1) franchise networks (section 703(b)), (2) certain existing collectively bargained arrangements which fail to meet the statutory exemption criteria (section 703(c)), and (3) certain arrangements not meeting the statutory exemption criteria for single employer plans (section 703(d)). (Section 709 of ERISA, added by section 166 of this subtitle, also makes eligible certain church plans electing to seek an exemption.)

3. Other requirements for exemption

The House bill would require a MEHP to meet the following additional requirements: (1) its governing instruments must provide that the board of trustees serves as the named fiduciary and plan administrator, that the sponsor serves as plan sponsor, and that the reserve requirements of new section 705 are met; (2) the contribution rates must be adequate, and (3) any other requirements set out in regulations by the Secretary of Labor must be met.

4. Maintenance of reserves

The House bill would require that MEHPs establish and maintain reserves sufficient for unearned contributions, benefit liabilities incurred but not yet satisfied, and for

which risk of loss has not been transferred, expected administrative costs, and any other obligations and margin for error recommended by the qualified actuary. The minimum reserves must be no less than 25% of expected incurred claims and expenses for the year or $400,000, whichever is greater. The Secretary may provide additional requirements relating to reserves and excess/stop loss coverage and may provide adjustments to the levels of reserves otherwise required to take into account excess/stop loss coverage or other financial arrangements. The bill provides for an alternative means of compliance in which the Secretary could permit an arrangement to substitute, for all or part of the requirements of this section, such security, guarantee, hold-harmless arrangement, or other financial arrangement as the Secretary of Labor determined to be adequate to enable the arrangement to fully meet its financial obligations on a timely basis.

5. Notice requirements for voluntary termination

The House bill would provide that, except as permitted in new section 707 below, a MEHP may terminate only if the board of trustees provides 60 days advance written notice to participants and beneficiaries and submits to the Secretary a plan providing for timely payment of all benefit obligations.

6. Corrective actions and mandatory termination

The House bill would require a MEHP to continue to meet the reserve requirements even if its exemption is no longer in effect. The board of trustees must quarterly determine whether the reserve requirements of new section 705 (as described above) are being met and, if they are not, must, in consultation with the qualified actuary, develop a plan to ensure compliance and report such information to the Secretary. In any case where a MEHP notifies the Secretary that it has failed to meet the reserve requirements and corrective action has not restored compliance, and the Secretary of Labor determines that the failure will result in a continuing failure to pay benefit obligations, the Secretary may direct the board to terminate the arrangement and take action needed to ensure that the arrangement's affairs are resolved in a manner which will result in timely provision of all benefits for which the arrangement is obligated.

7. Temporary application of state laws

a. Provides for exclusion of arrangements from the small group market in any state upon the state's certification of guaranteed access to health insurance coverage in such state (i.e, state opt-out). Provides that a state which certifies to the Secretary that it provides guaranteed access to health coverage may deny a MEHP the right to offer coverage in the small group market (or otherwise regulate such MEHP with respect to such coverage), except as described below. The certification triggering the state opt-out could be in effect no longer than 3 years.

A state is considered to provide such guaranteed access, if (1) the state certifies that at least 90% of all state residents are covered by a group health plan or otherwise have health insurance coverage, or (2) the state has, in the small group market, provided for guaranteed issue of at least one standard benefits package and for rating reforms designed to make health insurance coverage more affordable. In states without such guaranteed access, MEHPs could offer coverage in the small group market in the state as long as they met the standards set forth in Part 7 (as established by this subtitle).

b. Provides for exceptions to the exclusion of MEHPs from state small group markets. Provides a limited exception to the state opt out for certain large, multi-state arrangements. The State opt out would not apply to new and existing MEHPs that meet the following criteria: (1) the sponsor operates in a majority of the 50 states and in at least 2 of the regions of the country; (2) the arrangement covers or will cover at least 7,500 participants and beneficiaries; and (30 at the time the application to become a MEHP is filed, the arrangement does not have pending against it any enforcement action by the state. In addition, the state opt out would not apply in a state in which an arrangement meeting the MEHP standards operates on March 6, 1996, to the extent a state enforcement action is not pending against such an entity at the time an application for an exemption is made.

The above two exceptions do not apply to any state which, as of January 1, 1996, either (1) has enacted a law providing for guaranteed issue of fully community rated individual health insurance coverage offered by insurers and HMOs, or (2) requires insurers offering group health coverage to reimburse insurers offering individual coverage for losses resulting from their offering individual coverage on an open enrollment basis. Regulations may also provide for an exemption to the application of state law for certain single industry plans.

c. Premium tax assessment authority with respect to new arrangements. Provides that a state could assess new association-based MEHPs (formed after March 6, 1996) nondiscriminatory state premium taxes set at a rate no greater than that applicable to any insurer or health maintenance organization offering health insurance coverage in the state. MEHPs existing as of March 6, 1996 would remain exempt from state premium taxes. However, if they expanded into a new state, the state could apply the above rule.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

VI. State Authority Over Non-Exempt MEWAs

Current law

Under section 514(6)(A) of ERISA, a state may apply and enforce state insurance laws with respect to a MEWA so long as the law or regulation is not inconsistent with ERISA.

House bill

The House bill would provide that states have the authority under ERISA to regulate without limitation non-fully-insured MEWAs which are not provided an exemption under new Part 7 of ERISA (see item V above). In other words, states can continue to regulate MEWAs that are not MEHPs.

Senate amendment

No provision.

Conference agreement

the conference agreement does not include the House provision.

VII. Additional MEWA and Related Provisions

A. Clarification of Treatment of Single-Employer Arrangements

Current law

Section 3(40) of ERISA defines a MEWA and specifies the conditions under which two or more trades or businesses shall be deemed a single employer, if such trades or businesses are within the same control group. Common control could not be based on an interest of less than 25%.

House bill

The House bill would modify the treatment of certain single employer arrangements under section 3(40) of ERISA. The treatment of a single employer plan as being excluded from the definition of a MEWA (and thus from state law) is clarified by defining the minimum interest required for two or more entities to be in ''common control'' as a percentage which cannot be required to be greater than 25%. Also a plan would be considered a single employer plan if less than 25% of the covered employees are employed by other participating employers.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

B. Clarification of Treatment of Certain Collectively-Bargained Arrangements

Current law

Under section 3(40) of ERISA, a MEWA is defined not to include any plan or arrangement which is established or maintained under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements, or by a rural electric cooperative. (No such Secretarial finding has ever been issued).

House bill

The House bill would establish the conditions under which multiemployer and other collectively-bargained arrangements are exempted from the MEWA definition, and thus exempt from state law. Amends the definition of a MEWA to exclude a plan or arrangement which is established or maintained under or pursuant to a collective bargaining arrangement (as described in the National Labor Relations Act, the Railway Labor Act, and similar state public employee relations laws). It then specifies additional conditions which must be met for such a plan to be a statutorily excluded collectively bargained arrangement and thus not a MEWA.

These conditions include: (1) The plan cannot utilize the services of any licensed insurance agent or broker to solicit or enroll employers or pay a commission or other form of compensation to certain persons that is related to the volume or number of employers or individuals solicited or enrolled in the plan; (2) a maximum 15 percent rule applies to the number of covered individuals in the plan who are not employees (or their beneficiaries) within a bargaining unit covered by any of the collective bargaining agreements with a participating employer or who are not present or former employees (or their beneficiaries) of sponsoring employee organizations or employers who are or were a party to any of the collective bargaining agreements (provides for a higher maximum in the case of certain plans or arrangements in existence as of the date of enactment); and (3) the employee organization or other entity sponsoring the plan or arrangement must certify annually to the Secretary the plan has met the previous requirements.

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

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

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

C. TREATMENT OF CHURCH PLANS

Current law

Section 4(b)(2) of ERISA exempts from its requirements church plans that do not elect to participate in qualified pension plans under the IRC.

House bill

The House bill would add a new section 709 to ERISA treating certain church plans (including a church, convention or association of churches or similar organization) as a MEWA and permitting such plans to voluntarily elect to apply to the Department of Labor for an exemption from state laws that would otherwise apply to a MEWA under section 514(b)(6)(B) and in accordance with new ERISA Part 7. An exempted church plan would, with certain exceptions, have to comply with the provisions of ERISA Title I in order to receive an exception from state law. The election to be covered by ERISA would be irrevocable. A church plan is covered under this section if the plan provides benefits which include medical care and some or all of the benefits are not fully insured. (Certain provisions of ERISA, such as its COBRA continuation coverage requirements, would not apply to the church plans described herein.)

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

D. ENFORCEMENT PROVISIONS RELATING MEWAS

Current law

MEWAs are subject to ERISA's enforcement and other provisions of title I.

House bill

The House bill would amend ERISA to establish enforcement provisions relating to the multiple employer elements of the bill: (1) a civil penalty would apply for failure of MEWAs to file registration statements; (2) state enforcement would be authorized through Federal courts with respect to violations by multiple employer health plans, subject to the existence of enforcement agreements between the states and the federal government; (3) willful misrepresentation that an entity is an exempted MEWA or collectively-bargained arrangement could result in criminal penalties; (4) cease activity orders could be issued for arrangements found to be neither licensed, registered, or otherwise approved under State insurance law, or operating in accordance with the terms of an exemption granted by the Secretary under new part 7; and (5) provides that each MEHP require its fiduciary or board of trustees to comply with the required claims procedure under ERISA.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

E. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES

Current law

Section 506 of ERISA provides for coordination between the Department of Labor and other federal agencies in the enforcement of ERISA. The Secretary is authorized to use the facilities or services of the states, with the consent of the affected departments, agencies, or establishments in enforcing ERISA.

House bill

The House bill would amend section 506 of ERISA to specify State responsibility with respect to self-insured MEHPs and voluntary health insurance associations (VHIAs). A State could enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority to enforce provisions of ERISA applicable to exempted MEHPs or to VHIAs. The Secretary would be required to enter into the agreement if the Secretary determined that delegation to the State would not result in a lower level or quality of enforcement. However, if the Secretary delegated authority to a State, the Secretary could continue to exercise such authority concurrently with the State. The Secretary would be required to provide enforcement assistance to the States with respect to MEWAs.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

F. FILING AND DISCLOSURE REQUIREMENTS FOR MEWAS OFFERING HEALTH BENEFITS

Current law

ERISA provides for certain reporting and disclosure requirements.

House bill

The reporting and disclosure requirements of ERISA would be amended to require MEWAs offering health benefits to file with the Secretary a registration statement within 60 days before beginning operations (for those starting on or after January 1, 1997) and no later than February 15 of each year. In addition, MEWAs providing medical care would be required to issue to participating employers certain information including summary plan descriptions, contribution rates, and the status of the arrangement (whether fully-insured or an exempted self-insured plan).

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

G. SINGLE ANNUAL FILING FOR ALL PARTICIPATING EMPLOYERS

Current law

Section 110 of ERISA provides for alternative methods of compliance with reporting and disclosure requirements to those specified in previous sections of the law.

House bill

This section would amend ERISA's section 110 to provide for a single annual filing for all participating employers of fully insured MEWAs.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

H. EFFECTIVE DATES/TRANSITION RULES

Current law

No provision.

House bill

The House bill would provide that in general, the amendments made by this title would be effective January 1, 1998. In addition, the Secretary would be required to issue all regulations needed to carry out the amendments before January 1, 1998.

The bill would provide for transition rules for self-insured MEWAs which meet the requirements of Part 7 and which are in operation as of the effective date so that those applying to the Secretary for an exemption from State regulation are deemed to be excluded for a period not to exceed 18 months unless the Secretary denies the exemption or finds the MEWAs application deficient, provided that the arrangement does not have pending against it an enforcement action by a state. The Secretary could revoke the exemption at any time if it would be detrimental to the interests of individuals covered under the Act.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

VIII. VOLUNTARY HEALTH INSURANCE ASSOCIATIONS/HEALTH PLAN PURCHASING COOPERATIVES (HPPCS)

Current law

While the states regulate insurance sold to purchasing cooperatives, a purchasing cooperative that is also a MEWA is also regulated under ERISA. Under ERISA, a state may apply and enforce its insurance laws with respect to fully-insured MEWAs.

As of December 1995, 15 states had enacted laws relating to voluntary purchasing alliances/cooperatives.

House bill

The House bill would add a new subsection (d) to section 514 of ERISA defining under ERISA voluntary health insurance associations and establishing federal requirements for such associations. Associations meeting these requirements would be exempt from specific state laws.

Senate amendment

The Senate Amendment would provide for limited exemptions from state laws for health insurance purchasing cooperatives that meet the requirements established by this section.

Conference agreement

The conference agreement does not include the House or Senate provision.

A. DEFINITIONS/NATURE OF ORGANIZATION

Current law

No provision.

House bill

The House bill would define a voluntary health insurance association as a multiple employer welfare arrangement, maintained by a qualified association, under which all medical benefits are fully-insured, under which no employer is excluded as a participating employer (subject to minimum participation requirements of an insurer), under which the enrollment requirements of section 103 of the Act apply (see item II above), under which all health insurance coverage options are aggressively marketed, and under which the health insurance coverage is provided by an insurer or HMO to which the laws of the state in which it operates apply.

A qualified association would be an association in which the sponsor of the association is, and has been (together with its immediate predecessor, if any) for a continuous period of not less than 5 years, organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group), for substantial purposes other than that of obtaining or providing medical care, is established as a permanent entity which receives the active support of its members and meets at least annually, and collects dues without conditioning such dues on the basis of the health status or claims experience of plan participants or beneficiaries or on the basis of participation in a VHIA.

A ''small employer'' would be defined as one who employs at least 2 but fewer than 51 employees on a typical business day in the year.

Senate amendment

The Senate Amendment would define a ''health plan purchasing cooperative'' or HPPC to mean a group of employees or a group of individuals and employers that, on a voluntary basis and in accordance with this section, form a cooperative for the purpose of purchasing an individual health plan or group health plans offered by health plan issuers.

An HPPC could not: (a) perform any activity relating to the licensing of health plan issuers; (b) assume financial risk directly or indirectly (that is, it would have to be fully-insured); (c) establish eligibility, enrollment, or premium contribution requirements for individual participants or beneficiaries based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, genetic information, or disability; (d) operate on a for-profit or other basis where the legal structure of the cooperative permits profits to be made and not returned to the members of the cooperative, or (e) perform any other activities that conflict or are inconsistent with the performance of its duties under this Act. A for-profit cooperative could be formed by a nonprofit organization or organizations in which: (1) membership in such organization is not based on health status, medical condition, claims experience, receipt of health care, medical history, evidence of insurability, genetic information, or disability and (2) that accepts as members all employers or individuals on a first-come, first-serve basis, subject to any established limit on the maximum size of an employer that may become a member.

Conference agreement

The conference agreement does not include the House or Senate provision.

B. CERTIFICATION

Current law

No provision.

House bill

No provision.

Senate agreement

The Senate Amendment would provide that a state certify a group as a HPPC if it appropriately notifies the state and the Secretary of Labor that it wants to form a HPPC under the requirements of this section. The state would be required to determine in a timely fashion whether the group is in compliance with the section's requirements and to oversee the operations of the HPPC to ensure continued compliance with the requirements. Each certified HPPC would have to register with the Secretary of Labor.

If a state failed to implement a HPPC certification program in accordance with this Act's standards, the Secretary of Labor would certify and oversee the HPPCs in that state.

However, the Secretary would not certify a HPPC if, upon submission of an application of the state to the Secretary, the Secretary determined that a state law was in effect on the date of enactment of this Act providing that all small employers in the state had a means readily available that ensured: (a) that individuals and employees had a choice of multiple, unaffiliated health plan issuers; (b) that health plan coverage was subject to state premium rating requirements that were not based on the health and other risk factors described above and that contained a mandatory minimum loss ratio; (c) that comparative health plan materials were disseminated (including information about cost, quality, benefits, and other information); and that (d) the state program otherwise met the objectives of this Act.

A HPPC operating in more than one state would be certified by the state in which the cooperative was domiciled. States could enter into cooperative agreements for the purpose of overseeing a HPPC's operation. A HPPC would be considered to be domiciled in the state in which most of the members of the HPPC reside.

Conference agreement

The conference agreement does not include the Senate provision.

C. STRUCTURE AND RESPONSIBILITIES OF ORGANIZATION

Current law

No provision.

House bill

The House bill would provide that VHIAs and qualified associations meet certain conditions (described in items VIII(A) and VIII(D)) to qualify as a VHIA and therefore for exemption from state insurance laws.

Senate amendment

The Senate Amendment would provide for the following requirements for HPPCs:

I. Board of Directors.—Requires each HPPC to be governed by a board of directors that would be responsible for ensuring the performance of the HPPC. The board would have to be composed of a cross-section of representatives of employers, employees, and individuals participating in the HPPC. The board members could not be compensated but could receive reimbursement for reasonable and necessary expenses incurred in performing their HPPC responsibilities.

2. Membership and marketing area.—Permits a HPPC to establish limits on the maximum size of employers who could become members and to determine whether to allow individuals to be members. Once membership limits were established, the HPPC would be required to accept all employers (or individuals) residing within the area served by the HPPC who met the membership requirements on a first-come, first-served basis, or on another basis established by the state to ensure equitable access to the HPPC.

3. Duties and responsibilities.—Requires a HPPC to: (a) objectively evaluate potential health plan issuers and enter into agreements with multiple, unaffiliated ones, except that this requirement would not apply in regions, such as remote or frontier areas, where compliance was not possible; (b) enter into agreements with employers and individuals who become members; (c) participate in any program of risk-adjustment or reinsurance, or any similar program established by the state; (d) prepare and disseminate comparative health plan materials concerning the plans offered through the HPPC; (e) broadly solicit and actively market to all eligible employers and individuals residing within the service area; and (f) act as an ombudsman for enrollees.

4. Permissible activities.—Permits a HPPC to perform other functions as needed to further the purposes of this Act, such as: (a) collecting and distributing premiums and performing other administrative functions; (b) collecting and analyzing surveys of satisfaction; (c) charging fees for membership and participation fees to issuers; (d) cooperating with (or accepting as members) employers who provide health benefits directly but only for the purpose of negotiating with providers; and (5) negotiating with health care providers and health plan issuers.

5. Limitation on cooperative activities.—see item VIII(A) above.

6. Conflict of interest.—Prohibits any individual, partnership, or corporation from serving on the HPPC board, being employed by or receiving compensation from the HPPC, or initiating or financing a HPPC if such individual, partnership, or corporation (a) fails to discharge the duties and responsibilities in a manner that is solely in the interest of the members; or (b) derives personal benefit from the sale of, or financial interest in, health plans, services, or products sold through the HPPC. However, a HPPC could contract with third parties to provide administrative, marketing, consultive, or other services.

Conference agreement

The conference agreement does not include the House or Senate provision.

D. PREEMPTION OF STATE LAWS

Current law

Section 514(a) of ERISA preempts state laws relating to employee benefit plans. Section 514(b)(2) of ERISA provides that state laws apply in the case of the regulation of insurance.

House bill

The House bill would amend section 514 of ERISA to preempt the following state laws: (1) laws that preclude an insurer or HMO from offering health insurance coverage under VHIAs; (2) laws that preclude an insurer or HMO from setting premium rates under a VHIA based on the claims experience of the VHIA (except the VHIA's premium rates could not vary on the basis of any particular employer's claims experience); (3) laws that require coverage in connection with a VHIA to include specific items or services of medical care or that require an insurer or HMO offering coverage in connection with a VHIA to include specific item or services consisting of medical care, except to the extent that such state laws prohibit an exclusion for a specific disease in such coverage. This preemption of mandated benefits would apply only with respect to those items and services specified in a list which would be prescribed in regulations by the Secretary of Labor.

In general, states would be able to apply their laws if they had in place guaranteed access measures meeting certain conditions. A state which certified to the Secretary that it provided ''guaranteed access'' to health coverage could deny a VHIA the right to offer coverage in the small group market (or otherwise regulate such VHIA with respect to such coverage), except as described below. (The certification could not be in effect for more than 3 years.)

A state would be considered to provide such guaranteed access, if (1) it certified that at least 90% of all state residents were covered by a group health plan or otherwise had health insurance coverage, or (2) that it had, in the small group market, provided for guaranteed issue of at least one option of coverage and for small group rating reforms designed to make health insurance coverage more affordable. However, an exception to this provision would apply for certain large, multi-state arrangements that demonstrated to the Secretary that it met the following criteria. In other words, state laws would not apply if: (1) the VHIA sponsor operates in a majority of the 50 states and in at least 2 of the regions of the country; (2) the arrangement covers or will cover (in the case of new VHIAs) at least 7,500 participants and beneficiaries; and (3) under the terms of the arrangement, either the qualified association does not exclude from membership any small employer in the state, or the arrangement accepts every small employer in the state that applies for coverage. In addition, state laws would not apply in a state in which a VHIA operated on March 6, 1996 and under the terms of the arrangement, either the qualified association does not exclude from membership any small employer in the state, or the arrangement accepts every small employer in the state that applies for coverage.

The exemption from state laws for multistate plans and existing plans would not apply to any state which, as of January 1, 1996, either (1) had enacted a law providing for guaranteed issue of fully community rated individual health insurance coverage offered by insurers and HMOs, or (2) required insurers offering group health coverage to reimburse insurers offering individual coverage for losses resulting from their offering individual coverage on an open enrollment basis. In other words, such states could apply their insurance laws.

Senate amendment

The Senate Amendment would provide that HPPCs that meet the requirements of this Act would be exempt from state fictitious group laws.

A health plan issuer offering a group or individual health plan through a HPPC meeting the requirements of this Act would be required to comply with all otherwise applicable state rating requirements if the plan were to be offered outside the cooperative except a state would be required to permit an issuer to reduce its premiums negotiated with a HPPC to reflect savings derived from administrative costs, marketing costs, profit margins, economies of scale, or other factors. However, such premium reductions could not be based on the health status, demographic factors, industry type, duration, or other indicators of risk of HPPC members.

Health plan issuers offering coverage through the HPPC would be required to comply with state mandated benefit laws. However, in states that have enacted laws authorizing alternative benefit plans for small employers, such issuers could offer such small employer plan through a HPPC.

Conference agreement

The conference agreement does not include the House or Senate provision.

E. RULES OF CONSTRUCTION

Current law

No provision.

House bill

No provision.

Senate amendment

The Senate Amendment would provide that nothing in this section should be construed to: (1) require that a state organize, operate, or create HPPCs; (2) otherwise establish HPPCs; (3) require individuals, plan sponsors, or employers to purchase coverage through a HPPC; (4) preempt a state from requiring licensure for individuals who are involved in directly supplying advice or selling health plans on behalf of a HPPC; (5) require that a HPPC be the only type of purchasing arrangement permitted to operate in a state; (6) confer authority upon a state that the state would not otherwise have to regulate health plan issuers or employee health benefit plans; (7) confer authority upon a state (or the federal government) that it would not otherwise have to regulate group purchasing arrangements, coalitions, association plans, or similar entities that do not desire to become a HPPC; or (8) except as specifically provided for above, prevent the application of state laws and regulations otherwise to health plan issuers offering coverage through a HPPC.

Conference agreement

The conference agreement does not include the Senate provision.

F. ENFORCEMENT THROUGH ERISA

Current law

Part 4 of subtitle B of title I of ERISA provides for fiduciary responsibilities, including the fiduciary duties of a plan sponsor and prohibited transactions; part 5 provides for administration and enforcement, including criminal and civil penalties.

House bill

The House bill contains no specific provision (but as MEWAs, VHIAs would be subject to ERISA requirements including those related to fiduciary responsibilities and administration and enforcement, including enforcement of the new VHIA rules as added by this subtitle.)

Senate amendment

The Senate Amendment would provide that for enforcement purposes only, that parts 4 and 5 of subtitle B of title I of ERISA apply to a HPPC as if such plan were an employee benefit plan.

Conference agreement

The conference agreement does not include the Senate provision.

IX. ADDITIONAL DEFINITIONS/OTHER PROVISIONS

Current law

Section 3 of ERISA defines numerous terms relating to pension and employee welfare benefit plans.

House bill

The House bill:

A. Defines the following terms: group health plan, including treatment of governmental and church plans, and defines Medicaid, medicare, and the Indian Health Service programs as group health plans.

B. Incorporates specific ERISA definitions such as beneficiary, participant, employee, and employer.

C. Provides additional definitions including applicable state authority, bona fide association, COBRA continuation provision, health insurance coverage, health maintenance organization, health status, individual health insurance coverage, insurer, medical care network plan, and waiting period.

D. Provides for the treatment of partnerships.

E. Provides definitions related to markets and small employers, including individual market, large group market, small employer and small group market.

Senate bill

The Senate Amendment:

A. Defines an employee health benefit plan to include a governmental or church plan. An employee health benefit plan is not a group health plan, individual plan, or a health plan. Provides different definition for group health plan.

B. Similarly incorporates many ERISA definitions such as that for beneficiary, participant, employee, and employer.

C. Defines group purchaser and health plan issuer.

Conference agreement

The conference agreement:

A. Defines under ERISA the following terms relating to health insurance: health insurance coverage, health insurance issuer, health maintenance organization, group health insurance coverage, and excepted benefits. Also defines placed for adoption.

B. Defines under PHS Act the following terms relating to health insurance: health insurance coverage, health insurance issuer, health maintenance organization, group health insurance coverage, and excepted benefits.

C. Defines under the PHS Act: state, applicable state authority, state law, beneficiary, and bona fide association. Also, provides definitions under the PHS Act relating to markets and small employers for: large group market, small employer, and small group market.

D. Provides definitions under ERISA and the PHS Act relating to portability for: preexisting condition exclusion, enrollment date, late enrollee, waiting period, creditable coverage, and affiliation period.

E. Defines under ERISA and the PHS Act group health plan, medical care, COBRA continuation provision, and health status-related factor.

The definition of medical care is intended to parallel that of the IRC using current law, and is intended to be broad enough to encompass the services of Christian Science practitioners, nurses, and sanatoriums and nursing facilities.

F. Amends ERISA to provide for the treatment of partnerships.

G. Incorporated in the PHS Act specific ERISA definitions such as employee, employer, beneficiary, church plan, governmental plan, participant, plan sponsor.

H. Provides definitions under the PHS Act for federal governmental plan, nonfederal governmental plan, and placed for adoption.

X. EFFECTIVE DATES

Current law

No provision.

House bill

The House bill, except as otherwise provided, would apply with respect to (a) group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning on or after January 1, 1998; (b) individual health insurance coverage issued, renewed, in effect, or operated on or after July 1, 1998. The bill would require the Secretaries of HHS, Treasury, and Labor to jointly establish rules regarding the treatment of certain coverage periods before the applicable effective dates, and would require the 3 Secretaries to issue such regulations on a timely basis.

Senate amendment

The Senate Amendment, except as otherwise provided, (a) with respect to group health plans, would apply to plans offered, sold, issued, renewed, in effect, or operated on or after January 1, 1997; (b) with respect to individual health plans, would apply to plans offered, sold, issued, renewed, in effect, or operated on or after the date that is 6 months after enactment or January 1, 1997, whichever is later; and (c) with respect to employee health benefit plans, would apply on the first day of the first plan year beginning on or after January 1, 1997, whichever is later.

Conference agreement

The conference agreement, except as otherwise provided, would apply with respect to (a) group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after July 1, 1997; (b) individual health insurance coverage offered, sold, issued, renewed, in effect, or operated after July 1, 1997. In general, group health plans and health plan issuers would be required to issue certifications of coverage for periods of coverage after July 1, 1996; actual certifications need not be issued before October 1, 1996. A special rule directs the Secretaries to provide for a process whereby individuals who need to establish creditable coverage for periods before July 1, 1996 may be given credit through the presentation of documents or other means. A special rule would apply to collective bargaining agreements.

A good faith compliance provision is provided with respect to a transition period.

XI. HEALTH COVERAGE AVAILABILITY STUDIES

Current law

No provision.

House bill

No provision.

Senate amendment

The Senate Amendment would require the Secretary of HHS, in consultation with the Secretary of Labor, representatives of state

officials, consumers, and other representatives of individuals and entities that have expertise in health insurance and employee benefits, to conduct a three-part study and prepare and submit reports. (A) By January 1, 1998, the Secretary would be required to prepare and submit to Congress an evaluation of the various mechanisms used to ensure the availability of reasonably priced health coverage and whether standards that limit premium variations would further the purposes of this Act. (B) No later than January 1, 1999, the Secretary would be required to prepare and submit to Congress a report concerning the effectiveness of provisions of the Act and various state laws in ensuring the availability of reasonably priced health coverage. (C) No later than January 1, 1998, the Secretary would be required to prepare and submit to Congress a report (1) evaluating the extent to which patients have direct access to, and choice of, health care providers, as well as the opportunity to utilize providers outside of the network, under the various types of coverage offered under the provisions of this Act; (2) evaluating the cost to the insurer of providing out-of-network access to providers and the feasibility of offering out-of-network access under all plans offered under this Act; and (3) evaluating the percent of premium used for medical care administration of the various types of coverage offered.

Conference agreement

The conference agreement requires the Secretary of HHS, in consultation with the Secretary of Labor, representatives of state officials, consumers, and other representatives of individuals and entities that have expertise in health insurance and employee benefits, to conduct two studies by January 1, 2000. The first study, on the effectiveness of federal and state reforms, would examine the availability of reasonably priced health coverage to employers purchasing group coverage and individuals purchasing coverage on a non-group basis. The second study, on access and choice, would examine the extent to which patients have direct access to, and choice of, health care providers, including specialty providers, within a network plan, as well as the opportunity to use providers outside of the network plan, under the various types of coverage offered under the provisions of this title. This study will also examine the cost and cost-effectiveness to health insurance issuers of providing access to out-of-network providers, and the potential impact of providing such access on the cost and quality of health insurance coverage offered under provisions of this title.

XII. REIMBURSEMENT OF TELEMEDICINE

Current law

No provision.

House bill

No provision.

Senate amendment

The Senate amendment would direct the Health Care Financing Administration (HCFA) to complete its ongoing study of reimbursement of all telemedicine services and submit a report to Congress with a proposal for reimbursement of fee-for-service medicine by March 1, 1997. The report would be required to use data compiled from the current demonstration projects already under review and gather data from other ongoing telemedicine networks, and include an analysis of the cost of services provided via telemedicine.

Conference agreement

The conference agreement directs the HCFA to complete its ongoing study of Medicare reimbursement of all telemedicine services and submit a report to Congress on reimbursement of telemedicine services by March 1, 1997. The report would be required to use data compiled from the current demonstration projects already under review and gather data from other ongoing telemedicine networks, include an analysis of the cost of services provided via telemedicine, and include a proposal for Medicare reimbursement of telemedicine services.

XIII. HMOs AND MEDICAL SAVINGS ACCOUNTS (MSAs)

Current law

Under the Public Health Service Act, federally qualified HMOs may require enrollees to pay only nominal copayments and a reasonable deductible if services are obtained from an out-of-network provider.

House bill

No provision, but see Title III, Subtitle A on Medical Savings Accounts.

Senate amendment

The PHS Act would be amended to allow federally-qualified HMOs, at the request of the HMO member, to charge a deductible to the HMO member if he or she has an MSA.

Provides that it is the sense of the Committee on Labor and Human Resources that the establishment of MSAs should be encouraged as part of any health insurance reform legislation passed by the Senate through the use of tax incentives relating to contributions to, the income growth of, and the qualified use of, such accounts.

Provides that it is the sense of the Senate that Congress should take measures to further the purposes of this Act, including any necessary changes to the Internal Revenue Code to encourage groups and individuals to obtain health coverage, and to promote access, equity, portability, affordability, and security of health benefits.

Conference agreement

The conference agreement amends the PHS Act to allow federally qualified HMOs to offer a high-deductible health plan as defined in the IRC. All other requirements of the federal HMO Act remain in effect.

XIV. VOLUNTEER SERVICES PROVIDED BY HEALTH PROFESSIONALS AT FREE CLINICS

See report language for Title II.

XV. FINDINGS; SEVERABILITY

Current law

No provision.

House bill

The House bill would provide that Congress finds: (1) that group health plans and health insurance coverage that impose preexisting conditions impact the ability of employees to seek employment in interstate commerce and thereby impedes such commerce; (2) that health insurance coverage is commercial in nature and is in and affects interstate commerce; (3) that it is a necessary and proper exercise of congressional authority to impose requirements on group health plans and health insurance coverage to promote commerce among states; and (4) that Congress intends however to defer to the states to the maximum extent practicable in carrying out requirements with respect to insurers and HMOs that are subject to state regulation, consistent with ERISA.

Senate amendment

The Senate Amendment would provide that if any provision of the Act or application of a provision of the Act to any person or circumstance is held to be unconstitutional, the remainder of the Act and the application of the provisions of such to any person or circumstances would not be affected.

Conference agreement

The conference agreement provides that Congress finds: (1) that group health plans and health insurance coverage that impose preexisting conditions impact the ability of employees to seek employment in interstate commerce and thereby impedes such commerce; (2) that health insurance coverage is commercial in nature and is in and affects interstate commerce; (3) that it is a necessary and proper exercise of congressional authority to impose requirements under this title on group health plans and health insurance coverage, including coverage offered to individuals previously covered under group health plans, to promote commerce among states; and (4) that Congress intends to defer to the states, to the maximum extent practicable, in carrying out such requirements with respect to insurers and HMOs that are subject to state regulation, consistent with ERISA.

The conference agreement provides that if any provision of this title or application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this title and the application of the provisions of such to any person or circumstances would not be affected.

XVI. COBRA CLARIFICATIONS

Current law

Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99–272) amends the Internal Revenue Code (IRC), ERISA, and the Public Health Service Act to require employers who provide group health plans with 20 or more employees to offer continuation coverage to employees and their dependents who experience specific qualifying events, including changes in job or family status. In general, when a covered employee experiences termination or reductions in hours of employment, the continued coverage of the employee and any qualified beneficiaries is for 18 months. For other qualifying events (e.g., death, divorce, legal separation, and child turns age of majority under the plan), the duration of coverage is 3 years. The Omnibus Budget Reconciliation Act of 1989 (P.L. 10–239) provides that if a covered employee is determined to be disabled under the Social Security Act at the time in which he or she terminates or reduces hours of employment, then the employee is eligible for 29 months of continued coverage.

House bill

No provision.

Senate amendment

The Senate Amendment would amend the PHS Act, ERISA, and the IRC to provide for clarifications of COBRA continuation requirements. Provides that individuals who have disabled family members or who become disabled at any time during their coverage under an initial COBRA period (the first 18 months) be able to extend their coverage for the additional 11 month period currently available only to workers who are disabled at the time they lose their coverage.

Provides that newborns and children who are placed for adoption may be covered immediately under a parent's COBRA policy.

Conference agreement

See Title IV, Subtitle B.

XVII. SENSE OF THE COMMITTEE REGARDING MEDICARE

Current law

No provision.

House bill

No provision.

Senate amendment

The Committee on Labor and Human Resources notes that the Medicare trustees concluded in their 1995 report that: (i) the Medicare program is unsustainable in its present form; (ii) that the hospital insurance

trust fund will only be able to pay for benefits for about 7 years and is severely out of financial balance in the long run; and (iii) the Public Trustees recommended that the problems be urgently addressed on a comprehensive basis including a review of the program's financing methods, benefit provisions, and delivery mechanisms. The provision expresses the sense of the Committee that the Senate should take up measures necessary to reform the Medicare program, to provide increased choice for seniors, and to respond to the findings of the Public Trustees by protecting the short term solvency and long-term sustainability of the Medicare program.

Conference agreement

The conference agreement does not include the Senate provision.

XVIII. PARITY FOR MENTAL HEALTH SERVICES

Current law

No provision.

House bill

No provision.

Senate amendment

The Senate Amendment would prohibit an employee health benefit plan, or a health plan issuer offering a group health plan or individual health plan from imposing treatment limitations or financial requirements on the coverage of mental health services if similar requirements are not imposed on coverage for services for other conditions.

It would provide for a rule of construction that the preceding should not be construed as prohibiting an employee health benefit plan or a health plan issuer offering a group or individual health plan from requiring preadmission screening prior to the authorization of services covered under the plan or from applying other limitations that restrict coverage for mental health services to those services that are medically necessary.

Conference agreement

The conference agreement does not include the Senate provision.

XIX. WAIVER OF FOREIGN COUNTRY RESIDENCE WITH RESPECT TO INTERNATIONAL MEDICAL GRADUATES

Current law

The Immigration and Nationality Technical Corrections Act of 1994 provides for a waiver of the requirement that nonimmigrant international medical graduates entering as J exchange visitors return to their country of nationality for two years before being eligible to return to the U.S. The provision applies to aliens admitted to the U.S. before June 1, 1996.

House bill

No provision.

Senate bill

The Senate Amendment would extend waivers for the requirement that nonimmigrant international medical graduates entering as J exchange visitors return to their country of nationality for two years before being eligible to return to the U.S. through June 1, 2002.

It would amend provisions related to federally requested waivers requested by an interested U.S. agency on behalf of certain aliens.

Conference agreement

The conference agreement does not include the Senate provision.

XX. ORGAN AND TISSUE DONATION INFORMATION INCLUDED WITH INCOME TAX REFUND PAYMENTS

Current law

No provision.

House bill

No provision.

Senate bill

The Senate Amendment would require the Secretary of Treasury to include with any payment of a refund of individual income tax made during the period beginning on February 1, 1997 through June 30, 1997, a copy of the document developed in consultation with the Secretary of HHS and organizations promoting organ and tissue donation which encourages organ and tissue donation. The document would also include a detachable organ and tissue donor card, and would urge recipients to sign the card, discuss organ and tissue donations with family members, and encourage family members to request or authorize organ and tissue donation if the occasion arises.

Conference agreement

The conference agreement does not include the Senate provision.

XXI. SENSE OF THE SENATE REGARDING ADEQUATE HEALTH CARE COVERAGE FOR ALL CHILDREN AND PREGNANT WOMEN

Current law

No provision.

House bill

No provision.

Senate amendment

The Senate Amendment provides that the Senate finds that the health care coverage of mothers and children in the United States is unacceptable, with more than 9.3 million children and 500,000 expectant mothers having no health insurance, in addition to there being high levels of infant and maternal mortality and other enumerated indicators of inadequate access to care.

The Senate Amendment provides that it is the sense of the Senate that the issue of adequate health care for our mothers and children is important to the future of the United States, and in consideration of the importance of such issue, the Senate should pass health care legislation that will ensure health care coverage for all of the United States' pregnant women and children.

Conference agreement

The conference agreement does not include the Senate provision.

XXII. SENSE OF THE SENATE REGARDING AVAILABLE TREATMENTS

Current law

No provision.

House bill

No provision.

Senate amendment

The Senate Amendment provides that it is the sense of the Senate that patients deserve to know the full range of treatments available to them and Congress should thoughtfully examine these issues to ensure that all patients get the care they deserve.

Conference agreement

The conference agreement does not include the Senate provision.

XXIII. RULE OF CONSTRUCTION

Current law

No provision.

House bill

The House bill would provide that nothing in this title or any amendment made by it may be construed to require (or to authorize any regulation that requires) the coverage of any specific procedure, treatment, or service under a group health plan or health insurance coverage.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision, but see section III(E).

TITLE II—PREVENTING HEALTH CARE FRAUD AND ABUSE: ADMINISTRATIVE SIMPLIFICATION; MEDICAL LIABILITY REFORM

1. Fraud and abuse control program

(Subtitle A of title II of the House bill; title V of the Senate amendment.)

I. IN GENERAL

A. FRAUD AND ABUSE CONTROL PROGRAM

(Section 201 of the House bill; section 501 of the Senate amendment.)

Current law

Currently, the investigation and prosecution of fraud related to Federal health programs is the responsibility of the Department of Health and Human Services (DHHS), the FBI and the Department of Justice. The DHHS Office of Inspector General investigates Federal cases of fraud regarding Medicare, Medicaid, and the Maternal and Child Health Block Grant programs and is authorized by the Secretary to impose civil monetary penalties and program exclusions on fraudulent providers. The FBI can investigate both Federal and private payer cases of fraud but cannot impose sanctions. Both the Office of Inspector General and the FBI refer investigative findings to the Department of Justice which may prosecute persons for violations of federal criminal laws. State Medicaid fraud control units are responsible for the investigation, prosecution, or referral for prosecution, of fraudulent activities associated with State Medicaid programs.

House bill

The Secretary of the Department of Health and Human Services (acting through the Office of the Inspector General) and the Attorney General would be required to jointly establish a national health care fraud and abuse control program to coordinate Federal, State and local law enforcement to combat fraud with respect to health plans. To facilitate the enforcement of this fraud and abuse control program the Secretary and Attorney General would be authorized to conduct investigations, audits, evaluations and inspections relating to the delivery of and payment for health care, and would be required to arrange for the sharing of data with representatives of public and private third party payers. This program, implemented by guidelines issued by the Secretary and the Attorney General, would also facilitate the enforcement of applicable Federal statutes relating to health care fraud and abuse, and would provide for the provision of guidance to health care providers through the issuance of safe harbors, advisory opinions and special fraud alerts.

The Secretary and Attorney General would consult with and share data with representatives of health plans. Guidelines issued by the Secretary and Attorney General would ensure the confidentiality of information furnished by health plans, providers and others, as well as the privacy of individuals receiving health care services. The Inspector General would retain all current authorities.

For purposes of this section the term ''health plan'' means a plan or program that provides health benefits through insurance or otherwise. Such plans include health insurance policies, contracts of service benefit organizations, and membership agreements with health maintenance organizations or other prepaid health plans.

The Health Care Fraud and Abuse Control Account would be established as an expenditure account within the Federal Hospital Insurance (HI) Trust Fund. Amounts equal to monies derived from the coordinated health care anti-fraud and abuse programs from the imposition of civil money penalties, fines,

forfeitures and damages assessed in criminal, civil or administrative health care cases, along with any gifts or bequests would be transferred into the Medicare HI trust fund from the U.S. Treasury. There are appropriated from the HI trust fund to the Account such sums as the Secretary and the Attorney General certify are necessary to carry out certain functions, subject to specified limits to each fiscal year beginning with 1997.

There would be appropriated from the general fund of the U.S. Treasury to the Fraud and Abuse Account for transfer to the FBI certain funds, subject to fiscal year limitations, for specified functions. These functions include prosecuting health care matters, investigations, audits of health care programs and operations, inspections and other evaluations, and provider and consumer education regarding compliance with fraud and abuse provisions. Specified amounts in the Account would also be available to carry out the Medicare Integrity Program. The Secretary and the Attorney General would be required to submit a joint annual report to Congress on the revenues and expenditures, and the justification for such disbursements from the Health Care Fraud and Abuse Control Account.

Senate amendment

Similar.

Conference agreement

The conference agreement includes the House provision with an amendment adding a requirement that the Comptroller General submit to Congress a report for certain fiscal years regarding amounts deposited in the Hospital Insurance Trust Fund under this section. The conference agreement also includes a provision regarding the availability of recoveries and forfeitures for purposes of certain provisions of the Employee Retirement Income Security Act of 1974.

B. MEDICARE INTEGRITY PROGRAM

(Section 202 of the House bill; section 502 of the Senate amendment.)

Current law

Currently Medicare's program integrity functions are subsumed under Medicare's general administrative budget. These functions are performed, along with general claims processing functions, by insurance companies under contract with the Health Care Financing Administration.

House bill

Establishes a Medicare Integrity Program under which the Secretary would promote the integrity of the Medicare program by entering into contracts with eligible private entities to carry out certain activities. These activities would include the following: (1) review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under the Medicare program, including medical and utilization review and fraud review, (2) audit of cost reports, (3) determinations as to whether payment should not be, or should not have been, made by reason of Medicare as secondary payor provisions and recovery of payments that should not have been made, (4) education of providers of services, beneficiaries and other persons with respect to payment integrity and benefit quality assurance issues, and (5) developing and updating a list of durable medical equipment pursuant to section 1834(a)(15) of the Social Security Act. An entity is eligible to enter into a contract under this program if it meets certain requirements, including demonstrating to the Secretary that the entity's financial holdings, interests, or relationships will not interfere with its ability to perform the required functions.

Senate amendment

Similar except for differences in applicable conflict of interest requirements with regard to entities eligible to enter into contracts under this program.

Conference agreement

The conference agreement includes the House provision with a modification of the applicable conflict of interest requirements for eligible entities and assurance that current contractors meeting applicable requirements may compete for contracts on new program integrity activities.

C. BENEFICIARY INCENTIVE PROGRAMS

(Section 203 of the House bill; section 503 of the Senate amendment.)

Current law

No provision.

House bill

The Secretary would be required to provide an explanation of Medicare benefits with respect to each item or service for which payment may be made, without regard to whether a deductible or coinsurance may be imposed with respect to the item or service.

This provision would require the Secretary, within three months after enactment of this bill, to establish a program to encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions that constitute grounds for sanctions under sections 1128, 1128A, or 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the Medicare program. If an individual reports information to the Secretary under this program that serves as a basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than amounts paid as a penalty under section 1128B), the Secretary may pay a portion of the amount collected to the individual, under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986.

The Secretary would be required, within three months after enactment of this bill, to establish a program to encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the Medicare program. If the Secretary adopts a suggestion and savings to the program result, the Secretary would make a payment to the individual of an amount the Secretary considers appropriate.

Senate amendment

Identical.

Conference agreement

The conference agreement includes the House provision.

D. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST FEDERAL HEALTH CARE PROGRAMS

(Section 204 of the House bill; section 504 of the Senate amendment.)

Current law

Section 1128B provides for certain criminal penalties for convictions of Medicare and Medicaid (and certain other state health care programs) program-related fraud.

House bill

This provision would extend certain criminal penalties for fraud and abuse violations under the Medicare and Medicaid programs to similar violations in Federal health care programs generally. The term ''Federal health care program'' would mean any plan or program that provides health benefits, whether directly, through insurance, or otherwise which is funded directly, in whole or in part by the United States Government (other than the Federal Employee Health Benefit Program, Chapter 89 of Title 5 of the United States Code). The term also would include any state health care program, which under section 1128(h), includes Medicaid, the Maternal and Child Health Services Block Grant Program and the Social Services Block Grant Program.

Senate amendment

Identical.

Conference agreement

The conference agreement includes the House provision.

E. GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

(Section 205 of House bill, section 505 of Senate amendment.)

Current law

The 1987 Medicare and Medicaid Patient and Program Protection Act specified various payment practices which, although potentially capable of including referrals of business under Medicare or State health care programs, are protected from criminal prosecution or civil sanction under the anti-kickback provisions of the law. The 1987 law also established authority for the Secretary to promulgate regulations specifying additional payment practices, known as ''safe harbors,'' which will not be subject to sanctions under the fraud and abuse provisions.

House bill

The Secretary would publish an annual notice in the Federal Register soliciting proposals for modifications to existing safe harbors and new safe harbors. After considering such proposals the Secretary, in consultation with the Attorney General, would issue final rules modifying existing safe harbors and establishing new safe harbors, as appropriate. The Inspector General would submit an annual report to Congress describing the proposals received, as well as the action taken regarding the proposals. The Secretary, in considering proposals, may consider a number of factors including the extent to which the proposals would affect access to health care services, quality of care services, patient freedom of choice among health care providers, competition among health care providers, ability of health care facilities to provide services in medically underserved areas or to medically underserved populations, and the like.

The Secretary of Health and Human Services would publish the first notice in the Federal Register soliciting proposals for new or modified safe harbors no later than January 1, 1997.

The Secretary would issue written advisory opinions regarding what constitutes prohibited remuneration under section 1128B(b), whether an arrangement or proposed arrangement satisfies the criteria for activities which do not result in prohibited remuneration, what constitutes an inducement to reduce or limit services to individuals entitled to benefits, and, whether an activity constitutes grounds for the imposition of civil or criminal sanctions under sections 1128, 1128A or 1128B. Advisory opinions would be binding as to the Secretary and the party requesting the opinion.

Any person would be able to request the Inspector General to issue a special fraud alert informing the public of practices which the Inspector General considers to be suspect or of particular concern under the Medicare program or a State health care program, as defined in section 1128(h) of the Social Security Act. After investigation of the subject matter of the request, and, if appropriate, the Inspector General would issue a special fraud alert in response to the request, published in the Federal Register.

Senate amendment

Identical to the House bill provisions regarding the issuance of safe harbors and special fraud alerts. However, provides for the issuance of ''interpretative rulings'' instead of ''advisory opinions'' by the Secretary.

Conference agreement

The conference agreement includes the House provision with modifications to the advisory opinion provisions. The Secretary will be required to issue to a party requesting an advisory opinion within 60 days and the advisory opinion provisions will apply to requests made for opinions on or after the date which is 6 months after the date of enactment of this section and before the date which is 4 years after such date of enactment.

II. Revision to Current Sanctions for Fraud and Abuse

(Subtitle B of the House bill; subtitle B of the Senate amendment.)

A. Mandatory exclusion from participation in Medicare and State health care programs

(Section 211 of the House bill; section 511 of the Senate amendment.)

Current law

Section 1128 of the Social Security Act authorizes the Secretary to impose mandatory and permissive exclusions of individuals and entities from participation in the Medicare program, Medicaid program and programs receiving funds under the Maternal and Child Health Service Block Grant, or the Social Services Block Grant. Mandatory exclusions are authorized for convictions of criminal offenses related to the delivery of health care services under Medicare and State health care programs, as well as for convictions relating to patient abuse in connection with the delivery of a health care item or service. In the case of an exclusion under the mandatory exclusion authority the minimum period of exclusion could be no less than 5 years, with certain exceptions. Permissive exclusions are authorized for a number of offenses relating to fraud, kickbacks, obstruction of an investigation, and controlled substances, and activities relating to license revocations or suspensions, claims for excessive charges or unnecessary services, and the like. Thee are no specified minimum periods of exclusion under the permissive exclusion authority.

Under Section 1128A of the Social Security Act civil monetary penalties may be imposed for false and fraudulent claims for reimbursement under the Medicare and State health care programs.

Under section 1128B, upon conviction of a program-related felony, an individual may be fined not more than $25,000 or imprisoned for not more than five years, or both.

House bill

The provision would require the Secretary to exclude individuals and entities from Medicare and State health care programs who have been convicted of felony offenses relating to health care fraud for a minimum five year period. The Secretary would also retain the discretionary authority to exclude individuals from Medicare and State health care programs who have been convicted of misdemeanor criminal health care fraud offenses, or who have been convicted of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in programs (other than health care programs) funded in whole or part by any Federal, State or local agency.

The Secretary would also be required to exclude individuals and entities from Medicare and State health care programs who have been convicted of felony offenses relating to controlled substances for a minimum five year period. The Secretary would retain the discretionary authority to exclude individuals from Medicare and State health care programs who have been convicted of misdemeanor offenses relating to controlled substances.

Senate amendment

Identical.

Conference agreement

The conference agreement includes the House provision.

B. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from Medicare

(Section 212 of the House bill; section 512 of the Senate amendment.)

Current law

See above.

House bill

This section would establish a minimum period of exclusion for certain permissive exclusions from participation in Medicare and State health care programs.

For convictions of misdemeanor criminal health care fraud offenses, criminal offenses relating to fraud in non-health care Federal or State programs, convictions relating to obstruction of an investigation of health care fraud offenses, and convictions of misdemeanor offenses relating to controlled substances, the minimum period of exclusion would be three years, unless the Secretary determines that a longer or shorter period is appropriate, due to aggravating or mitigating circumstances.

For permissive exclusions from Medicare or State health care programs due to the revocation or suspension of a health care license of an individual or entity, the minimum period of exclusion would not be less than the period during which the individual's or entity's license was revoked or suspended.

For permissive exclusions from Medicare or State health care programs due to exclusion from any Federal health care program or State health care program for reasons bearing on an individual's or entity's professional competence of financial integrity, the minimum period of exclusion would not be less than the period the individual or entity is excluded or suspended from a Federal or State health care program.

For permissive exclusions from Medicare or State health care programs due to a determination by the Secretary that an individual or entity has furnish items or services to patients substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care, the period of exclusion would be not less than one year.

Senate amendment

Identical.

Conference agreement

The conference agreement includes the House provision.

C. Permissive exclusion of individuals with ownership or control interest in sanctioned entities

(Section 213 of the House bill; section 513 of the Senate amendment.)

Current law

See above.

House bill

Under this provision an individual who has a direct or indirect ownership or control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the conviction or exclusion, or who is an officer or managing employee of such an entity, may also be excluded from participation in Medicare and State health care programs by the Secretary if the entity has been convicted of an offense listed in section 1129(a) or (b)(1), (2) or (3) or otherwise excluded from program participation. Under this provision, the culpable individual would also be subject to program exclusion, even if not initially convicted or excluded.

Senate amendment

Identical.

Conference agreement

The conference agreement includes the House provision.

D. Sanctions against practitioners and persons for failure to comply with statutory obligations

(Section 214 of the House bill; section 514 of the Senate amendment.)

Current law

See above.

House bill

Under this provision the Secretary may exclude a practitioner or person who has failed to comply with certain statutory obligations relating to quality of health care for such period as the Secretary may prescribe, except that such period shall be not less than one year.

The Secretary, in making his determination that a practitioner or person should be sanctioned for failure to comply with certain statutory obligations relating to quality of health care, will no longer be required to prove that the individual was either unwilling or unable to comply with such obligations.

Senate amendment

Identical.

Conference agreement

The conference agreement includes the House provision.

E. Intermediate sanctions for Medicare health maintenance organizations

(Section 215 of the House bill; section 515 of the Senate amendment.)

Current law

A contract between the Secretary and a Medicare Health Maintenance Organization (HMO) is generally for a 1 year term, with an option for automatic renewal. However, the Secretary may terminate any such contract at any time, after reasonable notice and an opportunity for a hearing, if the Medicare HMO has failed substantially to carry out the contract, or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the requirements of section 1876 of the Social Security Act, or if the Medicare HMO no longer substantially meets the statutory requirements contained in Section 1876(b), (c), (e) and (f).

House bill

Under this section the Secretary may terminate a contract with a Medicare Health Maintenance Organization (HMO) or may impose certain intermediate sanctions on the organization if the Secretary determines that the Medicare HMO has failed substantially to carry out the contract; is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or, if the Medicare HMO no longer substantially meets the statutory requirements contained in Section 1876(b), (c), (e) and (f) of the Social Security Act.

If the basis for the determination by the Secretary that intermediate sanctions should be imposed on an eligible organization is other than that the organization has failed substantially to carry out its contract with the Secretary, then the Secretary may

apply intermediate sanctions as follows: civil money penalties of not more than $25,000 for each determination if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract; civil money penalties or not more than $10,000 for each week of a continuing violation; and suspension of enrollment of individuals until the Secretary is satisfied that the deficiency has been corrected and is not likely to recur.

Whenever the Secretary seeks to either terminate a Medicare HMO contract or impose intermediate sanctions on such an organization, the Secretary must do so pursuant to a formal investigation and under compliance procedures which provide the organization with a reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's adverse determination. In making a decision whether to impose sanctions the Secretary is required to consider aggravating factors such as whether an entity has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to their attention. The Secretary's compliance procedures must also include notice and opportunity for a hearing (including the right to appeal an initial decision) before the Secretary imposes any sanction or terminates the contract of a Medicare HMO, and there must not be any unreasonable or unnecessary delay between the finding of a deficiency and the imposition of sanctions.

Under this section each risk-sharing contract with a Medicare HMO must provide that the organization will maintain a written agreement with a utilization and quality control peer review organization or similar organization for quality review functions.

The amendments made by this section would apply to contract years beginning on or after January 1, 1996.

Senate amendment

Same as the House bill provision except specifies a different effective date, i.e., January 1, 1997.

Conference agreement

The Conference agreement includes the House provision, but with an effective date of January 1, 1997.

F. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PENALTIES FOR RISK-SHARING ARRANGEMENTS

(Section 216 of the House bill; section 516 of the Senate amendment,)

Current law

The anti-kickback provision in section 1128B(b) contains several exceptions. These exceptions include discounts or other reductions in price obtained by a provider of services or other entity under Medicare or a State health care program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under Medicare or a State health care program; any amount paid by an employer to an employee for employment in the provision of covered items or services; any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities under specified conditions; a waiver of any co-insurance under Part B of Medicare by a federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act; and any payment practice specified by the Secretary as a safe harbor exception.

House bill

This section would add a new exception to the anti-kickback provisions allowing remuneration between an eligible organization under section 1876 and an individual or entity providing items or services pursuant to a written agreement between an eligible organization under section 1876 and the individual or entity. Remuneration would also be allowed between an organization and an individual or entity if a written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is obligated to provide. The risk arrangement may be provided through a withhold, capitation, incentive pool, per diem payment or other similar risk arrangement. This amendment would apply to acts of omissions occurring after January 1, 1997.

Senate amendment

Similar. However, the House provision specifically lists two permissible risk arrangements, i.e., incentive pools, and per diem payments, which are not listed in the Senate provision, and the Senate provision provides for the issuance of regulations by the Secretary, in consultation with the Attorney General, to define substantial financial risk as necessary to protect program or patient abuse.

Conference agreement

The conference agreement includes the House provision with modifications to the definition of allowable remuneration. In addition, the conference agreement adds a provision setting forth a negotiated rulemaking process for standards relating to the new exception to the anti-kickback penalties added by this section.

G. CRIMINAL PENALTY FOR FRAUDULENT DISPOSITION OF ASSETS IN ORDER TO OBTAIN MEDICAID BENEFITS

(Section 217 of the House bill.)

Current law

Under section 1128B, upon conviction of a program-related felony, an individual may be fined not more than $25,000 or imprisoned for not more than five years or both.

House bill

This provision would add a new crime to the list of prohibited activities under section 1128B of the Social Security Act for cases where a person knowingly and willfully disposes of assets by transferring assets in order to become eligible for benefits under the Medicaid program, if disposing of the assets results in the imposition of a period of ineligibility.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

III. DATA COLLECTION

(Subtitle C of the House bill; subtitle C of the Senate amendment.)

A. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

(Section 221 of the House bill; section 521 of the Senate amendment.)

Current law

No provision.

House bill

The Secretary of Health and Human Services would be required to establish a national health care fraud and abuse data collection program for reporting final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners.

Each government agency and health plan would, on a monthly basis, report any final adverse action taken against a health care provider, supplier, or practitioner. Certain information would be included in the report, including a description of the acts or omissions and injuries upon which the final adverse action was taken. The Secretary would, however, protect the privacy of individuals receiving health care services.

The Secretary would, by regulation, provide for disclosure of the information about adverse actions, upon request, to the health care provider, supplier, or licensed practitioner and provide procedures in the case of disputed accuracy of the information. Each government agency and health plan is required to report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner in such form and manner that the Secretary prescribes by regulation.

The information in the database would be available to Federal and State government agencies and health plans. The Secretary may approve reasonable fees for the disclosure of information in the data base (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the data base.

No person or entity would be held liable in any civil action with respect to any report made as required by this section, unless the person or entity knows the information is false.

The Secretary may impose appropriate fees on physicians to cover the costs of investigation and recertification activities with respect to the issuance of identifiers for physicians who furnish services for which Medicare payments are made.

Senate amendment

Similar with one additional provision requiring that the Secretary implement this section in such a manner as to avoid duplication with the reporting requirements established for the National Practitioner Data Bank.

Conference agreement

The conference agreement includes the House provision with a modification directing the Secretary to implement this section so as to avoid duplication with the reporting requirements of the National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986.

IV. CIVIL MONETARY PENALTIES

(Subtitle D of the House bill; subtitle D of the Senate amendment.)

A. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES

(Section 231 of the House bill; section 531 of the Senate amendment.)

Current law

Under Section 1128A of the Social Security Act civil monetary penalties may be imposed for false and fraudulent claims for reimbursement under the Medicare and State health care programs.

House bill

The Medicare and Medicaid program provisions providing for civil monetary penalties for specified fraud and abuse violations would apply to similar violations involving other Federal health care programs. Federal health care programs would include any health insurance plans or programs funded, in whole or part, by the Federal government, such as CHAMPUS. Civil monetary penalties and assessments received by the Secretary would be deposited into the Health Care Fraud and Abuse Control Account established under this Act.

Any person who has been excluded from participating in Medicare or a State health care program and who retains a direct or indirect ownership or control interest in an entity that is participating in a program under

Medicare or a State health care program, and who knows or should know of the action constituting the basis for the exclusion, or who is an officer or managing employee of such an entity, would be subject to a civil monetary penalty of not more than $10,000 for each day the prohibited relationship occurs.

Amends the civil monetary penalty provisions of Section 1128A(a) by increasing the amount of a civil money penalty from $2,000 to $10,000 for each item or service involved. Also increases the assessment which a person may be subject to from ''not more than twice the amount'' to ''not more than three times the amount'' claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim.

Adds two practices to the list of prohibited practices for which civil money penalties may be assessed. The first occurs when a person engages in a pattern or practice of presenting a claim for an item or service based on a code that the person knows or should know will result in greater payments than appropriate. The second is the practice whereby a person submits a claim or claims that the person knows or should know is for a medical item or service which is not medically necessary.

The sanction against practitioners and persons who fail to comply with certain statutory obligations is changed from an amount equal to ''the actual or estimated cost'' of the medically improper or unnecessary services provided, to ''up to $10,000 for each instance of medically improper or unnecessary services provided.

The procedural provisions outlined in Section 1128A, such as notice, hearings, and judicial review rights, would apply to civil monetary penalties assessed against Medicare Health Maintenance Organizations in the same manner as they apply to civil monetary penalties assessed against health care providers generally.

This provision also adds a new practice to the list of prohibited practices for which civil monetary penalties could be assessed. Any person who offers remuneration to an individual eligible for benefits under Medicare or a State health care program that such individual knows or should know is likely to influence such individual to order or received from a particular provider, practitioner or supplier any item or service reimbursable under Medicare or a State health care program would be subject to the various civil monetary penalties, assessments and exclusion provisions of section 1128A of the Social Security Act.

The term ''remuneration'' is defined to include the waiver of part or all of coinsurance and deductible amounts, as well as transfers of items or services for free, or for other than fair market value. There would be exceptions to this definition. The waiver of part or all of coinsurance and deductible amounts would not be considered remuneration under this section if the waiver is not offered as part of any advertisement or solicitation, the person does not routinely waive coinsurance or deductible amounts, and the person either waives the coinsurance and deductible amounts because the individual is in financial need, or fails to collect the amounts after reasonable collection efforts, or provides for a permissible waiver under regulations issued by the Secretary. In addition, the term remuneration would not include differentials in coinsurance and deductible amounts as part of a benefit plan design if the differentials have been disclosed in writing to all beneficiaries, third party payors, and providers, and if the differentials meeting the standards defined in the Secretary's regulations. Remuneration would also not include incentives given to individuals to promote the delivery of preventive care under the Secretary's regulations.

The effective date of these provisions is January 1, 1997.

Senate amendment

Identical.

Conference agreement

The conference agreement includes the House provision. The conferees do not intend that the language of section 231(d) create any new standard for coverage of a claim. The intent is to assure that a proper evaluation by a practitioner is completed and evidence of treatment need is established before services are delivered for which claims are submitted. The conferees recognize that under current law the reasonableness of a service provided by a non-medical practitioner, including a practitioner of alternative medicine, in judged by the application of principles particular to such non-medical health care professions. For example, the provision and reasonableness of chiropractic services under Medicare is judged by the application of chiropractic principles.

There is significant concern regarding the impact of the anti-fraud provisions on the practice of complementary or alternative medicine and health care. The practice of complementary or alternative medical or health care practice itself would not constitute fraud.

The conferees do not intend to penalize the exercise of medical judgment of health care treatment choices made in good faith and which are supported by significant evidence or held by a respectable minority of those providers who customarily provide similar methods of treatment. The Act is not intended to penalize providers simply because of a professional difference of opinion regarding diagnosis or treatment.

A sanction is not intended for providers who submit claims they know will not be considered reimbursable as medically necessary services, but who are required to submit the claims because their patients need to document that Medicare will not reimburse the service. In submitting such claims, providers shall notify carriers that a claim is being submitted solely for purpose of seeking reimbursement from secondary payers.

Moreover, the conferees intend that a penalty will be imposed on presentation of a claim that is false or fraudulent. No sanction is intended for providers who simply inform beneficiaries that are particular service is not covered by Medicare. Moreover, nothing in this section is intended to supersede the limitation on liability provisions established under Section 1879 of the Social Security Act.

In addition, the conferees intend, with respect to allowable remuneration, that this provision not preclude the provision of items and services of nominal value, including, for example, refreshments, medical literature, complimentary local transportation services, or participation in free health fairs.

B. CLARIFICATION OF LEVEL OF INTENT REQUIRED FOR IMPOSITION OF SANCTIONS

(Section 232 of the House bill.)

Current law

Civil monetary penalties may be imposed for seeking reimbursement under the Medicare and Medicaid programs for items of services not provided or for services provided by someone who is not a licensed physician, whose license was obtained through misrepresentation, or who misrepresented his or her qualification as a specialist, or where the claim is otherwise fraudulent. Civil penalties may also be sought for presenting a claim due for payments which are in violation of (1) contracts payment due to assignment of a patient, (2) agreements with state agencies limiting permitted charges, (3) agreements with participating physicians or suppliers, and (4) agreements with providers of services. Civil monetary penalties may also be sought against persons who provide false or misleading information that could reasonably be expected to influence a decision to discharge a person from a hospital. A person is subject to these provisions if he or she presented a claim and he or she ''knows or should have known'' that the claim fell into one of the categories listed above.

House bill

This provision adds a requirement, similar to the False Claims Act, that a person is subject to this provision when the person ''knowingly'' presents a claim that the person ''knows or should know'' falls into one of the prohibited categories. Thus, an assessment under this provision would only be made where a person had actual knowledge that he or she had submitted a claim or had provided false or misleading information, and where the person had actual knowledge of the fraudulent nature of the claim, acted in deliberate ignorance, or acted in reckless disregard of the truth or falsity of the information. The requirement that a person ''knowingly'' present a claim or ''knowingly'' make a false or misleading statement which influences discharge would prevent charging persons who inadvertently perform these acts.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision, but this provision has been added to the section of this bill entitled ''Social Security Act Civil Monetary Penalties'', above.

C. PENALTY FOR FALSE CERTIFICATION FOR HOME HEALTH SERVICES

(Section 233 of the House bill.)

Current law

No provision.

House bill

This provision would add an additional civil monetary penalty of not more than three times the amount of the payments, or $5,000, whichever is greater, for a physician who certifies that an individual meets all of Medicare's requirements to receive home health care while knowing that the individual does not meet all such requirements. This provision would apply to certifications made on or after the date of enactment of this Act.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

V. REVISIONS TO CRIMINAL LAW

(Subtitle E of the House bill; subtitle E of the Senate amendment.)

A. DEFINITIONS RELATING TO FEDERAL HEALTH CARE OFFENSE

(Section 241 of the House bill; section 542 of the Senate amendment.)

Current law

No provision.

House bill

This provision defines the term ''Federal health care offense'' to include violations of, or criminal conspiracies to violate, section 669, 1035, 1347 or 1518 of Title 18 of the United States Code, or section 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title, if the violation or conspiracy relates to a health care benefit program. A ''health care benefit program'' is any public or private plan affecting

commerce under which any medical benefit, item or service is provided to any individual, and includes any individual or entity providing such a medical benefit, item or service for which payment may be made under the plan.

Senate amendment

The Senate amendment defines ''Federal health care offense'' as a violation of, or a criminal conspiracy to violate section 1128B of the Social Security Act, section 1347 of this title, and sections 287, 371, 664, 666, 669, 1001, 1027, 1341, 1343, or 1954 of this title if the violation or conspiracy relates to health care fraud.

Conference agreement

The conference agreement includes the House provision.

B. HEALTH CARE FRAUD

(Section 242 of the House bill; section 541 of the Senate amendment.)

Current law

Depending on the facts of a particular case, criminal penalties may be imposed on persons engaged in health care fraud under federal mail and wire fraud statutes, the False Claims Act, false statement statues, money laundering statutes, racketeering, and other related laws.

House bill

Under this provision criminal penalties would be imposed for knowingly executing or attempting to execute a scheme or artifice (1) to defraud any health care benefit program; or (2) to obtain, by means of false or fraudulent pretense, money or property owned by, or under the custody or control of, any health care benefit program. Penalties include fines and up to 10 years imprisonment. If the violation results in serious bodily injury, the person may be imprisoned up to 20 years. If the violation results in death, the person may be imprisoned for life.

Senate amendment

Similar. However, the Senate provision provides that the crime be commended ''willfully'' as well as knowingly, and the penalties are listed as ''any term of years'' if the violation results in serious bodily injury. The Senate provision also provides that criminal fines imposed under this section be deposited into the Federal Hospital Insurance Trust Fund.

Conference agreement

The conference agreement includes the House provision with a modification specifying that the standard of intent will be ''knowingly and willfully''.

There has been significant concern regarding the impact of the anti-fraud provisions on the practice of complementary and alternative medicine and health care. The practice of complementary, alternative, innovative, experimental or investigational medical or health care itself would not constitute fraud. The conferees intend that this proposal not be interpreted as a prohibition of the practice of these types of medical or health care. The Act is not intended to penalize a person who exercises a health care treatment choice or makes a medical or health care judgment in good faith simply because there is a difference of opinion regarding the form of diagnosis or treatment. Nor does this provision in general prohibit plans from covering specific types of treatment. Whether certain complementary and alternative practices will be covered is and should be a decision left to health care plan administrators.

C. THEFT OR EMBEZZLEMENT

Section 243 of the House bill; section 546 of the Senate amendment)

Current law

No provision.

House bill

Criminal penalties would be imposed for embezzling, stealing, or otherwise without authority knowingly converting or intentionally misapplying any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program. A person convicted under this provision would be subject to a fine under Title 18 of the United States Code, or imprisoned not more than 10 years, or both. If the value of property does not exceed $100, the defendant would be fined or imprisoned not more than one year, or both.

Senate amendment

Requires that this crime be committed ''willfully'', and the person convicted is subject to a fine under this title or imprisonment of not more than 10 years, or both.

Conference agreement

The conference agreement includes the House provision with a modification specifying that the standard of intent will be ''knowingly and willfully''.

D. FALSE STATEMENTS

(Section 244 of the Hose bill; section 544 of the Senate amendment.)

Current law

The Federal false statements provision at 18 U.S.C. §1001 generally prohibits false statements with regard to any matter within the jurisdiction of a Federal department or agency.

House bill

Criminal penalties would be imposed for knowingly falsifying, concealing, or covering up by any trick, scheme, or device a material fact, or making false, fictitious, or fraudulent statements or representations, or making or using any falsewriting or document knowing the same to contain any false, fictitious, or fraudulent statement or entry in any matter involving a health care benefit program. A person convicted under this provision may be punished by the imposition of fines under title 18 of the United States Code, or by imprisonment of not more than 5 years, or both.

Senate amendment

Contains additional elements of the crime of false statements, including the words ''willfully'' and ''materially''. The House bill language specifying that the false statements be ''in connection with the delivery of or payment for health care benefits, items, or services'' does not appear in the Senate amendment provision.

Conference agreement

The conference agreement includes the House provision with a modification specifying that the standard of intent will be ''knowingly and willfully''.

E. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF HEALTH CARE OFFENSES

(Section 245 of the House bill; section 545 of the Senate amendment.)

Current law

Under current law, criminal penalties are imposed for obstructing, delaying or preventing the communication of information to law enforcement officials regarding the violation of criminal statues by using bribery, intimidation, threats, corrupt persuasion, or harassment.

House bill

Criminal penalties would be imposed for willfully preventing, obstructing, misleading, delaying or attempting to prevent, obstruct, mislead or delay the communication of information or records relating to a Federal health care offense to a criminal investigator. A person convicted under this provision could be punished by the imposition of fines under title 18 of the United States Code or by imprisonment of not more than 5 years, or both. Criminal investigator would mean any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage investigations for prosecution for violations of health care offenses.

Senate amendment

Similar, with only minor drafting differences.

Conference agreement

The conference agreement includes the House provision.

F. LAUNDERING OF MONETARY INSTRUMENTS

(Section 246 of the House bill; section 547 of the Senate amendment.)

Current law

The current Federal money laundering provision is found at 18 U.S.C. §1956(c)(7), but does not include money laundering as related to health care fraud.

House bill

An act or activity constituting a Federal health care offense would be considered a ''specified unlawful activity'' for purposes of the prohibition on money laundering, so that any person who engages in money laundering in connection with a Federal health care offense would be subject to existing criminal penalties.

Senate amendment

Similar, with only minor drafting differences.

Conference agreement

The conference agreement includes the House provision.

G. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES

(Section 247 of the House bill; section 543 of the Senate amendment.)

Current law

Depending on the facts of a particular case, injunctive relief may be imposed on persons who are committing or about to commit health care fraud under federal racketeering statutes and other related laws.

House bill

If a person is violating or about to commit a Federal health care offense, the Attorney General of the United States could commence a civil action in any Federal court to enjoin such a violation. If a person is alienating or disposing of property or intends to alienate or dispose of property obtained as a result of a Federal health care offense, the Attorney General could seek to enjoin such alienation or disposition, or could seek a restraining order to prohibit the person from withdrawing, transferring, removing, dissipating or disposing of any such property or property of equivalent value and appoint a temporary receiver to administer such restraining order.

Senate amendment

Similar.

Conference agreement

The conference agreement includes the House provision.

H. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES

(Section 248 of the House bill; section 548 of the Senate amendment.)

Current law

No provision.

House bill

This provision would establish procedures for the Attorney General to make investigative demands in cases regarding health care

fraud. Under this section, the Attorney General could issue a summons for records and/or a witness to authenticate the records.

Administrative summons would be authorized for investigations of any scheme to defraud an health care benefit program in connection with the delivery of or payment for health care. This section would provide for service of a subpoena and enforcement of a subpoena in all United States courts, as well as a grant of immunity to persons responding to a subpoena from civil liability for disclosure of such information.

The provision would also provide that health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of, and is directly related to, receipt of health care of payment for health care or action involving a fraudulent claim related to health, or if good cause is shown.

Senate amendment

Contains additional language relating to testimony by a custodian of records, the production of records, witness fees, and administrative summons.

Conference agreement

The conference agreement includes the House provision with an amendment to include Senate bill language relating to testimony by a custodian of records.

I. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES

(Section 249 of the House bill; section 542 of the Senate amendment.)

Current law

Depending on the facts of a particular case, criminal forfeiture may be imposed on persons convicted under federal money laundering statutes, racketeering statutes, and other related laws.

House bill

A court imposing a sentence on a person convicted of a Federal health care offense could order the person to forfeit all real or personal property that is derived, directly or indirectly, from proceeds traceable to the commission of the offense. After payment of the costs of asset forfeiture have been made, the Secretary of the Treasury would deposit into the Federal Hospital Insurance Trust Fund an amount equal to the net amount realized from the forfeiture of property by reason of a federal health care offense.

Senate amendment

Identical.

Conference agreement

The conference agreement includes the House provision.

J. RELATION TO ERISA AUTHORITY

(Section 250 of the House bill.)

Current law

The Employee Retirement Income Security Act of 1974 sets forth comprehensive requirements for employee pension and welfare benefit plans, including reporting and disclosure requirements and fiduciary standards for trustees and fiduciaries; pension plans are also subject to funding, participation, and vesting requirements.

House bill

The provision states that nothing in this subtitle (Revisions to Criminal law), shall affect the authority of the Secretary of Labor under section 506(b) of ERISA to detect and investigate civil and criminal violations related to ERISA.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

2. Administrative simplification

(Sections 251 and 252 of subtitle F of title II of the House bill.)

Current law

No provision.

House bill

The bill would provide that the purpose of the subtitle was to improve the Medicare and Medicaid programs, and the efficiency and effectiveness of the health care system, by encouraging the development of health information network through the establishment of standards and requirements for the electronic transmission of certain health information. Amends title XI of the Social Security Act by adding Part C—Administrative Simplification.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

A. DEFINITIONS

(New section 1171 of the Social Security Act.)

Current law

No provision.

House bill

The bill would provide definitions for this part of the Act including the following: clearinghouse, code set, coordination of benefits, health care provider, health information, health plan, individually identifiable health information, standard, and standard setting organization.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with an amendment to exclude a definition for coordination of benefits and clarifies the definition of health plan.

B. GENERAL REQUIREMENTS FOR ADOPTION OF STANDARDS

(New section 1172 of the Social Security Act.)

Current law

No provision.

House bill

The bill would require that any standard or modification of a standard adopted would apply to the following: (1) a health plan, (2) a clearinghouse, or (3) a health care provider, but only to the extent that the provider was conducting electronic transactions referred to in the bill. The bill would require that any standard or modification of a standard adopted must reduce the administrative cost of providing and paying for health care. The standard setting organization would be required to develop or modify any standard or modification adopted. The Secretary could adopt a standard or modification of a standard that was different from any standard developed by such organization if the different standard or modification was promulgated in accordance with rulemaking procedures and would substantially reduce administrative costs to providers and plans. The Secretary would be required to establish specifications for implementing each of the standards and modifications adopted. The standards adopted would be prohibited from requiring disclosure of trade secrets or confidential commercial information by a participant in the health information network. In complying with the requirements of this part, the Secretary would be required to rely on the recommendations of the Health Information Advisory Committee established by the bill, and consult with appropriate Federal and State agencies and private organizations.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with a modification that requires the Secretary to rely on the recommendations of the National Committee on Vital and Health Statistics. The standard-setting organization should consult with the National Uniform Billing Committee, the National Uniform Claim Committee, the Working Group for Electronic Data Interchange, and the American Dental Association.

C. STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS

New section 1173 of the Social Security Act.)

Current law

No provision.

House bill

The bill would require the Secretary to adopt appropriate standards for financial and administrative transactions and data elements exchanged electronically that are consistent with the goals of improving the operation of the health care system and reducing administrative costs. Financial and administrative transactions would include claims, claims attachments, enrollment and disenrollment, eligibility, health care payment and remittance advice, premium payments, first report of injury, claims status, and referral certification and authorization. Standards adopted by the Secretary would be required to accommodate the needs of different types of health care providers.

The Secretary would be required to adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system. The Secretary would be required to establish security standards that (1) take into account the technical capabilities of record systems to maintain health information, the costs of security measures, the need for training persons with access to health information, the value of audit trails in computerized record systems used, and the needs and capabilities of small health care providers and rural health care providers; and (2) ensure that a clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of such service to prevent unauthorized access to such information by such larger organization. The Secretary would be required to establish standards and modifications to such standards regarding the privacy of individually identifiable health information that is in the health information network. The Secretary, in coordination with the Secretary of Commerce, would be required to adopt standards specifying procedures for the electronic transmission and authentication of signatures, compliance with which would be deemed to satisfy Federal and State statutory requirements for written signatures with respect to the transactions specified by the bill. This part would not be construed to prohibit the payment of health care services or health plan premiums by debit, credit, payment card or numbers, or other electronic means. The Secretary would be required to adopt standards for determining the financial liability of health plans when health benefits are payable under two or more health plans, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

The conferees recognize that certain uses of individually identifiable information are appropriate, and do not compromise the privacy of an individual. Examples of such use of information include the transfer of information when making referrals from primary care to specialty care, and the transfer of information from a health plan to an organization for the sole purpose of conducting health care-related research. As health plans and providers continue to focus on outcomes research and innovation, it is important that the exchange and aggregated use of health care data be allowed.

The conference agreement includes a modification that this part would not be construed to regulate the payment of health care services or health care premiums by debit, credit, payment card or other electronic means.

D. TIMETABLES FOR ADOPTION OF STANDARDS

(New section 1174 of the Social Security Act.)

Current law

No provision.

House bill

The bill would require the Secretary to adopt standards relating to the transactions, data elements of health information, security and privacy by not later than 18 months after the date of enactment of the part, except that standards relating to claims attachments would be required to be adopted not later than 30 months after enactment. The Secretary would be required to review the adopted standards and adopt additional or modified standards as appropriate, but not more frequently than once every 6 months, except during the first 12-month period after the standards are adopted unless the Secretary determines that a modification is necessary in order to permit compliance with the standards. The Secretary would also be required to ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with a modification that the Secretary would be required to adopt additional or modified standards not more frequently than 12 months.

E. REQUIREMENTS

(New section 1175 of the Social Security Act.)

Current law

No provision.

House bill

The bill would establish that if a person desires to conduct a financial or administrative transaction with a health plan as a standard transaction, (1) the health plan may not refuse to conduct such transaction as a standard transaction, (2) the health plan may not delay such transaction, or otherwise adversely affect, or attempt to adversely affect, the person or the transaction on the grounds that the transaction is a standard transaction, and (3) the information transmitted and received in connection with the transaction would be required to be in a form of standard data elements for health information. Health plans could satisfy the transmission of information by directly transmitting standard data elements of health information, or submitting nonstandard data elements to a clearinghouse for processing in to standard data elements and transmission. Not later than 24 months after the date on which standard or implementation specification was adopted or established under this part, each person to which the standard applied would be required to comply with the standard or specification. Small health plans, determined by the Secretary, would be required to comply not later than 36 months after standards were adopted.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

F. GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS

(Section 1176 of the Social Security Act.)

Current law

No provision.

House bill

The bill would require the Secretary to impose on any person who violates a provision under the bill a penalty of not more than $100 for each such violation of a specific standard or requirement, except that the total amount imposed on the person for all such violations during a calendar year would not exceed $25,000. A penalty would not be imposed if it was established that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision. A penalty would not be imposed if (1) the failure to comply was due to reasonable cause and not willful neglect, and (2) the failure to comply with corrected during the 30-day period beginning on the first date the person liable for the penalty knows, or would have known, that the failure to comply occurred.

Senate amendment

No provision.

Conference agreement.

The conference agreement includes the House provision.

G. WRONGFUL DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

(New section 1177 of the Social Security Act.)

Current law

No provision.

House bill

The bill would define the offense of wrongful disclosure of individually identifiable health information as instances when a person who knowingly (1) uses or causes to be used a unique health identifier violation of a provision in this part, (2) obtains individually identifiable health information relating to an individual in violation of a provision in this part, or (3) discloses individually identifiable health information to another person in violation of this part. A person committing such an offense would be required to (1) be fined not more than $50,000, imprisoned not more than 1 year, or both; (2) if the offense was committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both; and (3) if the offense was committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, fined not more than $250,000, imprisoned not more than 10 years, or both.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

H. EFFECT ON STATE LAW

(New section 1178 of the Social Security Act.)

Current law

No provision.

House bill

The bill would require that a provision, requirement, or standard provided by the bill supersede any contrary provision of state law, including a provision of state law that required medical or health plan records (including billing information) to be maintained or transmitted in written rather that electronic form. A provision under the bill would not supersede a contrary provision of state law if the provision of state law (1) was more stringent than the requirements of the bill with respect to privacy or individually identifiable health information, or (2) was a provision the Secretary determined was necessary to prevent fraud and abuse with respect to controlled substances or for other purposes.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with a modification, that the provision would not supersede a contrary State law only if the Secretary determines that the State law (1) is necessary to prevent fraud and abuse; (2) to ensure appropriation State regulation of insurance and health plans; (3) for state reporting on health care delivery or costs, or for other purposes; or (4) addresses controlled substances.

The conference agreement also includes the requirement that any standard adopted under this part would not apply to the following: (1) the use or disclosure of information for authorizing, processing, clearing, settling, billing, transferring, collecting, or reconciling a payment for, health plan premiums or health care, where such payment is made by means of a credit, debit, or other payment card, or by an account, check, electronic funds transfer or other such means; (2) the use or disclosure of information relating to a payment described above for transferring receivables, resolving customer disputes or inquiries, auditing, supplying a statement to a consumer of a financial institution regarding the customer's account with such an institution, reporting to customer reporting agencies, or complying with a civil or criminal subpoena or a Federal or State law regulating financial institutions.

The conferees do not intend to exclude the activities of financial institutions or their contractors from compliance with the standards adopted under this part if such activities would be subject to this part. However, conferees intend that this part does not apply to use or disclosure of information when an individual utilizes a payment system to make a payment for, or related to, health plan premiums or health care. For example, the exchange of information between participants in a credit card system in connection with processing a credit card payment for health care would not be covered by this part. Similarly sending a checking account statement to an account holder who uses a credit or debit card to pay for health care services, would not be covered by this part. However, this part does apply if a company clears health care claims, the health care claims activities remain subject to the requirements of this part.

1. CHANGES IN MEMBERSHIP AND DUTIES OF NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

(Section 253 of the House bill.)

Current law

No provision.

House bill

The bill would amend the membership and duties of the National Committee on Vital and Health Statistics, authorized under section 306(k) of the Public Health Service Act, as amended, by increasing the number of members to 18. The committee would be required to (1) provide assistance and advice to the Secretary on issues related to health statistical and health information; health with complying with the requirements of the bill; (2) study the issues related to the adoption of uniform data standards for patient medical record information and electronic exchange of such information; (3) report to the Secretary not later than 4 years after enactment of the Health Coverage Availability and Affordability Act of 1996, and annually thereafter, recommendations and legislative proposals for such standards and electronic exchange; and (4) be generally advising the Secretary and the Congress on the status of the future of the health information network. The committee would be required, not later than 1 year after enactment, to report to Congress, health care providers, health plans, and other entities using the health information network regarding (1) the extent to which entities using the network were meeting the standards adopted and working together to form an integrated network that meets the needs of its users; (2) the extent to which entities were meeting the privacy and security standards, and the types of penalties assessed for noncompliance; (3) whether the federal and state governments were receiving information of sufficient quality to meet their responsibilities; (4) any problems that exist with implementation of the network; and (5) the extent to which timetables established by under this part of the bill were being met.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

The conference agreement also includes a requirement that the Secretary submit detailed recommendations on standards with respect to the privacy of individually identifiable health information not later than 12 months after enactment. The recommendations would be required to address at least: (1) the rights an individual should have relating to individually identifiable health information; (2) the procedures that should be established for the exercise of such rights; and (3) the uses and disclosures of such information that should be authorized or required. The Secretary would be required to consult with the Attorney General, and the National Committee on Vital and Health Statistics for carrying out this requirement. If Congress fails to enact privacy legislation, the Secretary is required to develop standards with respect to privacy of individually identifiable health information not later than 42 months from the date of enactment.

The conferees recognize that industry experts are essential to the membership of the National Committee on Vital and Health Statistics. It is the conferees' intent that the Committee select representatives from the insurer, HMO, provider, employer, accreditation communities, and a representative from the Workgroup for Electronic Data Interchange (WEDI).

The conferees recognize that technological innovation with respect to electronic transmission of health-care related transactions is progressing rapidly in the marketplace. The conferees do not intend to stifle innovation in this area. Therefore, the conferees intend that the Committee take into account private sector initiatives.

3. Duplication and coordination of Medicare-related plans

(Subtitle G of title II of the House bill.)

A. DUPLICATION AND COORDINATION OF MEDICARE-RELATED PLANS

(Section 281 of House bill.)

Current law

Many Medicare beneficiaries purchase private health insurance to supplement their Medicare coverage. These individually purchased policies are known as Medigap policies. The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990, P.L. 101–508) provided for a standardization of Medigap policies. OBRA also substantially modified the antiduplication provision contained in law. The intent of the OBRA 1990 anti-duplication provision was to prohibit sales of duplicative Medigap policies. However, the statutory language applied, with very limited exceptions, to all ''health insurance policies'' sold to Medicare beneficiaries. Observers noted that this provision could thus apply to a broad range of policies including hospital indemnity plans, dread disease policies, and long-term care insurance policies.

The Social Security Amendments of 1994 (P.L. 103–432) included a number of technical modifications to the Medigap statute, including modifications to the anti-duplication provisions contained in section 1882(d)(3) of the Act. Under the revised language, it is illegal to sell or issue the following policies to Medicare beneficiaries: (i) a health insurance policy with knowledge that is duplicates Medicare or Medicaid benefits to which a beneficiary is otherwise entitled; (ii) a Medigap policy, with knowledge that the beneficiary already has a Medigap policy; or (iii) a health insurance policy (other than Medigap) with knowledge that it duplicates private health benefits to which the beneficiary is already entitled.

A number of exceptions to these prohibitions are established. The sale of a medigap policy is not in violation of the provisions relating to duplication of Medicaid coverage if: (i) the State Medicaid program pays the premiums for the policy; (ii) in the case of qualified Medicare beneficiaries (QMBs), the policy includes prescription drug coverage; or (iii) the only Medicaid assistance the individual is entitled to is payment of Medicare Part B premiums.

The sale of a health insurance policy (other than a Medigap policy) that duplicates private coverage is not prohibited if the policy pays benefits directly to the individual without regard to other coverage. Further, the sale of a health insurance policy (other than a Medigap policy to an individual entitled to Medicaid) is not in violation of the prohibition relating to selling of a policy duplicating Medicare or Medicaid, if the benefits are paid without regard to the duplication in coverage. This exception is conditional on the prominent disclosure of the extent of the duplication, as part of or together with, the application statement.

P.L. 103–432 provided for the development by the National Association of Insurance Commissioners (NAIC) of disclosure statements describing the extent of duplication for each of the types of private health insurance policies. Statements were to be developed, at a minimum, for policies paying fixed cash benefits directly to the beneficiary and policies limiting benefits to specific diseases. The NAIC identified 10 types of health insurance policies requiring disclosure statements and developed statements for them. These were approved by the Secretary and published in the *Federal Register* on June 12, 1995.

House bill

The provision would modify the anti-duplication provisions. The requirement for obtaining a written application statement would be limited to the sale of Medigap policies to persons already having Medigap policies.

Anti-duplicative provisions would specifically state that a policy which pays benefits to or on behalf of an individual without regard to other health benefit coverage would not be considered to duplicate any health benefits under Medicare, Medicaid, or a health insurance policy. Further, such policies would be excluded from the sales prohibitions.

The provision would specifically state that a health insurance policy (or a rider to an insurance contract which is not a health policy) which provides benefits for long term care, nursing home care, home health care or community-based care and that coordinates or excludes against services covered under Medicare would not be considered duplicative, provided such coordination or exclusion was disclosed in the policy's outline of coverage.

The provision would specify that a health insurance policy (which may be a contract with a health maintenance organization), provided to a disabled beneficiary, that is a replacement product for another policy that is being terminated by the insurer would not be considered duplicative if it coordinates with Medicare.

The provision would prohibit the imposition of criminal or civil penalties, or taking of legal action, with respect to any actions which occurred between enactment of P.L. 103–432 and enactment of this measure, provided the policies the policies met the new requirements.

The provision would prohibit States from imposing duplication requirements with respect to a policy (other than Medigap policy) or rider to an insurance contract which is not a health policy if the policy or rider pays benefits without regard to other benefits coverage or if it is a long-term care, policy or policy sold to the disabled (as such policies are described above).

The provision would also delete current language relating to required disclosure statements.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with modifications. The agreement would clarify that policies offering only long-term care nursing home care, home health care, or community based care, or any combination thereof would be allowed to coordinate benefits with Medicare and not be considered duplicative, provided such coordination was disclosed. The conference agreement does not include the provision relating to replacement policies sold to disabled persons.

The conference agreement would modify, rather than repeal, the current law requirement for disclosure statements for policies that pay regardless of other coverage. Disclosure statements, for the type of policy being applied for, would be furnished to a Medicare beneficiary applying for a health insurance policy. The statement would be furnished as a part of (or together with) the policy application.

The conference agreement would specify that whoever issues or sells a health insurance policy to a Medicare beneficiary and fails to furnish the required disclosure statement would be fined under title 18 of the United States Code, or imprisoned not more than five years or both. In addition, or in lieu of the criminal penalty, a civil money penalty of $25,000 (or $15,000 in the case of someone who is not an issuer) could be imposed for each violation.

The disclosure requirements would not apply to Medigap policies or health insurance policies identified in the July 12, 1995 Federal Register notice (i.e. policies that do not duplicate Medicare (even incidentally), life insurance policies that contain long-term care riders or accelerated death benefits, disability insurance policies, property and casualty policies, employer and union group health plans, managed care organizations with Medicare contracts, and health care prepayment plans (HCPPs) that provide some or all of Part B benefits under an agreement with HCFA.)

The conference agreement would modify existing disclosure statements to remove the wording that implies the policies duplicate Medicare coverage. New language would be substituted which states that: ''Some health care services paid for by Medicare may also trigger the payment of benefits under this policy''.

The agreement would further modify the required statement for policies providing both nursing home and non-institutional coverage, nursing home benefits only, or home health care benefits only. The reference to Federal law would be modified to read: ''Federal law requires us to inform you that in certain situations this insurance may pay for some care also covered by Medicare''. All other policies would be required to include the following statement: ''This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.''

The conference agreement would further modify the language relating to State actions. The law would specifically state that nothing in the provision restricts or precludes a State's ability to regulate health insurance, including the policies subject to disclosure requirements. However, a State may not declare or specify, in statute, regulation, or otherwise, that a health insurance policy (other than a Medigap policy) or rider to an insurance contract which is not a health insurance policy that pays regardless of other coverage duplicates Medicare or Medigap benefits.

The conference agreement further narrows the language relating to application of penalties and legal action with respect to non-duplication requirements during a transition period, defined as beginning on November 5, 1991 and ending on the date of enactment. No criminal or civil monetary penalty could be imposed for an act or omission that occurred during the transition period relating to policies that pay benefits without regard to other coverage or long-term care policies. No legal action could be brought or continued in any Federal or State court with respect to the sale of such policies insofar as such action includes a cause of action which arose or is based on action occurring during the transition period and relating to non-duplication requirements. This limitation on legal actions would be conditional on the existing disclosure requirements being met with respect to any policy sold during the period beginning on the effective date of the disclosure requirements required by the 1994 Act (i.e. August 11, 1995) and ending 30 days after enactment.

The conference agreement further provides that the new disclosure rules only apply after enactment to health insurance policies that pay regardless of other coverage and 30-days after enactment to another health insurance policy.

The conference agreement would further permit a seller or issuer of a health insurance policy to use current disclosure statements rather than the new disclosure statements.

4. Medical liability reform

(Subtitle H of title II of the House bill; section 310 of title I of the Senate amendment.)

I. GENERAL PROVISIONS

A. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS

(Section 271 of House bill.)

Current law

There are no uniform Federal standards governing health care liability actions.

House bill

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

(2) Preemption; Effect on Sovereign Immunity. The provisions would preempt State law to the extent State law provisions were inconsistent with the new requirements. However, it would not preempt State law to the extent State law provisions were more stringent. The provision specifies that nothing in the preemption provision could be construed to: (i) waive or affect any defense of sovereign immunity asserted by any State under any provision of law; (ii) waive or affect any defense of sovereign immunity asserted by the U.S.: (iii) affect any provision of the Foreign Services Immunity Act of 1976; (iv) preempt State choice-of-law rules with respect to claims brought by a Foreign nation or a citizen of a foreign nation; or (v) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(3) Amount in Controversy; Federal Court Jurisdiction. The provision would specify that in the case of a health care liability action brought under section 1332 of Title 28 of the U.S. Code, the amount of noneconomic and punitive damages and attorneys fees would not be included in establishing the amount in controversy for purposes of establishing original jurisdiction. Further, the provision would specify that nothing in this subtitle would be construed to establish any jurisdiction in the U.S. district courts over health care liability action on the basis of Federal question grounds specified in section 1331 or 1337 of title 28 of the U.S. Code.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

B. DEFINITIONS

(Section 272 of House bill.)

Current law

No provision.

House bill

The provision would define the following terms for purposes of the Federal reforms: actual damages; alternative dispute resolution system; claimant; clear and convincing evidence; collateral source payments; drug; economic loss; harm; health benefit plan; health care liability action; health care liability claim; health care provider; health care service; medical device; noneconomic damages; person; product seller; punitive damages; and State.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

C. EFFECTIVE DATE

(Section 273 of House bill.)

Current law

No provision.

House bill

The provision would specify that Federal reforms apply to any health care liability action brought in any State or Federal court that is initiated after the date of enactment. The provision would also apply to any health care liability claim subject to an alternative dispute resolution system, Any health care liability claim or action arising from an injury occurring prior to enactment would be governed by the statute of limitations in effect at the time the injury occurred.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

II. UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

A. STATUTE OF LIMITATIONS

(Section 281 of House bill.)

Current law

To date reforms of the malpractice system have occurred primarily at the State level and have generally involved changes in the rules governing tort cases. (A tort case is a civil action to recover damages, other than for a breach of contract.)

House bill

The provision would establish a uniform statute of limitations. Actions could not be brought more than two years after the injury was discovered or reasonably should have been discovered. In no event could the action be brought more than five years after the date of the alleged injury.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

B. CALCULATION AND PAYMENT OF DAMAGES

(Section 282 of House bill.)

Current bill

No provision.

House bill

1. Noneconomic Damages. The provision would limit noneconomic damages to $250,000 in a particular case. The limit would apply regardless of the number of persons against whom the action was brought or the number of actions brought.

The provision would specify that a defendant would only be liable for the amount of noneconomic damages attributable to that defendant's proportionate share of the fault or responsibility for that claimant's injury.

2. Punitive Damages. The provision would permit the award of punitive damages (to the extent allowed under State law) only if the claimant established by clear and convincing evidence either that the harm was the result of conduct that specifically intended to cause harm or the conduct manifested a conscious flagrant indifference to the rights or safety of others. The amount of punitive damages awarded could not exceed $250,000 or three times the amount of economic damages, whichever was greater. The determination of punitive damages would be determined by the court and not be disclosed to the jury. The provision would not create a cause of action for punitive damages. Further, it would not preempt or supersede any State or Federal law to the extent that such law would further limit punitive damage awards.

The provision would permit either party to request a separate proceeding (bifurcation) on the issue of whether punitive damages should be awarded and in what amount. If a separate proceeding was requested, evidence related only to the claim of punitive damages would be inadmissible in any proceeding to determine whether actual damages should be awarded.

The provision would prohibit the award of punitive damages in a case where the drug or device was subject to premarket approval by the Food and Drug Administration, unless there was misrepresentation or fraud. A manufacturer or product seller would not be held liable for punitive damages related to adequacy of required tamper resistant packaging unless the packaging or labeling was found by clear and convincing evidence to be substantially out of compliance with the regulations.

3. Periodic Payments for Future Losses. The provision would permit the periodic (rather than lump sum) payment of future losses in excess of $50,000. The judgment of a court awarding periodic payments could not, in the absence of fraud, be reopened at any time to contest, amended, or modify the schedule or amount of payments. The provision would not preclude a lump sum settlement.

4. Treatment of Collateral Source Payments. the provision would permit a defendant to introduce evidence of collateral source payments. Such payments are those which are any amounts paid or reasonably likely to be paid by health or accident insurance, disability coverage, workers compensation, or other third party sources. If such evidence was introduced, the claimant could introduce evidence of any amount paid or reasonably likely to be paid to secure the right to such collateral source payments. No provider of collateral source payments would be permitted to recover any amount against the claimant or against the claimant's recovery. The provision would apply to settlements as well as actions resolved by the courts.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

C. ALTERNATIVE DISPUTE RESOLUTION

(Section 283 of House bill.)

Current law

No provision.

House bill

The provision would require that any alternative dispute resolution system used to resolve health care liability actions or claims must include provisions identical to those specified in the bill.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

III. MEDICAL VOLUNTEERS

(Section 310 of Senate bill.)

Current law

The Federally Supported Health Centers Assistance Act of 1992 (P.L. 102–501) provides protection from legal liability for certain health professionals providing services under the Public Health Service Act P.L. 104–73 made the provision permanent.

House bill

No provision.

Senate amendment

Section 310 of the bill would be known as the Medical Volunteer Act. It would provide that under certain circumstances a health care professional would be regarded for purposes of a malpractice claim to be a Federal employee for purposes of the Federal tort claims provisions of title 28 of the U.S. Code. Specifically this would occur when such professional provided services to a medically underserved person without receiving compensation for such services. The professional would be deemed to have provided services without providing compensation only if prior to furnishing services the professional: (i) agreed to furnish services without charge to any person, including any health insurance plan or program under which the recipient is covered; and (ii) provided the recipient with adequate notice (as determined by the Secretary) of the limited liability of the professional. These provisions would preempt any State law to the extent such law was inconsistent; they would not preempt any State law that provided greater incentives or protections.

A medically underserved person would be defined as a person residing in either: (I) a medically underserved area as defined for purposes of determining a medically underserved population under section 330 of the Public Health Service Act; or (ii) a health professional shortage area as defined in section 332 of that Act. Further the individual would have to receive care in a facility substantially comparable to any of those designated in the Federally-Supported Health Centers Act, as determined in regulations of the Secretary.

Conference agreement

The conference agreement includes the Senate provision. The provision extends Federal Tort Claims Act coverage to certain medical volunteers in free clinics in order to expand access to health care services to low-income individuals in medically underserved areas. Such coverage is currently provided in the Public Health Service Act to certain community and other health centers under the Federally Supported Health Centers Assistance Act. The provision tracks to the extent possible the provisions of that Act with respect to the coverage provided, quality assurance, and the process by which a free clinic applies to have a free clinic health professional deemed an employee of the Public Health Service.

Health professionals must meet certain conditions before they are deemed employees of the Public health Service Act. They must be licensed or certified in accordance with applicable law and they must be volunteers; they may not receive compensation for the services in the form of salary, fees, or third-party payments. However, they may receive reimbursement from the clinic for reasonable expenses, such as costs of transportation and the cost of supplies they provide. Further, the free clinic may receive a voluntary donation from the individual served.

Eligible health professionals must provide qualifying services (i.e., otherwise available for Medicaid reimbursement) at a free clinic or through programs or events conducted by the clinic. These programs or events may include the provision of health services in a clinic-owned or clinic-operated mobile van or at a booth in a health fair. They may not include the provision of health services in a private physician's office following a referral from the free clinic. The health care professional or the free clinic must provide prior written notice of the extent of the limited liability to the individual.

The free clinic must be licensed or certified under applicable law and may not impose a charge on or accept reimbursement from any private or public third-party payor. The free clinic may, however, receive voluntary donations from individuals receiving health care services and is not precluded from receiving donations, grants, contracts, or awards from private or public sources for the general support of the clinic, or for specific purposes other than for payment or reimbursement for a health care service.

A free clinic must apply, consistent with the provisions applicable to community health centers, to have each health care professional ''deemed'' an employee of the Public Health Service Act, and therefore eligible for coverage under the Federal Tort Claims Act. A free clinic may not be deemed such an employee under this provision.

The Committee is aware that each of the 50 states have passed laws to limit the liability of volunteers in a variety of circumstances. This provision does not preempt those laws beyond the preemption provided in the Federal Tort Claims Act. Instead, the United States shall be liable in the same manner and to the same extent as a private individual in the same circumstances under State law.

The provision applies only to causes of action filed against a health professional for acts or omissions occurring on or after the date on which the health professional is determined by the Secretary to be a ''free clinic health professional.''

The provision establishes for free clinics funding and estimating mechanisms that match to the extent possible those for community health centers. No funds appropriated for purposes of community health centers will be available to free clinics.

4. Other provisions

I. EXTENSION OF MEDICARE SECONDARY PAYER PROVISIONS

(Sec. 621 of Senate Amendment.)

Current law

Generally Medicare is the ''primary payer,'' that is, it pays health claims first, with an individual's private or other public insurance filling in some or all of Medicare's coverage gaps. However, in certain instances, the individual's other coverage pays first, while Medicare is the secondary payer. This phenomenon is referred to as the MSP program. A group health plan offered by an employer (with 20 or more employees is required to offer workers age 65 or over (and workers spouses age 65 or over) the same group health insurance coverage as is offered to younger workers. If the worker accepts the coverage, the employer is the primary payer, with Medicare becoming the secondary payer.

Similarly, a group health plan offered by a large employer (100 or more employees) is the primary payer for employees or their dependents who are on the Medicare disability program. The provision applies only to persons covered under the group plan because the employee is in ''current employment status'' (i.e. is an employee or is treated as an employee by the employer). The MSP provision for the disabled population expires October 1, 1998.

The MSP provisions apply to end-stage renal (ESRD) beneficiaries with employer group health plans, regardless of employer size. The group health plan is the primary payer for 18 months for persons who become eligible for Medicare ESRD benefits. The employer's role as primary payer is limited to a maximum of 21 months (18 months plus the usual 3-month waiting period for Medicare ESRD coverage). The 18-month MSP provisions for the ESRD population expire October 1, 1998; at that time the period would revert to 12 months.

The law authorizes a data match program which is intended to identify potential secondary payer situations. Medicare beneficiaries are matched against data contained

in Social Security Administration (SSA) and Internal Revenue Service (IRS) files to identify cases in which a working beneficiary (or working spouse) may have employer-based health insurance coverage. Cases of previous incorrect Medicare payments are identified and recoveries are attempted. The authority for the program extends through Sept. 30, 1998.

House bill

No provision.

Senate Amendment

The provision would make permanent the MSP provisions for the disabled and the 18-month period for the ESRD population. It would also make permanent the data match requirement.

Conference agreement

The conference agreement does not include the Senate provision.

TITLE III. TAX-RELATED HEALTH PROVISIONS

A. MEDICAL SAVINGS ACCOUNTS

(Sec. 301 of the House bill.)

Present law

The tax treatment of health expenses depends on whether the individual is an employee or self employed, and whether the individual is covered under an employer-sponsored health plan. Employer contributions to a health plan for coverage for the employee and the employee's spouse and dependents is excludable from the employee's income and wages for social security tax purposes. Self-employed individuals are entitled to deduct 30 percent of the amount paid for health insurance for a self-employed individual and his or her spouse or dependents. Any individual who itemizes tax deductions may deduct unreimbursed medical expenses (including expenses for medical insurance) paid during the year to the extent that the total of such expenses exceeds 7.5 percent of the individual's adjusted gross income (''AGI''). Present law does not contain any special rules for medical savings accounts.

House bill

In general

Within limits, contributions to a medical savings account (''MSA'') are deductible if made by an eligible individual and are excludable from income (and wages for social security purposes) if made by the employer of an eligible individual. Earnings on amounts in an MSA are not currently taxable. Distributions from an MSA for medical expenses are not taxable.

Eligible individuals

An individual is eligible to make a deductible contribution to an MSA (or to have employer contributions made on his or her behalf) if the individual is covered under a high deductible health plan and is not covered under another health plan (other than a plan that provides certain permitted coverage). An individual with other coverage in addition to a high deductible plan is still eligible for an MSA if such other coverage is certain permitted insurance or is coverage (whether provided through insurance to otherwise) for accidents, disability, dental care, vision care, or long-term care. Permitted insurance is (1) Medicare supplemental insurance; (2) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations, (3) insurance for a specified disease or illness, and (4) insurance that provides a fixed payment for hospitalization. An individual is not eligible to make deductible contributions to an MSA for a year if any employer contributions are made to an MSA on behalf of the individual for the year.

Tax treatment of and limits on contributions

Individuals contributions to an MSA are deductible (within limits) in determining AGI. Employer contributions are excludable (within the same limits) from gross income and wages for employment tax purposes, except that this exclusion does not apply to contributions made through a cafeteria plan. The maximum amount of contributions that can be deducted or excluded for a year is equal to the lesser of (1) the deductible under the high deductible health plan or (2) $2,000 in the case of single coverage and $4,000 if the high deductible plan covers the individual and a spouse or dependent. The annual limit is the sum of the limits determined separately for each month, based on the individual's status as of the first day of the month. The maximum contribution limit to an MSA is determined separately for each spouse in a married couple. In no event can the maximum contribution limit exceed $4,000 for a family. The dollar limits are indexed for medical inflation and rounded to the nearest multiple of $50.

Definition of high deductible health plan

A high deductible health plan is a health plan with a deductible of at least $1,500 in the case of single coverage and $3,000 in the case of coverage of more than one individual. These dollar limits are indexed for medical inflation, rounded to the nearest multiple of $50.

Tax treatment of MSAs

Earnings on amounts in an MSA are not currently includible in income.

Taxation of distributions

Distributions from an MSA for the medical expenses of the individual and his or her spouse or dependents are excludable from income. For this purpose, medical expenses do not include expenses for insurance other than long-term care insurance, premiums for health care continuation coverage, and premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law.

Distributions that are not for medical expenses are includible in income. Such distributions are also subject to an additional 10-percent tax unless made after age 59½, death or disability.

Upon death, if the beneficiary is the individual's surviving spouse, the spouse may continue the MSA as his or her own. Otherwise, the beneficiary must include the MSA balance in income in the year of death. If there is no beneficiary, the MSA balance is includible on the final return of the decedent. In any case, no estate tax applies.

Definition of MSA

In general, an MSA is a trust or custodial account created exclusively for the benefit of the account holder and is subject to rules similar to those applicable to individual retirement arrangements.

Effective date

Taxable years beginning after December 31, 1996.

Senate amendment

The Senate amendment does not contain provisions providing favorable tax treatment for MSAs. However, the Senate amendment amends the Public Health Services Act to permit health maintenance organizations to charge deductibles to individuals with an MSA. In addition, the Senate amendment provides that it is the sense of the Committee on Labor and Human Resources that the establishment of MSAs should be encouraged as part of any health insurance legislation passed by the Senate through the use of tax incentives relating to contributions to, the income growth of, and the qualified use of, MSAs. The Senate amendment also provides that it is the sense of the Senate that the Congress should take measures to further the purposes of the Senate amendment, including any necessary changes to the Internal Revenue Code to encourage groups and individuals to obtain health coverage, and to promote access, equity, portability, affordability, and security of health benefits.

Conference agreement

The conference agreement follows the House bill, with modifications.

In general

Within limits, contributions to a medical savings account (''MSA'') are deductible if made by an eligible individual and are excludable if made by the employer of an eligible individual. Earnings on amounts in an MSA are not currently taxable. Distributions from an MSA for medical expenses are not taxable.

Eligible individuals

Beginning in 1997, MSAs are available to employees covered under an employer-sponsored high deductible plan of a small employer and self-employed individuals. An employer is a small employer if it employed, on average, no more than 50 employees during either the preceding or the second preceding year.

In determining whether an employer is a small employer, a preceding year is not taken into account unless the employer was in existence throughout such year. In the case of an employer that was not in existence through the first preceding year, the determination of whether the employer has no more than 50 employees is based on the average number of employees that the employer reasonably expects to employ in the current year. In determining the number of employees of an employer, employers under common control are treated as a single employer.

In order for an employee of an eligible employer to be eligible to make MSA contributions (or to have employer contributions made on his or her behalf), the employee must be covered under an employer-sponsored high deductible health plan and must not be covered under any other health plan (other than a plan that provides certain permitted coverage). In the case of an employee, contributions can be made to an MSA either by the individual or by the individual's employer. However, an individual is not eligible to make contributions to an MSA for a year if any employer contributions are made to an MSA on behalf of the individual for the year.

Similarly, in order to be eligible to make contributions to an MSA, a self-employed individual must be covered under a high deductible health plan and no other health plan (other than a plan that provides certain permitted coverage).

An individual with other coverage in addition to a high deductible plan is till eligible for an MSA if such other coverage is certain permitted insurance or is coverage (whether provided through insurance to otherwise) for accidents, disability, dental care, vision care, or long-term care. Permitted insurance is: (1) Medicare supplemental insurance; (2) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations, (3) insurance for a specified disease or illness, and (4) insurance that provides a fixed payment for hospitalization.

If a small employer with an MSA plan (i.e., the employer or its employees made contributions to an MSA) ceases to become a small employer (i.e., exceeds the 50-employee limit), then the employer (and its employees) can continue to establish and make contributions to MSAs (including contributions for new employees and employees that did not previously have an MSA) until the year following the first year in which the employer has more than 200 employees. After that, those employees who had an MSA (to which individual or employer contributions were made in any year) can continue to make contributions (or have contributions made on their behalf) even if the employer has more than 200 employees. For example, suppose Employer A has 48 employees in 1995 and 1996, and 205 employees in 1997 and 1998. A would be a small employer in 1997 and 1998 because it has 50 or fewer employees in the preceding or the second preceding year. Employer A would still be considered a small employer in 1999. However, in years after 1999, Employer A would not be considered a small employer (even if the number of employees fell to 50 or below), and in years after 1999, only employees who previously had MSA contributions (or have employer contributions made on their behalf).

Tax treatment of and limits on contributions

Individual contributions to an MSA are deductible (within limits) in determining AGI (i.e., ''above the line''). In addition, employer contributions are excludable (within the same limits), except that this exclusion does not apply to contributions made through a cafeteria plan.

In the case of a self-employed individual, the deduction cannot exceed the individual's earned income from the trade or business with respect to which the high deductible plan is established. In the case of an employee, the deduction cannot exceed the individual's compensation attributable to the employer sponsoring the high deductible plan in which the individual is enrolled.

The maximum annual contribution that can be made to an MSA for a year is 65 percent of the deductible under the high deductible plan in the case of individual coverage and 75 percent of the deductible in the case of family coverage. No other dollar limits on the maximum contribution apply. The annual contribution limit is the sum of the limits determined separately for each month, based on the individual's status and health plan coverage as of the first day of the month.

Contributions for a year can be made until the due date for the individual's tax return for the year (determined without regard to extensions).

In order to facilitate application of the cap on the number of MSA participants, described below, the employer is required to report employer MSA contributions, and the individual is required to report such employer MSA contributions on the individual's tax return.

Comparability rule for employer contributions

If an employer provides high deductible health plan coverage coupled with an MSA to employees and makes employer contributions to the MSAs, the employer must make available a comparable contribution on behalf of all employees with comparable coverage during the same period. Contributions are considered comparable if they are either of the same amount or the same percentage of the deductible under the high deductible plan. The comparability rule is applied separately to part-time employees (i.e., employees who are customarily employed for fewer than 30 hours per week). No restrictions are placed on the ability of the employer to offer different plans to different groups of employees.

For example, suppose an employer maintains two high deductible plans, Plan A, with a deductible of $1,500 for individual coverage and $3,000 for family coverage, and Plan B, with a deductible of $2,000 for individual coverage and $4,000 for family coverage. The employer offers an MSA contribution to full-time employees in Plan A of $500 for individual coverage and $750 for family coverage. In order to satisfy the comparability rule, the employer would have to offer full-time employees covered under Plan B one of the following MSA contributions (1) $500 for employees with individual coverage and $750 for employees with family coverage or (2) $667 for employees with individual coverage and $1,000 for employees with family coverage. Different contributions (or no contributions) could be made for part-time employees covered under either high deductible plan.

If employer contributions do not comply with the comparability rule during a period, then the employer is subject to an excise tax equal to 35 percent of the aggregate amount contributed by the employer to MSAs of the employer for that period. The excise tax is designed as a proxy for the denial of employer contributions. In the case of a failure to comply with the comparability rule which is due to reasonable cause and not to willful neglect, the Secretary may waive part of all of the tax imposed to the extent that the payment of the tax would be excessive relative to the failure involved.

For purposes of the comparability rule, employers under common control are aggregated in the same manner as in determining whether the employer is a small employer. The comparability rule does not fail to be satisfied in a year if the employer is precluded from making contributions for all employees with high deductible plan coverage because the employer has more than 200 employees or due to operation of the cap during the initial 4-year period.

Definition of high deductible plan

A high deductible plan is a health plan with an annual deductible of a least $1,500 and no more than $2,250 in the case of individual coverage and at least $3,000 and no more than $4,500 in the case of family coverage. In addition, the maximum out-of-pocket expenses with respect to allowed costs (including the deductible) must be no more than $3,000 in the case of individual coverage and no more than $5,500 in the case of family coverage. Beginning after 1998, these dollar amounts are indexed for inflation in $50 dollar increments based on the consumer price index. In plan does not fail to qualify as a high deductible plan merely because it does not have a deductible for preventive care as required by State law.

As under present law, State insurance commissions would have oversight over the issuance of high deductible plans issued in conjunction with MSAs and could impose additional consumer protections. It is intended that the National Association of Insurance Commissioners (''NAIC'') will develop model standards for high deductible plans that individual States could adopt.

Tax treatment of MSAs

Earnings on amounts in an MSA are not currently includible in income.

Taxation of distributions

Distributions from an MSA for the medical expenses of the individual and his or her spouse or dependents generally are excludable from income. However, in any year for which a contribution is made to an MSA, withdrawals from an MSA maintained by that individual are excludable from income only if the individual for whom the expenses were incurred was eligible to make an MSA contribution at the time the expenses were incurred. This rule is designed to ensure that MSAs are in fact used in conjunction with a high deductible plan, and that they are not primarily used by other individuals who have health plans that are not high deductible plans. For example, suppose that, in 1997, individual A is covered by a high deductible plan, and A's spouse (''B'') is covered by a health plan that is not a high deductible plan. A makes contributions to an MSA for 1997. Withdrawals from the MSA to pay B's medical expenses incurred in 1997 would be includible in income (and subject to the additional tax on nonmedical withdrawals) because B is not covered by a high deductible plan.

For this purpose, medical expenses are defined as under the itemized deduction for medical expenses, except that medical expenses do not include expenses for insurance other than long-term care insurance, premiums for health care continuation coverage, and premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law.

Distributions that are not for medical expenses are includible in income. Such distributions are also subject to an additional 15-percent tax unless made after age 65, death, or disability.

Estate tax treatment

Upon death, any balance remaining in the decedent's MSA is includible in his or her gross estate.

If the account holder's surviving spouse is the named beneficiary of the MSA, then, after the death of the account holder, the MSA becomes the MSA of the surviving spouse and the amount of the MSA balance may be deducted in computing the decedent's taxable estate, pursuant to the estate tax marital deduction provided in Code section 2056. The MSA qualifies for the marital deduction because the account holder has sole control over disposition of the assets in the MSA. The surviving spouse is not required to include any amount in income as a result of the death; the general rules applicable to MSAs apply to the surviving spouse's MSA (e.g., the surviving spouse is subject to income tax only on distributions from the MSA for nonmedical purposes). The surviving spouse can exclude from income amounts withdrawn from the MSA for expenses incurred by the decedent prior to death, to the extent they otherwise are qualified medical expenses.

If, upon death, the MSA passes to a named beneficiary other than the decedent's surviving spouse, the MSA ceases to be an MSA as of the date of the decedent's death, and the beneficiary is required to include the fair market value of MSA assets as of the date of death in gross income for the taxable year that includes the date of death. The amount includable in income is reduced by the amount in the MSA used, within one year of the death, to pay qualified medical expenses incurred prior to the death. As is the case with other MSA distributions, whether the expenses are qualified medical expenses is determined as of the time the expenses were incurred. In computing taxable income, the beneficiary may claim a deduction for that portion of the Federal estate tax on the decendent's estate that was attributable to the amount of the MSA balance (calculated in accordance with the present-law rules relating to income in respect of a decedent set forth in sec. 691(c)).

If there is no named beneficiary for the decedent's MSA, the MSA ceases to be an MSA as of the date of death, and the fair market value of the assets in the MSA as of such date are includible in the decedent's gross income for the year of the death. This rule applies in all cases in which there is no named

beneficiary, even if the surviving spouse ultimately obtains the right to MSA assets (e.g., if the surviving spouse is the sole beneficiary of the decedent's estate). Because of the significant tax consequences if a married individual fails to name his or her spouse as the MSA beneficiary, even if the rights to MSA assets are otherwise acquired by the surviving spouse, it is anticipated that the marketing materials describing other tax aspects of MSAs will explain the consequences of failure to name the spouse as the beneficiary.

Cap on taxpayers utilizing MSAs

In general.—The number of taxpayers benefiting annually from an MSA contribution is limited to a threshold level (generally 750,000 taxpayers). If it is determined in a year that the threshold level has been exceeded (called a ''cut-off'' year) then, in general, for succeeding years during the 4-year pilot period 1997–2000, only those individuals who (1) made an MSA contribution or had an employer MSA contribution for the year or a preceding year (i.e. are active MSA participants) or (2) are employed by a participating employer, would be eligible for an MSA contribution. In determining whether the threshold for any year has been exceeded, MSAs of individuals who were not covered under a health insurance plan for the six month period ending on the date on which coverage under a high deductible plan commences would not be taken into account.[1] However, if the threshold level is exceeded in a year, previously uninsured individuals would be subject to the same restriction on contributions in succeeding years as other individuals. That is, they would not be eligible for an MSA contribution for a year following a cut-off-year unless they are an active MSA participant (i.e. had an MSA contribution for the year or a preceding year) or are employed by a participating employer.

In a year after a cut-off year, employees of a participating employer can establish new MSAs and make new contributions (even if the employee is a new employee or did not previously have an MSA). An employer is a participating employer if (1) the employer made any MSA contributions on behalf of employees in any preceding year or (2) at least 20 percent of the employees covered under a high deductible plan made an MSA contribution of at least $100 in the preceding year.

In the case of a cut-off year before 2000, an individual is not an eligible individual or an active MSA participant unless the individual was first covered under a high deductible plan on or before the cut-off date. The cut-off date is generally October 1 of the cut-off year. However, if the individual was enrolled in a plan pursuant to a regularly scheduled enrollment period, then the cut-off date is December 31. Similarly, an employer is not considered a participating employer if it first offered coverage after October 1 of a cut-off year unless the high deductible plan is offered pursuant to a regularly scheduled enrollment period. In addition, a self-employed individual is not considered an eligible individual or an active MSA participant unless the individual was covered under a high deductible plan on or before November 1 of a cut-off year.

These rules are designed to prevent high deductible plans from being offered just before the limitation on MSAs is effective in order to avoid application of the cap. They are not, however, intended to preclude individuals who first enroll in an employer-sponsored high deductible health plan or employees of employers that adopt a high deductible plan in a cut-off year due to normal health plan operation from having MSAs. For example, suppose a small employer offers a high deductible plan that provides that new employees may be covered under the plan beginning the first day of the month after the month in which they are hired. New employee A (whose previous coverage was not high deductible coverage) is hired on October 15, and is enrolled in the high deductible plan November 1 of that year. If the year is a cut-off year, Employee A is an eligible individual and, if he has an MSA contribution for the year, an active participant for the year because he was enrolled pursuant to a regularly scheduled enrollment period. Similarly, suppose that employer A is a small employer and does not currently offer health care coverage. In 1997, A decides to offer health plan coverage to its employees, including a high deductible plan coupled with an MSA. A takes steps to provide such coverage on or before October 1 of the year (e.g., making arrangements with insurance companies or distributing plan material to employees). The first enrollment period for the health plans begins September 1, and coverage under the plan will begin November 1. If the year is a cut-off year, the employer is a participating employer because the plan was established pursuant to a regularly scheduled enrollment period.

Under certain circumstances, MSA participation may be reopened after a cut-off year so that MSAs are again available to all individuals in the qualifying group of self-employed individuals and employees of small employers.

For the 1997 tax year, taxpayers are permitted to establish MSAs provided that they are in the qualifying group of self-employed individuals or employees working for small employers.

Rules for 1997

On or before June 1, 1997, each trustee or custodian of an MSA (e.g., insurance company or financial institution) is required to report to the Internal Revenue Service (''IRS'') the total number of MSAs established as of April 30, 1997, for which it acts as trustee or custodian, including the number of MSAs established for previously uninsured individuals.[2] If, based on this reporting, the number of MSAs established (but excluding those established for previously uninsured individuals) as of April 30, 1997, exceeds 375,000 (50 percent of 750,000), on or before September 1, 1997, the IRS would publish guidance providing that only active MSA participants or employees of participating employers would be eligible for an MSA contribution for the 1998 tax year and thereafter. If this threshold is exceeded, an individual who is first covered by an employer-sponsored high deductible health plan after September 1, 1997, is not an eligible individual or an active MSA participant (and therefore cannot have an MSA for 1997 or a subsequent year) unless the high deductible coverage is elected pursuant to a regularly scheduled enrollment period. Similarly, an employer is not considered a participating employer if it first offered a high deductible plan after September 1, 1997, unless the plan was offered pursuant to a regularly scheduled enrollment period. Also, a self-employed individual would not be an eligible individual or an active MSA participant unless the individual was first covered under a high deductible plan on or before October 1, 1997.

If the 375,000 cap is not exceeded, then another determination of MSA participation will be made, as follows. On or before August 1, 1997, each trustee or custodian of an MSA (e.g., insurance company or financial institution) is required to report to the Internal Revenue Service (''IRS'') the total number of MSAs established as of June 30, 1997, for which it acts as trustee or custodian, including the number of MSAs established for previously uninsured individuals. If, based on this reporting, the number of MSAs established (but excluding those established for previously uninsured individuals) exceeds the 1997 threshold level of 525,000 (70 percent of 750,000), on or before October 1, 1997, the IRS would publish guidance providing that only active MSA participants or employees of participating employers would be eligible for an MSA contribution for the 1998 tax year and thereafter. If the 1997 threshold is exceeded, an individual who is first covered by an employer-sponsored high deductible health plan after October 1, 1997, is not an eligible individual or an active MSA participant (and therefore cannot have an MSA for 1997 or a subsequent year) unless the high deductible coverage is elected pursuant to a regularly scheduled enrollment period. Similarly, an employer is not considered a participating employer if it first offered a high deductible plan after October 1, 1997, unless the plan was offered pursuant to a regularly scheduled enrollment period. Also, a self-employed individual would not be an eligible individual or an active MSA participant unless the individual was first covered under a high deductible plan on or before November 1, 1997.

If the 1997 threshold level is not exceeded, all taxpayers in the qualifying eligible group (i.e., self-employed individuals and employees working for employers with 50 or fewer employees) would be permitted to have MSA contributions for the 1998 tax year.

Rules for 1998 and succeeding years

In general—In 1998 and succeeding years, on or before August 1 of the year, each trustee or custodian of an MSA is required to report to the IRS the total number of MSAs established as of June 30 for the current year,[3] including the number of such MSAs established for previously uninsured individuals. In addition, the IRS is directed to collect data with respect to the number of taxpayers showing an MSA contribution on their individual income tax returns for the prior year and the extent to which such taxpayers were previously uninsured.[4] If, based on this information, the IRS determines as described below that the number of taxpayers anticipated to have MSA contributions (disregarding previously uninsured individuals) exceeds the applicable threshold level, the IRS is required to issue guidance to the public by no later than October 1. If this guidance is issued, then only taxpayers who are active MSA participants or who are employed by a participating employer would be entitled to MSA contributions in tax years following the year the guidance is issued.

For 1998 and succeeding years, the threshold is exceeded if either of the following limits are exceeded. The numerical limit is exceeded if: (1) the number of MSA returns filed on or before April 1 of the year, plus the estimate of the number of MSA returns for such year that will be filed after such date exceeds the threshold, or (2) 90 percent of the amount determined under (1), plus 15/6ths of the MSAs established for the year before July 1 exceeds $750,000.

[1] Permitted coverage, as described above, does not constitute coverage under a health insurance plan for this purpose.

[2] This report would include the name and social security number of taxpayers establishing an MSA. Failures to report are subject to a penalty of $25 for each MSA up to a maximum of $5,000. A trustee or custodian required to report could elect to do so on a company-wide or branch-by-branch basis.

[3] That is, the report would not include MSAs to which contributions are made for the prior year.

[4] Each income tax return on which an MSA contribution is shown is treated as one taxpayer for purposes of the cap. It is anticipated that the IRS would adjust the actual return information to take into account MSAs that may have been established by late filers.

1998.—In 1998, the IRS would analyze the return data from the filing of 1997 tax year returns and would determine, based on this data, the number of taxpayers with MSA contributions for 1997 and who were not previously uninsured. If the IRS determines that (1) MSA returns filed on or before April 15, 1998, plus the estimated number of MSA return for 1997 filed after such date exceeds 600,000, or (2) that 90 percent of the MSA returns in (1), plus 15/6ths of the number of MSAs established for 1998 between January 1 and July 1, 1998, the IRS would publish guidance on or before October 1, 1998, advising taxpayers that only taxpayers who had previously had MSA contributions (i.e., for either the 1997 or 1998 tax year) or who are employed by a participating employer would be eligible for MSA contributions in succeeding tax years. If the 1998 threshold is exceeded, an individual who is first covered by an employer-sponsored high deductible health plan after October 1, 1998, is not an eligible individual or an active MSA participant (and therefore cannot have an MSA for 1998 or a subsequent year) unless the high deductible coverage is elected pursuant to a regularly scheduled enrollment period. Similarly, an employer is not considered a participating employer if it first offered a high deductible plan after October 1, 1998, unless the plan was offered pursuant to a regularly scheduled enrollment period. Also, a self-employed individual would not be an eligible individual or an active MSA participant unless the individual was first covered under a high deductible plan on or before November 1, 1998.

In the event that the threshold level had not been exceeded, all taxpayers in the qualifying eligible group would be permitted to establish MSAs during the 1999 tax year.

1999.—In 1999, the IRS would analyze the return data from the filing of 1998 tax year returns and would determine, based on this data, the number of taxpayers with MSA contributions for 1998 and who were not previously uninsured. If the IRS determines that (1) MSA returns filed on or before April 15, 1999, plus the estimated number of MSA returns for 1998 filed after such date exceeds 600,000, or (2) that 90 percent of the MSA returns in (1), plus 15/6ths of the number of MSAs established for 1998 between January 1 and July 1, 1999, the IRS would publish guidance on or before October 1, 1999, advising taxpayers that only taxpayers who had previously had MSA contributions (i.e., for the 1997, 1998, or 1999 tax year) or who are employed by a participating employer would be eligible for MSA contributions in succeeding tax years. If the 1999 threshold is exceeded, an individual who is first covered by an employer-sponsored high deductible health plan after October 1, 1999, is not an eligible individual or an active MSA participant (and therefore cannot have an MSA for 1999 or a subsequent year) unless the high deductible coverage is elected pursuant to a regularly scheduled enrollment period. Similarly, an employer is not considered a participating employer if it first offered a high deductible plan after October 1, 1999, unless the plan was offered pursuant to a regularly scheduled enrollment period. Also, a self-employed individual would not be an eligible individual or an active MSA participant unless the individual was first covered under a high deductible plan on or before November 1, 1999.

In the event that the threshold level had not been exceeded, all taxpayers in the qualifying eligible group would be permitted to establish MSAs during the 2000 tax year.

Reopening of MSA participation.—If 1997 is a cut-off year, then in 1998, the IRS would (as described above) analyze the return data from the filing of 1997 tax year returns and would determine, based on this data, the number of taxpayers with MSA contributions for 1997 and who were not previously uninsured. If the IRS determines that MSA returns filed on or before April 15, 1998, plus the estimated number of MSA return for 1997 filed after such date (disregarding MSAs of previously uninsured individuals) exceeds 750,000, then the IRS will announce by October 1, 1998, that MSAs will be available to all eligible individuals in the qualifying eligible group of self-employed individuals and employees of small employers covered under a high deductible health plan during the first 6 months of 1999. Similarly, if 1998, is a cut-off year, then in 1999, MSA returns filed on or before April 15, 1999, plus the estimated number of MSA returns for 1998 filed after such date (disregarding MSAs of previously uninsured individuals) exceeds 750,000, then IRS will announce by October 1, 1998, that MSAs will be available to all eligible individuals in the qualifying eligible group of self-employed individual and employees of small employers with high deductible plan coverage during the first 6 months of 2000.

End of pilot project

After December 31, 2000, no new contributions may be made to MSAs except by or on behalf of individuals who previously had MSA contributions and employees who are employed by a participating employer. An employer is a participating employer if (1) the employer made any MSA contributions for any year to an MSA on behalf of employees or (2) at least 20 percent of the employees covered under a high deductible plan made MSA contributions of at least $100 in the year 2000.

Self-employed individuals who made contributions to an MSA during the period 1997–2000 also may continue to make contributions after 2000.

Measuring the effects of MSAs

During 1997–2000, the Department of the Treasury will evaluate MSA participation and the reduction in Federal revenues due to such participation and make such reports of such evaluations to the Congress as the Secretary determines appropriate.

The General Accounting Office is directed to contract with an organization with expertise in health economics, health insurance markets and actuarial science to conduct a study regarding the effects of MSAs in the small group market on (1) selection (including adverse selection), (2) health costs, including the impact on premiums of individuals with comprehensive coverage, (3) use of preventive care, (4) consumer choice, (5) the scope of coverage of high deductible plans purchased in conjunction with an MSA and (6) other relevant issues, to be submitted to the Congress by January 1, 1999.

The conferees intend that the study be broad in scope, gather sufficient data to fully evaluate the relevant issues, and be adequately funded. The conferees expect the study to utilize appropriate techniques to measure the impact of MSAs on the broader health care market, including in-depth analysis of local markets with high penetration. The conferees expect the study to evaluate the impact of MSAs on individuals and families experience high health care costs, especially low- and middle-income families.

Definiton of MSA

In general, an MSA is a trust or custodial account created exclusively for the benefit of the account holder and his subject to rules similar to those applicable to individual retirement arrangements.

Effective date

The provisions are effective for taxable years beginning after December 31, 1996.

B. INCREASE IN DEDUCTION FOR HEALTH INSURANCE EXPENSES OF SELF-EMPLOYED INDIVIDUALS

(Sec. 311 of the House bill and sec. 401 of the Senate amendment.)

Present law

Under present law, self-employed individuals are entitled to deduct 30 percent of the amount, paid for health insurance for the self-employed individual and the individual's spouse and dependents. The deduction is not available for any month in which the taxpayer is eligible to participate in a subsidized health plan maintained by the employer of the taxpayer of the taxpayer's spouse. The 30-percent deduction is available in the case of self insurance as well as commercial insurance. The self-insured plan must in fact be insurance (e.g., there must be appropriate risk shifting) and not merely a reimbursement arrangement.

House bill

Under the House bill, the deduction for health insurance for self-employed individuals is phased up to 50 percent as follows: for taxable years beginning in 1998, the amount of the deduction would be 35 percent of health insurance expenses; for taxable years beginning in 1999, 2000, and 2001, 40 percent; for taxable years beginning in 2002, 45 percent; and for taxable years beginning in 2003 and thereafter, 50 percent.

Effective date.—The provision is effective for taxable years beginning after December 31, 1997.

Senate amendment

Beginning in 1997, the Senate amendment phases up the deduction in 5 percent increments until it is 80 percent in 2006 and thereafter.

Effective date.—The provision is effective for taxable years beginning after December 31, 1996.

Conference agreement

The conference agreement increases the deduction for health insurance of self-employed individuals as follows: the deduction would be 40 percent in 1997; 45 percent in 1998 through 2002, 50 percent in 2003; 60 percent in 2004, 70 percent in 2005; and 80 percent in 2006 and thereafter.

The conference agreement also provides that payments for personal injury or sickness through and arrangements having the effect of accident or health insurance (and that are not merely reimbursement arrangements) are excludable from income. In order for the exclusion to apply, the arrangement must be insurance (e.g., there must be adequate risk shifting). This provision equalizes the treatment of payments under commercial insurance and arrangements other than commercial insurance that have the effect of insurance. Under this provision, a self-employed individual who receives payments from such an arrangement could exclude the payments from income.

Effective date.—The provision is effective for taxable years beginning after December 31, 1996. No inference is intended with respect to the excludability of payments under arrangements having the effect of accident or health insurance under present law.

C. TREATMENT OF LONG-TERM CARE INSURANCE AND SERVICES

(Secs. 321–323 and 325–328 of the House bill and secs. 411–415 and 421–424 of the Senate amendment.)

Present law

In general

Present law generally does not provide explicit rules relating to the tax treatment of long-term care insurance contracts or long-term care services. Thus, the treatment of

long-term care contracts and services is unclear. Present law does provide rules relating to medical expenses and accident or health insurance.

Itemized deduction for medical expenses

In determining taxable income for Federal income tax purposes, a taxpayer is allowed an itemized deduction for unreimbursed expenses that are paid by the taxpayer during the taxable year for medical care of the taxpayer, the taxpayer's spouse, or a dependent of the taxpayer, to the extent that such expenses exceed 7.5 percent of the adjusted gross income of the taxpayer for such year (sec. 213). For this purpose, expenses paid for medical care generally are defined as amounts paid: (1) for the diagnosis, cure, mitigation, treatment, or prevention of disease (including prescription medicines or drugs and insulin), or for the purpose of affecting any structure or function of the body (other than cosmetic surgery not related to disease, deformity, or accident); (2) for transportation primarily for, and essential to, medical care referred to in (1); or (3) for insurance (including Part B Medicare premiums) covering medical care referred to in (1) and (2).

Exclusion for amounts received under accident or health insurance

Amounts received by a taxpayer under accident or health insurance for personal injuries or sickness generally are excluded from gross income to the extent that the amounts received are not attributable to medical expenses that were allowed as a deduction for a prior taxable year (sec. 104).

Treatment of accident or health plans maintained by employers

Contributions of an employer to an accident or health plan that provides compensation (through insurance or otherwise) to an employee for personal injuries or sickness of the employee, the employee's spouse, or a dependent of the employee, are excluded from the gross income of the employee (sec. 106). In addition, amounts received by an employee under such a plan generally are excluded from gross income to the extent that the amounts received are paid, directly or indirectly, to reimburse the employee for expenses for the medical care of the employee, the employee's spouse, or a dependent of the employee (sec. 105). for this purpose, expenses incurred for medical care are defined in the same manner as under the rules regarding the deduction for medical expenses.

A cafeteria plan is an employer-sponsored arrangement under which employees can elect among cash and certain employer-provided qualified benefits. No amount is included in the gross income of a participant in a cafeteria plan merely because the participant has the opportunity to make such an election (sec. 125). Employer-provided accident or health coverage is one of the benefits that may be offered under a cafeteria plan.

A flexible spending arrangement (''FSA'') is an arrangement under which an employee is reimbursed for medical expenses or other nontaxable employer-provided benefits, such as dependent care, and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for such participant's coverage. Under proposed Treasury regulations, a maximum amount of reimbursement is not substantially in excess of the total premium if such maximum amount is less than 500 percent of the premium. An FSA may be part of a cafeteria plan or provided by an employer outside a cafeteria plan. FSAs are commonly used to reimburse employees for medical expenses not covered by insurance. If certain requirements are satisfied,[5] amounts reimbursed for nontaxable benefits from an FSA are excludable from income.

Health care continuation rules

The health care continuation rules require that an employer must provide qualified beneficiaries the opportunity to continue to participate for a specified period in the employer's health plan after the occurrence of certain events (such as termination of employment) that would have terminated such participation (sec. 4980B). Individuals electing continuation coverage can be required to pay for such coverage.

House bill

Tax treatment and definition of long-term care insurance contracts and qualified long-term care services

Exclusion of long-term care proceeds.—A long-term care insurance contract generally is treated as an accident and health insurance contract. Amounts (other than policyholder dividends or premium refunds) received under a long-term care insurance contract generally are excludable as amounts received for personal injuries and sickness, subject to a cap of $175 per day, or $63,875 annually, on per diem contracts only. If the aggregate amount of periodic payments under all qualified long-term care contracts exceeds the dollar cap for the period, then the amount of such excess payments is excludable only to the extent of the individual's costs (that are not otherwise compensated for by insurance or otherwise) for long-term care services during the period. The dollar cap is indexed by the medical care cost component of the consumer price index.

Exclusion for employer-provided long-term care coverage.—A plan of an employer providing coverage under a long-term care insurance contract generally is treated as an accident and health plan. Employer-provided coverage under a long-term care insurance contract is not, however, excludable by an employee if provided through a cafeteria plan; similarly, expenses for long-term care services cannot be reimbursed under an FSA.[6]

Definition of long-term care insurance contract.—A long-term care insurance contract is defined as any insurance contract that provides only coverage of qualified long-term care services and that meets other requirements. The other requirements are that (1) the contract is guaranteed renewable, (2) the contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged or borrowed, (3) refunds (other than refunds on the death of the insured or complete surrender or cancellation of the contract) and dividends under the contract may be used only to reduce future premiums or increase future benefits, and (4) the contract generally does not pay or reimburse expenses reimbursable under Medicare (except where Medicare is a secondary payor, or the contract makes per diem or other periodic payments without regard to expenses).

A contract does not fail to be treated as a long-term care insurance contract solely because it provides for payments on a per diem or other periodic basis without regard to expenses incurred during the period.

Medicare duplication rules.—The bill provides that no provision of law shall be construed or applied so as to prohibit the offering of a long-term care insurance contract on the basis that the contract coordinates its benefits with those provided under Medicare. Thus, long-term care insurance contracts are not subject to the rules requiring duplication of Medicare benefits.

Definition of qualified long-term care services.—Qualified long-term care services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services that are required by a chronically ill individual and that are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Chronically ill individual.—A chronically ill individual is one who has been certified within the previous 12 months by a licensed health care practitioner as (1) being unable to perform (without substantial assistance) at least 2 activities of daily living for at least 90 days[7] due to a loss of functional capacity, (2) having a similar level of disability as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services, or (3) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence.[8]

it is intended that an individual who is physically able but has a cognitive impairment such as Alzheimer's disease or another form of irreversible loss of mental capacity be treated similarly to an individual who is unable to perform (without substantial assistance) at least 2 activities of daily living. Because of the concern that eligibility for the medical expense deduction not be diagnosis-driven, the provision requires the cognitive impairment to be severe. It is intended that severe cognitive impairment mean a deterioration or loss in intellectual capacity that is measured by clinical evidence and standardized tests which reliably measure impairment in: (1) short- or long-term memory; (2) orientation to people, places or time; and (3) deductive or abstract reasoning. In addition, it is intended that such deterioration or loss place the individual in jeopardy of harming self or others and therefore require substantial supervision by another individual.

A licensed health care practitioner is a physician (as defined in sec. 1861(r)(l) of the Social Security Act) and any registered professional nurse, licensed social worker or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

Expenses for long-term care services treated as medical expenses.—Unreimbursed expenses for qualified long-term care services provided to the taxpayer or the taxpayer's spouse or dependents are treated as medical expenses for

[5] These requirements include a requirement that a health FSA can only provide reimbursement for medical expenses (as defined in sec. 213) and cannot provide reimbursement for premium payments for other health coverage and that the maximum amount of reimbursement under a health FSA must be available at all times during the period of coverage.

[6] The bill does not otherwise modify the requirements relating to FSAs. An FSA is defined as a benefit program providing employees with coverage under which specified incurred expenses may be reimbursed (subject to maximums and other reasonable conditions), and the maximum amount of reimbursement that is reasonably available to a participant is less than 500 percent of the value of the coverage.

[7] The 90-day period is not a waiting period. Thus, for example, an individual can be certified was chronically ill if the licensed health care practitioner certifies that the individual will be unable to perform at least 2 activities of daily living for at least 90 days.

[8] Nothing in the bill requires the contract to take into account all of the activities of daily living. For example, a contract could require that an individual be unable to perform (without substantial assistance) 2 out of any 5 such activities, or for another example, 3 out of the 6 activities.

purposes of the itemized deduction for medical expenses (subject to the present-law floor of 7.5 percent of adjusted gross income). For this purpose, amounts received under a long-term care insurance contract (regardless of whether the contract reimburses expenses or pays benefits on a per diem or other periodic basis) are treated as reimbursement for expenses actually incurred for medical care.

For purposes of the deduction for medical expenses, qualified long-term care services do not include services provided to an individual by a relative or spouse (directly, or through a partnership, corporation, or other entity), unless the relative is a licensed professional with respect to such services, or by a related corporation (within the meaning of Code section 267(b) or 707(b)).[9]

Long-term care insurance premiums treated as medical expenses.—Long-term care insurance premiums that do not exceed specified dollar limits are treated as medical expenses for purposes of the itemized deduction for medical expenses.[10] The limits are as follows:

In the case of an individual with an attained age before the close of the taxable year of:	The limitation on premiums paid for such taxable years is:
Not more than 40	$200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	2,000
More than 70	2,500

For taxable years beginning after 1997, these dollar limits are indexed for increases in the medical care component of the consumer price index. The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, is directed to develop a more appropriate index to be applied in lieu of the foregoing. Such an alternative might appropriately be based on increases in skilled nursing facility and home health care costs. It is intended that the Treasury Secretary annually publish the indexed amount of the limits as early in the year as they can be calculated.

Deduction for long-term care insurance of self-employed individuals.—The present-law 30 percent deduction for health insurance expenses of self-employed individuals is phased up to 50 percent under the bill. Because the bill treats payments of eligible long-term care insurance premiums in the same manner as medical insurance premiums, the self-employed health insurance deduction applies to eligible long-term care insurance premiums under the bill.

Long-term care riders on life insurance contracts.—In the case of long-term care insurance coverage provided by a rider on or as part of a life insurance contract, the requirements applicable to long-term care insurance contracts apply as if the portion of the contract providing such coverage were a separate contract. The term ''portion'' means only the terms and benefits that are in addition to the terms and benefits under the life insurance contract without regard to long-term care coverage. As a result, if the applicable requirements are met by the long-term care portion of the contract, amounts received under the contract as provided by the rider are treated in the same manner as long-term care insurance benefits, whether or not the payment of such amounts causes a reduction in the contract's death benefit or cash surrender value. The guideline premium limitation applicable under section 7702(c)(2) is increased by the sum of charges (but not premium payments) against the life insurance contract's cash surrender value, the imposition of which reduces premiums paid for the contract (within the meaning of sec. 7702(f)(1)). In addition, it is anticipated that Treasury regulations will provide for appropriate reduction in premiums paid (within the meaning of sec. 7702(f)(1)) to reflect the payment of benefits under the rider that reduce the cash surrender value of the life insurance contract. A similar rule should apply in the case of a contract governed by section 101(f) and in the case of the payments under a rider that are excludable under section 101(g) of the Code (as added by this bill).

Health care continuation rules.—The health care continuation rules do not apply to coverage under a long-term care insurance contract.

Inclusion of excess long-term care benefits

In general, the bill provides that the maximum annual amount of long-term care benefits under a per diem type contract that is excludable from income with respect to an insured who is chronically ill (not including amounts received by reason of the individual being terminally ill)[11] cannot exceed the equivalent of $175 per day for each day the individual is chronically ill. Thus, for per diem type contracts, the maximum annual exclusion for long-term care benefits with respect to any chronically ill individual (not including amounts received by reason of the individual being terminally ill) is $63,875 (for 1997). If payments under such contracts exceed the dollar limit, then the excess is excludable only to the extent the individual has incurred actual costs for long-term care services. If the insured is not the same as the holder of the contract, the insured may assign some or all of this limit to the contract holder at the time and manner prescribed by the Secretary.

This $175 per day limit is indexed for inflation after 1997 for increases in the medical care component of the consumer price index. The Treasury Secretary, in consultation with the Secretary of Health and Human Services, is directed to develop a more appropriate index, to be applied in lieu of the foregoing. Such an alternative might appropriately be based on increases in skilled nursing facility and home health care costs. It is intended that the Treasury Secretary annually publish the indexed amount of the limit as early in the year as it can be calculated.

A payor of long-term care benefits (defined for this purpose to include any amount paid under a product advertised, marketed or offered as long-term care insurance) is required to report to the IRS the aggregate amount of such benefits paid to any individual during any calendar year, and the name, address and taxypayer identification number of such individual. A copy of the report must be provided to the payee by January 31 following the year of payment, showing the name of the payor and the aggregate amount of benefits paid to the individual during the calendar year. Failure to file the report or provide the copy to the payee is subject to the generally applicable penalties for failure to file similar information reports.

Consumer protection provisions

Under the bill, long-term care insurance contracts, and issuers of contracts, are required to satisfy certain provisions of the long-term care insurance model Act and model regulations promulgated by the National Association of Insurance Commissioners (as adopted as of January 1993). The policy requirements relate to disclosure, nonforfeitability, guaranteed renewal or noncancellability, prohibitions on limitations and exclusions, extension of benefits, continuation or conversion of coverage, discontinuance and replacement of policies, unintentional lapse, post-claims underwriting, minimum standards, inflation protection, preexisting conditions, and prior hospitalization. The bill also provides disclosure and nonforfeiture requirements. The nonforfeiture provision gives consumers the option of selecting reduced paid-up insurance, extended term insurance, or a shortened benefit period in the event a policyholder who elects a nonforfeiture provision is unable to continue to pay premiums. The requirements for issuers of long-term care insurance contracts relate to application forms, reporting requirements, marketing, appropriateness of purchase, format, delivering a shopper's guide, right to return, outline of coverage, group plans, policy summary, monthly reports on accelerated death benefits, and incontestability period. A tax is imposed equal to $100 per policy per day for failure to satisfy these requirements.

Nothing in the bill prevents a State from establishing, implementing or continuing standards related to the protection of policyholders of long-term care insurance policies, if such standards are not inconsistent with standards established under the bill.

Effective date

The provisions defining long-term care insurance contracts and qualified long-term care services apply to contracts issued after December 31, 1996. Any contract issued before January 1, 1997, that met the long-term care insurance requirements in the State in which the policy was sitused at the time it was issued shall be treated as a long-term care insurance contract, and services provided under or reimbursed by the contract treated as qualified long-term care services.

A contract providing for long-term care insurance may be exchanged for a long-term care insurance contract (or the former cancelled and the proceeds reinvested in the latter within 60 days) tax free between the date of enactment and January 1, 1998. Taxable gain would be recognized to the extent money or other property is received in the exchange.

The issuance or conformance of a rider to a life insurance contract providing long-term care insurance coverage is not treated as a modification or a material change for purposes of applying sections 101(f), 7702, and 7702A of the Code.

The provision relating to treatment of eligible long-term care premiums as a medical expense is effective for taxable years beginning after December 31, 1996. The provision treating amounts paid for long-term care services as a medical expense (for purposes of the medical expense deduction) is effective for services furnished in taxable years beginning after December 31, 1997.

The provisions relating to the maximum exclusion for certain long-term care benefits and reporting are effective for taxable years

[9] The rule limiting such services provided by a relative or a related corporation does not apply for purposes of the exclusion for amounts received under a long-term care insurance contract, whether the contract is employer-provided or purchased by an individual. The limitation in unnecessary in such cases because it is anticipated that the insurer will monitor reimbursements to limit opportunities for fraud in connection with the performance of services by the taxpayer's relative or a related corporation.

[10] Similarly, within certain limits, in the case of a rider to a life insurance contract, charges against the life insurance contract's cash surrender value that are includible in income are treated as medical expenses (provided the rider constitutes a long-term care insurance contract).

[11] Terminally ill is defined as under the provision of the bill relating to accelerated death benefits. In general, under that provision, an individual is considered to be terminally ill if he or she is certified as having an illness or physical condition that reasonably can be expected to result in death within 24 months of the date of the certification.

beginning after December 31, 1996. Thus, the initial year in which reports will be filed with the IRS and copies provided to the payee will be 1998, with respect to long-term care benefits paid in 1997.

Senate amendment

The Senate amendment is the same as the House bill, except as follows.

Life insurance company reserves

In determining reserves for insurance company tax purposes, the Senate amendment provides that the Federal income tax reserve method applicable for a long-term care insurance contract issued after December 31, 1996, is the method prescribed by the National Association of Insurance Commissioners (''NAIC'') (or, if no reserve method has been so prescribed, a method consistent with the tax reserve method for life insurance, annuity or noncancellable accident and health insurance contracts, whichever is most appropriate). The method currently prescribed by the NAIC for long-term care insurance contracts is the one-year full preliminary term method. As under present law, however, in no event may the tax reserve for a contract as of any time exceed the amount which would be taken into account with respect to the contract as of such time in determining statutory reserves.

Exchanges of life insurance and other contracts for long-term care insurance contracts

The exchange of a life insurance contract or an endowment or annuity contract for a qualified long-term care insurance contract is not taxable under the Senate amendment.

Distributions from IRAs and retirement plans for long-term care insurance

The Senate amendment permits certain plans to make distributions to pay premiums for long-term care insurance for the individual or the individual's spouse and provides that the 10-percent tax on early withdrawals does not apply to such distributions. The provision applies to distributions from individual retirement arrangements (''IRAs'') and distributions attributable to elective deferrals to qualified cash or deferred arrangements (sec. 401(k) plans), tax-sheltered annuities (sec. 403(b) plans), nonqualified deferred compensation plans of governmental or tax-exempt employers (sec. 457 plans), and section 501(c)(18) plans used to pay premiums for long-term care insurance for the individual or the individual's spouse. Such distributions are includable in income (as under present law).

Effective dates

The effective dates are the same as the House bill, except as follows.

The provision treating long-term care services as a medical expense is effective for taxable years beginning after December 31, 1996.

The change in treatment of reserves for long-term care insurance contracts is effective for contracts issued after December 31, 1996.

The provision relating to tax-free exchanges of life insurance, endowment and annuity contracts for long-term care insurance contracts is effective for taxable years beginning after December 31, 1997.

The provision relating to certain distributions from IRSs and elective deferrals used to pay long-term care insurance premiums is effective for payments and distributions after December 31, 1996.

Conference agreement

The conference agreement generally follows the House bill, except as follows.

Tax treatment and definition of long-term care insurance contracts and qualified long-term care services

Chronically ill individual.—The conference agreement provides that, for purposes of determining whether an individual is chronically ill, the number of activities of daily living that are taken into account under the contract may not be less than five. For example, a contract could require that an individual be unable to perform (without substantial assistance) two out of any five of the activities listed in the bill. By contrast, a contract does not meet this requirement if it required that an individual be unable to perform two out of any four of the activities listed in the bill.

In addition, the conference agreement modifies the second test for whether an individual is chronically ill (i.e., that the individual has a level of disability similar to an individual who is unable to perform (without substantial assistance) at least two activities of daily living). Under the conference agreement, this test is met if the individual has been certified within the previous 12 months by a licensed health care practitioner as having a similar level of disability, as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services.

Health care continuation rules.—The health care continuation rules do not apply to coverage under a plan, substantially all of the coverage under which is for qualified long-term care services.

State-maintained plans.—The conference agreement modifies the definition of a qualified long-term care insurance contract. Under the conference agreement, an arrangement is treated as a qualified long-term care insurance contract if an individual receives coverage for qualified long-term care services under a State long-term care plan, and the terms of the arrangement would satisfy the requirements for a long-term care insurance contract under the provision, were the arrangement an insurance contract. For this purpose, a State long-term care plan is any plan established and maintained by a State (or instrumentality of such State) under which only employees (and former employees, including retirees) of a State or of a political subdivision or instrumentality of the State, and their relatives, and their spouses and spouses' relatives, may receive coverage only for qualified long-term care services. Relative is defined as under section 152(a)(1)–(8). No inference is intended with respect to the tax consequences of such arrangements under present law.

Inclusions of excess long-term care benefits

The conference agreement modifies the calculation of the dollar cap applicable to aggregate payments under per diem type long-term care insurance contracts and amounts received with respect to a chronically ill individual pursuant to a life insurance contract.[12] The amount of the dollar cap with respect to any one chronically ill individual (who is not terminally ill) is $175 per day ($63,875 annually, as indexed), reduced by the amount of reimbursements and payments received by anyone for the cost of qualified long-term care services for the chronically ill individual. If more than one payee receives payments with respect to any one chronically ill individual, then everyone receiving periodic payments with respect to the same insured is treated as one person for purposes of the dollar cap. The amount of the dollar cap is utilized first by the chronically ill person, and any remaining amount is allocated in accordance with Treasury regulations. If payments under such contracts exceed the dollar cap, then the excess is excludable only to the extent of actual costs (in excess of the dollar cap) incurred for long-term care services. Amounts in excess of the dollar cap, with respect to which no actual costs were incurred for long-term care services, are fully includable in income without regard to rules relating to return of basis under Code section 72.

The managers of the bill wish to clarify that, although the legislation imposes a daily (or equivalent) dollar cap on the amount of excludable benefits under certain types of long-term care insurance in certain circumstances, this limitation is not intended to suggest a preference or otherwise convey or facilitate a competitive advantage to one type of long-term care insurance compared to another type of long-term care insurance.

The Chairmen of the House Committee on Ways and Means and the Senate Finance Committee shall jointly request that the NAIC, in consultation with representatives of the insurance industry and consumer organizations, develop and conduct a study to determine the marketing and other effects, if any, of the dollar limit on excludable long-term care benefits under certain types of long-term care insurance contracts under the bill. Such Chairmen are to request that the NAIC, if it agrees to such request, shall submit the results of its study to the such Committees by no later than two years after agreeing to the request.

The conference agreement modifies the reporting requirement for payors of amounts excludable under the provision. Thus, in addition to the reporting requirements of the House bill, a payor is required to report the name, address, and taxpayer identification number of the chronically ill individual on account of whose condition such amounts are paid, and whether the contract under which the amount is paid is a per diem-type contract.

A grandfather rule is provided under the conference agreement in the case of a per diem type contract issued to a policyholder on or before July 31, 1996. Under the grandfather rule, the amount of the dollar cap with respect to such a per diem contract is calculated without any reduction for reimbursements for qualified long-term care services under any other contract issued with respect to the same insured on or before July 31, 1996. The other provisions of the dollar cap are not affected by the grandfather rule. The grandfather rule ceases to apply as of the time that any of the contracts issued on or before July 31, 1996, with respect to the insured are exchanged, or benefits are increased.

Life insurance company reserves

The conference agreement includes the Senate amendment provision with respect to life insurance reserves. Thus, under the conference agreement, in determining reserves for insurance company tax purposes, the Senate amendment provides that the Federal income tax reserve method applicable for a long-term care insurance contract is the method prescribed by the NAIC (or, if no reserve method has been so prescribed, a method consistent with the tax reserve method for life insurance, annuity or noncancellable accident and health insurance contracts, whichever is most appropriate). As under present law, in no event may the tax reserve for a contract as of any time exceed the amount which would be taken into account with respect to the contract as of such time in determining statutory reserves.

Consumer protection provisions

The conference agreement clarifies and modifies the category of contracts to which the consumer protection provisions apply. The conference agreement clarifies that the consumer protection provisions that apply with respect to the terms of the contract apply only for purposes of determining whether a contract is a qualified long-term

[12] See item D, below.

care insurance contract (within the meaning of the bill).

The conference agreement provides that, for purposes of both the requirements as to contract terms and the requirements relating to issuers of contracts, the determination of whether any requirement of a model regulation or model Act has been met is made by the Secretary of the Treasury. It is not intended that the Secretary create a Federal standard, but rather, look to applicable or appropriate State standards or to those provided specifically in the model regulation or model Act.

The conference agreement modifies the $100-per-day tax on failure to satisfy the requirements for issuers of contracts, to provide that the amount of the tax imposed is $100 per insured per day. The conference agreement provides that the consumer protection requirements for issues of contracts apply with respect to contracts that are qualified long-term care insurance contracts (within the meaning of the bill).

The conference agreement modifies the rule relating to State establishment of standards relating to contract terms or issuers of contracts. The conference agreement provides that an otherwise qualified long-term care insurance contract will not fail to be a qualified long-term care insurance contract, and will not be treated as failing to meet the analogous requirement under the conference agreement, solely because it satisfies a consumer protection standard imposed under applicable State law that is more stringent than the analogous standard provided in the bill. The conference agreement does not preclude States from enacting more stringent consumer protection provisions than the analogous standards under the bill.

Effective date

The conference agreement follows the Senate amendment with respect to the effective date of the provision treating long-term care services as a medical expenses. Thus, under the conference agreement, this provision is effective for taxable years beginning after December 31, 1996.

The conference agreement provides that the provision relating to life insurance company reserves is effective for contracts issued after December 31, 1997.

D. TREATMENT OF ACCELERATED DEATH BENEFITS UNDER LIFE INSURANCE CONTRACTS

(Secs. 331–332 of the House bill and secs. 431–432 of the Senate amendment).

Present law

Treatment of amounts received under a life insurance contract

If a contract meets the definition of a life insurance contract, gross income does not include insurance proceeds that are paid pursuant to the contract by reason of the death of the insured (sec. 101(a)). In addition, the undistributed investment income (''inside buildup'') earned on premiums credited under the contract is not subject to current taxation to the owner of the contract. The exclusion under section 101 applies regardless of whether the death benefits are paid as a lump sum or otherwise.

Amounts received under a life insurance contract (other than a modified endowment contract) prior to the death of the insured are includable in the gross income of the recipient to the extent that the amount received constitutes cash value in excess of the taxpayer's investment in the contract (generally, the investment in the contract is the aggregate amount of premiums paid less amounts previously received that were excluded from gross income).

If a contract fails to be treated as a life insurance contract under section 7702(a), inside buildup on the contract is generally subject to tax (sec. 7702(g)).

Requirements for a life insurance contract

To qualify as a life insurance contract for Federal income tax purposes, a contract must be a life insurance contract under the applicable State or foreign law and must satisfy either of two alternative tests: (1) cash value accumulation test or (2) a test consisting of a guideline premium requirement and a cash value corridor requirement (sec. 7702(a)). A contract satisfies the cash value accumulation test if the cash surrender value of the contract may not at any time exceed the net single premium that would have to be paid at such time to fund future benefits under the contract. A contract satisfies the guideline premium and cash value corridor tests if the premiums paid under the contract do not at any time exceed the greater of the guideline single premium or the sum of the guideline level premiums, and if the death benefit under the contract is not less than a varying statutory percentage of the cash surrender value of the contract.

Proposed regulations on accelerated death benefits

The Treasury Department has issued proposed regulations[13] under which certain ''qualified accelerated death benefits'' paid by reason of the terminal illness of an insured would be treated as paid by reason of the death of the insured and therefore qualify for exclusion under section 101. In addition, the proposed regulations would permit an insurance contract that includes a qualified accelerated death benefit rider to qualify as a life insurance contract under section 7702. Thus, the proposed regulations provide that including this benefit would not cause an insurance contract to fail to meet the definition of a life insurance contract.

Under the proposed regulations, a benefit would qualify as a qualified accelerated death benefit only if it meets three requirements. First, the accelerated death benefit can be payable only if the insured becomes terminally ill. Second, the amount of the benefit must equal or exceed the present value of the reduction in the death benefit otherwise payable.[14] Third, the cash surrender value and the death benefit payable under the policy must be reduced proportionately as a result of the accelerated death benefit.

For purposes of the proposed regulations, an insured would be treated as terminally ill if he or she has an illness that, despite appropriate medical care, the insurer reasonably expects to result in death within twelve months from the payment of the accelerated death benefit. The proposed regulations would not apply to viatical settlements.

House bill

The House bill provides an exclusion from gross income as an amount paid by reason of the death of an insured for (1) amounts received under a life insurance contract and (2) amount received for the sale or assignment of a life insurance contract to a qualified viatical settlement provider, provided that the insured under the life insurance contract is either terminally ill or chronically ill. The exclusion for amounts received under a life insurance contract on the life of an insured who is chronically ill applies if the amount is received under a rider or other provision of the contract that is treated as a long-term care insurance contract under section 7702B (as added by the bill), and the amount is excludable as a payment for long-term care services under section 7702B (including under the dollar cap on per diem type payments ($175 per day, or $63,875 annually, in 1997).

The provision does not apply in the case of an amount paid to any taxpayer other than the insured, if such taxpayer has an insurable interest by reason of the insured being a director, officer or employee of the taxpayer, or by reason of the insured being financial interested in any trade or business carried on by the taxpayer.

A terminally ill individual is defined as one who has been certified by a physician as having an illness or physical condition that reasonably can be expected to result in death within 24 months of the date of certification. A physician is defined for this purpose in the same manner as under the long-term care insurance rules of the bill.[15]

A chronically ill individual is defined under the long-term care provisions of the bill.[16] In the case of amounts received with respect to a chronically ill individual (but not amounts received by reason of the individual being terminally ill), the $175 per day ($63,875 annual) limitation on excludable benefits that applies for per diem type long-term care insurance contracts also limits amounts that are excludable with respect to such contracts under this provision.

The payor of a payment to which this provision applies is required to report to the IRS the aggregate amount of such benefits paid to any individual during any calendar year, and the name, address and taxpayer identification number of such individual. A copy of the report must be provided to the payee by January 31 following the year of payment, showing the name of the payer and the aggregate amount of such benefits paid to the individual during the calendar year. Failure to file the report or provide the copy to the payee is subject to the generally applicable penalties for failure to file similar information reports.

A qualified viatical settlement provider is any person that regularly purchases or takes assignments of life insurance contracts on the lives of the terminally ill individuals and either (1) is licensed for such purposes in the State in which the insured resides; or (2) if the person is not required to be licensed by that State, meets the requirements of sections 8 and 9 of the Viatical Settlements Model Act (issued by the National Association of Insurance Commissioners (NAIC)), and also meets the section of the NAIC

[13] Prop. Treas. Reg. Secs. 1.101–8, 1.7702.0, 1.7702.2, and 1.7702A–1 (December 15, 1992).

[14] For purposes of determining the present value under the proposed regulations, the maximum permissible discount rate would be the greater of (1) the applicable Federal rate that applies under the discounting rules for property and casualty insurance loss reserves, and (2) the interest rate applicable to policy loans under the contract. Also, the present value would be determined assuming that the death benefit would have been paid twelve months after payment of the accelerated death benefit.

[15] A physician is defined for these purposes as in section 1861(r)(1) of the Social Security Act, which provides that a physician means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7) of that Act). Section 1101(a)(7) of that Act provides that the term physician includes osteopathic practitioners within the scope of their practice as defined by State law.

[16] Thus, a chronically ill individual is one who has been certified within the previous 12 months by a licensed health care practitioner as (1) being unable to perform (without substantial assistance) at least 2 activities of daily living for at least 90 days due to a loss of functional capacity, (2) having a similar level of disability as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services, or (3) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence. Nothing in the bill requires the contract to take into account all of the activities of daily living.

Viatical Settlements Model Regulation relating to standards for evaluation of reasonable payments, including discount rates, in determining amounts paid by the viatical settlement provider.

For life insurance company tax purposes, the bill provides that a life insurance contract is treated as including a reference to a qualified accelerated death benefit rider to a life insurance contract (except in the case of any rider that is treated as a long-term care insurance contract under section 7702B, as added by the bill). A qualified accelerated death benefit rider is any rider on a life insurance contract that provides only for payments of a type that are excludable under this provision.

Effective date

The provision applies to amounts received after December 31, 1996. The provision treating a qualified accelerated death benefit rider as life insurance for life insurance company tax purposes takes effect on January 1, 1997. The issuance of a qualified accelerated death benefit rider to a life insurance contract, or the addition of any provision required to conform an accelerated death benefit rider to these provisions, is not treated as a modification or material change to the contract (and is not intended to affect the issue date of any contract under section 101(f)).

Senate amendment

The Senate amendment is the same as the House bill, except that, in the case of a chronically ill insured, while the Senate amendment does provide that the exclusion for amounts received under a life insurance contract applies if the amount is received under a rider or other provision of the contract that is treated as a long-term care insurance contract under section 7702B (as added by the bill), the Senate amendment does not include the explicit language of the House bill requiring that the amount be treated as a payment for long-term care services under section 7702B.

Conference agreement

The conference agreement follows the House bill and the Senate amendment, with technical modifications and clarifications.

The conference agreement provides that the amount paid for the sale or assignment of any portion of the death benefit under a life insurance contract on the life of a terminally or chronically ill individual to a viatical settlement provider is excludable by the recipient as an amount paid under the contract by reason of the death of the insured. For example, the sale or assignment of a life insurance contract that has a rider providing for long-term care insurance, payments under which rider are funded by and reduce the death benefit, is considered the sale or assignment of the death benefit. Sale or assignment of a stand-alone rider providing for long-term care insurance (where payments under the rider are not funded by reductions in the death benefit), however, is not considered the sale or assignment of the death benefit.

The conference agreement provides that a viatical settlement provider is any person regularly engaged in the trade or business of purchasing or taking assignments of life insurance contracts on the lives of insured individuals who are terminally ill or chronically ill, so long as the viatical settlement provider meets certain requirements. The viatical settlement provider must either (1) be licensed, in the State where the insured resides, to engage in such transactions with terminally ill individuals (if the insured is terminally ill) or with chronically ill individuals (if the insured is chronically ill), or (2) if such licensing with respect to the insured individual is not required in the State, meet other requirements depending on whether the insured is terminally or chronically ill. If the insured is terminally ill, the viatical settlement provider must meet the requirements of sections 8 and 9 of the Viatical Settlements Model Act, relating to disclosure and general rules (issued by the National Association of Insurance Commissioner (NAIC)), and also meet the section of the NAIC Viatical Settlements Model Regulation relating to standards for evaluation of reasonable payments, including discount rates, in determining amounts paid by the viatical settlement provider. If the insured is chronically ill, the viatical settlement provider must meet requirements similar to those of sections 8 and 9 of the NAIC Viatical Settlements Model Act, and also must meet the standards, if any, promulgated by the NAIC for evaluating the reasonableness of amounts paid in viatical settlement transactions with chronically ill individuals.

The conference agreement clarifies the rules for chronically ill insureds so that the tax treatment of payments with respect to chronically ill individuals is reasonably similar under the long-term care rules of the bill and under this provision. In the case of a chronically ill individual, the exclusion under this provision with respect to amounts paid under a life insurance contract and amounts paid in a sale or assignment to a viatical settlement provider applies if the payment received is for costs incurred by the payee (not compensated by insurance or otherwise) for qualified long-term care services (as defined under the long-term care rules of the bill) for the insured person for the period, and two other requirements (similar to requirements applicable to long-term care insurance contracts under the bill) are met. The first requirement is that under the terms of the contract giving rise to the payment, the payment is not a payment or reimbursement of expenses reimbursable under Medicare (except where Medicare is a secondary payor under the arrangement, or the arrangement provides for per diem or other periodic payments without regard to expenses for qualified long-term care services). The conference agreement provides that no provision of law shall be construed or applied so as to prohibit the offering of such a contract giving rise to such a payment on the basis that the contract coordinates its payments with those provided under Medicare. The second requirement is that the arrangement complies with those consumer protection provisions applicable under the bill to long-term care insurance contracts and issuers that are specified in Treasury regulations. It is intended that such guidance incorporate rules similar to those of section 6F (relating to right to return, permitting the payee 30 days to rescind the arrangement) of the NAIC Long-Term Care Insurance Model Act, and section 13 (relating to requirements for application, requiring that the payee be asked if he or she already has long-term care insurance, Medicaid, or similar coverage) of the NAIC Long-Term Care Insurance Model Regulations. If the NAIC or the State in which the policyholder resides issues standards relating to chronically ill individuals, then the analogous requirements under Treasury regulations cease to apply.

An individual who meets the definition of a terminally ill individual is not treated as chronically ill, for purposes of this provision.

Payments made on a per diem or other periodic basis, without regard to expenses incurred for qualified long-term care services, are nevertheless excludable under this provision, subject to the dollar cap on excludable benefits that applies for amounts that are excludable under per diem type long-term care insurance contracts. The conference agreement modifies the calculation of the dollar cap applicable to aggregate payments under per diem type long-term care insurance contracts and amounts received with respect to a chronically ill individual pursuant to a life insurance contract.[17] The amount of the dollar cap with respect to the aggregate amount received under per diem type long-term care insurance contracts and this provision with respect to any one chronically ill individual (who is not terminally ill) is $175 per day ($63,875 annually) (indexed), reduced by the amount of reimbursements and payments received by anyone for the cost of qualified long-term care services for the chronically ill individual. If more than one payee receives payments with respect to any one chronically ill individual, the amount of the dollar cap is utilized first by the chronically ill person, and any remaining amount is allocated in accordance with Treasury regulations. If payments under such contracts exceed the dollar cap, then the excess is excludable only to the extent of actual costs incurred for long-term care services. Amounts in excess of the dollar cap, with respect to which no actual costs (in excess of the dollar cap) were incurred for long-term care services, are fully includable in income without regard to rules relating to return of basis under Code section 72.

The conference agreement modifies the reporting requirement for payors of amounts excludable under the provision. Thus, in addition to the reporting requirements of the House bill, a payor is required to report the name, address, and taxpayer identification number of the chronically ill individual on account of whose condition such amounts are paid, and whether the contract under which the amount is paid is a per diem-type contract.

E. EXEMPTION FROM INCOME TAX FOR STATE-SPONSORED ORGANIZATIONS PROVIDING HEALTH COVERAGE FOR HIGH-RISK INDIVIDUALS; EXEMPTION FROM INCOME TAX FOR STATE-SPONSORED WORKERS' COMPENSATION REINSURANCE ORGANIZATIONS

(Sec. 341 of the House bill and sec. 451 of the Senate amendment).

Present law

In general, the Internal Revenue Service (''IRS'') takes the position that organizations that provide insurance for their members or other individuals are not considered to be engaged in a tax-exempt activity. The IRS maintains that such insurance activity is either (1) a regular business of a kind ordinarily carried on for profit, or (2) an economy or convenience in the conduct of members' businesses because it relieves the members from obtaining insurance on an individual basis.

Certain insurance risk pools have qualified for tax exemption under Code section 501(c)(6). In general, these organizations (1) assign any insurance policies and administrative functions to their member organizations (although they may reimburse their members for amounts paid and expenses), (2) serve an important common business interest of their members, and (3) must be membership organizations financed, at least in part, by membership dues.

State insurance risk pools may also qualify for tax-exempt status under section 501(c)(4) as a social welfare organizations or under section 115 as serving an essential governmental function of a State. In seeking qualification under section 501(c)(4), insurance organizations generally are constrained by the restrictions on the provision of ''commercial-type insurance'' contained in section

[17] See item C, above.

501(m). Section 115 generally provides that gross income does not include income derived from the exercise of any essential governmental function and accruing to a State or any political subdivision thereof. However, the IRS may be reluctant to rule that particular State risk-pooling entities satisfy the section 501(c)(4) or 115 requirements for tax-exempt status.

House bill

Health coverage for high-risk individuals

The House bill provides tax-exempt status to any membership organization that is established by a State exclusively to provide coverage for medical care on a nonprofit basis to certain high-risk individuals, provided certain criteria are satisfied.[18] The organization may provide coverage for medical care either by issuing insurance itself or by entering into an arrangement with a health maintenance organization (''HMO'').

High-risk individuals eligible to receive medical care coverage from the organization must be residents of the State who, due to a pre-existing medical condition, are unable to obtain health coverage for such condition through insurance or an HMO, or are able to acquire such coverage only at a rate that is substantially higher than the rate charged for such coverage by the organization. The State must determine the composition of membership in the organization. For example, a State could mandate that all organizations that are subject to insurance regulation by the State must be members of the organization.

The House bill further requires the State or members of the organization to fund the liabilities of the organization to the extent that premiums charged to eligible individuals are insufficient to cover such liabilities. Finally, no part of the net earnings of the organization can inure to the benefit of any private shareholder or individual.

Effective date.—The provision applies to taxable years beginning after December 31, 1996.

Workers' compensation reinsurance organizations

No provision.

Senate amendment

The Senate amendment is the same as the House bill.

Conference agreement

Health coverage for high-risk individuals

The conference agreement follows the House bill and the Senate amendment.

Workers' compensation reinsurance organizations

The conference agreement provides tax-exempt status to any membership organization that is established by a State before June 1, 1996, exclusively to reimburse its members for workers' compensation insurance losses, and that satisfies certain other conditions. A State must require that the membership of the organization consist of all persons who issue insurance covering workers' compensation losses in such State, and all persons who issue insurance covering workers' compensation losses in such State, and all persons and governmental entities who self-insure against such losses. In addition, the organization must operate as a nonprofit organization by returning surplus income to members or to workers' compensation policyholders on a periodic basis and by reducing initial premiums in anticipation of investment income.

Effective date.—The provision applies to taxable years ending after the date of enactment.

[18] No inference is intended as to the tax treatment of other types of State-sponsored organizations.

F. HEALTH INSURANCE ORGANIZATIONS ELIGIBLE FOR BENEFITS OF SECTION 833

(Sec. 351 of the House bill).

Present law

An organization described in sections 501(c)(3) or (4) of the Code is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance (sec. 501(m)). Special rules apply to certain eligible health insurance organizations. Eligible health insurance organizations are (1) Blue Cross and Blue Shield organizations existing on August 16, 1986, which have not experienced a material change in structure or operations since that date, and (2) other organizations that meet certain community-service related requirements and substantially all of whose activities involve the providing of health insurance. Section 833 provides that eligible organizations are generally treated as stock property and casualty insurance companies.

Section 833 provides a special deduction for eligible organizations, equal to 25 percent of the claims and expenses incurred during the year, less the adjusted surplus at the beginning of the year. This deduction is calculated by computing surplus, taxable income, claims incurred, expenses incurred, tax-exempt income, net operating loss carryovers, and other items attributable to health expenses. The deduction may not exceed taxable income attributable to health business for the year (calculated without regard to this deduction).

In addition, section 833 eliminates, for eligible organizations, the 20 percent reduction in unearned premium reserves that applies generally to all property and casualty insurance companies.

House bill

The House bill applies the special rules under section 833 to the same extent they are provided to certain existing Blue Cross or Blue Shield organizations, in the case of any organization that (1) is not a Blue Cross or Blue Shield organization existing on August 16, 1986, and (2) otherwise meets the requirements of section 833(c)(2) (including the requirement of no material change in operations or structure since August 16, 1986). Under the provision, an organization qualifies for this treatment only if (1) it is not a health maintenance organization and (2) it is organized under and governed by State laws which are specifically and exclusively applicable to not-for-profit health insurance or health service type organizations.

Effective date.—The provision is effective for taxable years ending after December 31, 1996.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

G. PENALTY-FREE WITHDRAWALS FROM IRAS FOR MEDICAL EXPENSES

(Sec. 461 of the Senate amendment).

Present law

Amounts withdrawn from an individual retirement arrangement (''IRA'') are includible in income (except to the extent of any nondeductible contributions). In addition, a 10-percent additional tax applies to withdrawals from IRAs made before age 59½, unless the withdrawal is made on account of death or disability or is made in the form of annuity payments.

A similar additional tax applies to early withdrawals from employer-sponsored tax-qualified pension plans. However, the 10-percent additional tax does not apply to withdrawals form such plans to the extent used for medical expenses that exceed 7.5 percent of adjusted gross income (''AGI'').

House bill

No provision.

Senate amendment

The Senate amendment extends the exception to the 10-percent tax for medical expenses in excess of 7.5 percent of AGI to withdrawals from IRAs. In addition, the Senate amendment provides that the 10-percent additional tax does not apply to withdrawals for medical insurance (without regard to the 7.5 percent of AGI floor) if the individual (including a self-employed individual) has received unemployment compensation under Federal or State law for at least 12 weeks, and the withdrawal is made in the year such unemployment compensation is received or the following year. If a self-employed individual is not eligible for unemployment compensation under applicable law, then, to the extent provided in regulations, a self-employed individual is treated as having received unemployment compensation for at least 12 weeks if the individual would have received unemployment compensation but for the fact that the individual was self-employed.

Effective date.—The provision is effective for taxable years beginning after December 31, 1996.

Conference agreement

The conference agreement follows the Senate amendment, with the modification that the exception ceases to apply if the individual has been reemployed for at least 60 days.

H. REQUIRE TREASURY TO INCLUDE ORGAN AND TISSUE DONATION INFORMATION WITH TAX REFUNDS

(Sec. 307 of the Senate amendment).

Present law

There is no statutory requirement that Treasury include organ and tissue donation information with any payment of a refund of individual income taxes.

House bill

No provision.

Senate amendment

The Senate amendment requires Treasury to include organ and tissue donation information with any payment of a refund of individual income taxes made on or after February 1, 1997, through June 30, 1997.

Effective date.—The provision is effective for refunds made on or after February 1, 1997, through June 30, 1997.

Conference agreement

The conference agreement generally follows the Senate amendment, with two technical modifications. the first modification requires that the organ donor card be included to the extent particable. The second modification clarifies that the organ donor card is to be included with the mailing of any payment of a refund of individual income taxes.

Effective date.—The provision is effective for refunds made on or after February 1, 1997, through June 30, 1997.

TITLE IV. APPLICATION AND ENFORCEMENT OF GROUP HEALTH PLAN REQUIREMENTS

A. APPLICATION AND ENFORCEMENT OF GROUP HEALTH PLAN PORTABILITY, ACCESS, AND RENEWABILITY REQUIREMENTS

(Sec. 104(b) of the House bill).

Present Law

Under present law, the health care continuation rules (referred to as ''COBRA'' rules, after the Consolidated Omnibus Budget Reconciliation Act of 1985 in which they were enacted) require that most employer-sponsored group health plans must offer certain employees and their dependents (''qualified beneficiaries'') the option of purchasing

continued health coverage in the case of certain qualifying events. These qualifying events include: termination or reduction in hours of employment, death, divorce or legal separation, enrollment in Medicare, or the end of a child's dependency under a parent's health plan. In general, the maximum period of COBRA coverage is 18 months. An employer is permitted to charge qualified beneficiaries 102 percent of the applicable premium for COBRA coverage.

A tax is imposed on the failure of a group health plan to satisfy the COBRA rules. The tax must be imposed on the employer sponsoring the plan in the case of a plan other than a multiemployer plan, on the plan in the case of a multiemployer plan, or on each person who is responsible for administering or providing benefits under the plan if such person has, by written agreement, assumed responsibility for performing the act pursuant to which the violation occurs.

The amount of the tax is generally equal to $100 per day for each day on which there is a violation. The tax applies separately with respect to each qualified beneficiary for whom a failure occurs. In general, a tax will not be imposed if the violation was unintentional and is corrected within 30 days. The maximum tax for unintentional violations that can be imposed for a taxable year generally is the lesser of (1) 10 percent of the employer's payments under group health plans (or under the trust funding the plan in the case of a multiemployer plan), or (2) $500,000. If the tax is imposed on another person responsible for administering or providing benefits under the plan, the maximum penalty for failures during the year is $2 million. The Secretary may waive all or part of the tax to the extent that payment of the tax would be excessive relative to the failure involved.

Other than the COBRA rules, there are no other requirements in the Code which apply to group health plans (or insurers or health maintenance organizations (''HMOs'')) regarding portability through limitations on preexisting condition exclusions, prohibitions on excluding individuals from coverage based on health status, and guaranteed renewability of health plan coverage.

House bill

Under the House bill, group health plans, insurers, and HMOs are subject to certain requirements regarding portability through limitations on preexisting condition exclusions and prohibitions on excluding individuals from coverage based on health status. The House bill generally extends the tax for failures to satisfy the COBRA rules to failures to comply with these requirements.

No tax is imposed on an insurer or HMO that is governed under a State law that the Secretary of Health and Human Services has determined to provide enforcement of similar requirements. In addition, no tax may be imposed on a small employer (defined as an employer who employs at least 2, but fewer than 51 employees on a typical business day) that provides health care benefits through a contract with an insurer or HMO and the violation is solely because of the product offered by the insurer or HMO under such contract. In addition, no tax is imposed if there has been enforcement by the Secretary of Labor or the Secretary of Health and Human Services.

Effective date.—The provision generally is effective with respect to plan years beginning on or after January 1, 1998.

Senate amendment

No provision. The requirements in the Senate amendment on group health plans, insurers, and HMOs regarding portability through limitations on preexisting condition exclusions and prohibitions on excluding individuals from coverage based on health status are not applied or enforced through the Code.

Conference agreement

Under the conference agreement, group health plans are subject to certain requirements regarding portability through limitations on preexisting condition exclusions, prohibitions on excluding individuals from coverage based on health status, and guaranteed renewability of health insurance coverage.[19] The conference agreement incorporates these requirements into the Code and generally imposes a tax with respect to any failure of a group health plan to comply with the requirements. The tax may generally be imposed on the employer sponsoring the plan. However, the tax may be imposed on the plan in the case of a multiemployer plan, and, with respect to violations of the requirements relating to guaranteed renewability, on the arrangement in the case of a multiple employer welfare arrangement.

The group health plan requirements contained in the Code do not apply to governmental plans and plans which on the first day of the plan year cover less than 2 current employees. In addition, no tax may be imposed on a small employer (defined as an employer who employed an average of 50 or fewer employees on business days during the preceding calendar year) that provides health care benefits through a contract with an insurer or HMO and the violation is solely because of the coverage offered by the insurer or HMO.

The amount of the tax is generally equal to $100 per day for each day during which a failure occurs until the failure is corrected. The tax applies separately with respect to each individual affected by the failure. In general, a tax will not be imposed if the violation was unintentional and is corrected within 30 days.[20] The maximum tax for unintentional violations that can be imposed generally is the lesser of (1) 10 percent of the employer's payments during the taxable year in which the failure occurred under group health plans (or 10 percent of the amount paid by the multiemployer plan or multiple employer welfare arrangement during the plan year in which the failure occurred for medical care, if applicable), or (2) $500,000. The Secretary may waive all or part of the tax to the extent that payment of the tax would be excessive relative to the failure involved.

Effective date.—The provision applies with respect to failures of group health plans to satisfy the requirements regarding portability through limitations on preexisting condition exclusions, prohibitions on excluding individuals from coverage based on health status, and guaranteed renewability of health insurance coverage.

B. CLARIFICATION OF CERTAIN COBRA HEALTH CARE CONTINUATION REQUIREMENTS

(Sec. 121 of the Senate amendment).

Present law

Under present law, the health care continuation rules (referred to as ''COBRA'' rules, after the Consolidated Omnibus Budget Reconciliation Act of 1985 in which they were enacted) require that most employer-sponsored group health plans must offer certain employees and their dependents (''qualified beneficiaries'') the option of purchasing continued health coverage in the case of certain qualifying events. These qualifying events include; termination or reduction in hours of employment, death, divorce or legal separation, enrollment in Medicare, or the end of a child's dependency under a parent's health plan. In general, the maximum period of COBRA coverage is 18 months. An employer is permitted to charge qualified beneficiaries 102 percent of the applicable premium for COBRA coverage. A $100 per day tax generally may be assessed against employers (plans in the case of multiemployer plans) for failures to comply with the COBRA rules, subject to certain exceptions and limitations.

The 18-month maximum COBRA coverage period is extended to 29 months if the qualified beneficiary is determined under the Social Security Act to have been disabled at the time of the qualifying event and the qualified beneficiary provides notice of such determination to the employer before the end of the 18-month period. A qualified beneficiary has 60 days to notify the employer of a disability determination. During the 11-month period of extended COBRA coverage, the qualified beneficiary may be charged 150 percent of the applicable premium.

COBRA coverage may be terminated before the 18-month maximum coverage period in the case of certain events. These include: the employer ceases to maintain any group health plan, the qualified beneficiary fails to pay the premium, the qualified beneficiary becomes covered under another group health plan with no preexisting condition limitation or exclusion, or the qualified beneficiary becomes entitled to Medicare.

Under present law, the term qualified beneficiary only includes individuals who were either the spouse or the dependent of the covered employee at the time of the qualifying event.

A group health plan is required to notify each covered employee and the covered employee's spouse of their COBRA rights upon commencement of participation in the plan. Further, the group health plan administrator must notify each qualified beneficiary of their COBRA rights within 14 days after notification of the occurrence of a qualifying event.

House bill

No provision. However, the House bill modifies the COBRA rules so that the penalties applicable to failures to comply with the COBRA rules generally apply to failures to comply with the requirements in the House bill on group health plans, insurers, and health maintenance organizations (''HMOs'') regarding portability through limitations on preexisting condition exclusions and prohibitions on excluding individuals from coverage based on health status.

Senate amendment

The Senate amendment modifies the COBRA rules by clarifying that the extended maximum COBRA coverage period of 29 months in cases of disability also applies to the disabled qualified beneficiary of the covered employee. In addition, the Senate amendment provides the extended COBRA coverage if the disability exists at any time during the initial 18-month COBRA coverage period as opposed to requiring the disability to exist at the time of the qualifying event. As under present law, the disability determination still has to be made, and the notice of the disability still has to be given, before the end of the initial COBRA coverage period.

[19] These requirements are discussed earlier in greater detail.

[20] In the case of a church plan, this correction is generally extended to 270 days after the date of mailing by the Secretary of a notice of default with respect to a failure to comply with the group health plan requirements.

The Senate amendment coordinates the COBRA rules with the new requirements regarding preexisting condition exclusions so that COBRA coverage can be terminated if a qualified beneficiary becomes covered under another group health plan, even if such group health plan contains a preexisting condition limitation or exclusion, provided the preexisting condition limitation or exclusion does not apply to the qualified beneficiary by reason of the new requirements restricting the application of preexisting condition limitations and exclusions.

The Senate amendment also modifies the definition of qualified beneficiary to include a child born to our placed for adoption with the covered employee during the period of COBRA coverage. Consequently, since the health care availability provisions in the Senate amendment require group health plans to allow participants to change their coverage status (i.e., to change from individual coverage to family coverage, or to add on the new child) upon the birth or adoption of a new child, COBRA participants would also be allowed to change their coverage status upon the birth or adoption of a new child.

The Senate amendment requires a group health plan to notify each qualified beneficiary who has elected COBRA coverage of the changes to the COBRA rules contained in the Senate amendment no later than November 1, 1996.

Effective date.—The provision applies to qualifying events occurring on or after the date of enactment for plan years beginning after December 31, 1997.

Conference agreement

The conference agreement follows the Senate amendment, except the extended period of COBRA coverage in cases of disability applies if the disability exists at any time during the first 60 days of COBRA coverage.

Effective date.—The provision is effective on January 1, 1997, regardless of whether the qualifying event occurred before, on, or after such date.

TITLE V. REVENUE OFFSETS

A. DISALLOW INTEREST DEDUCTION FOR CORPORATE-OWNED LIFE INSURANCE POLICY LOANS

(Sec. 495 of the Senate amendment).

Present law

No Federal income tax generally is imposed on a policyholder with respect to the earnings under a life insurance contract (''inside buildup'').[21] Further, an exclusion from Federal income tax is provided for amounts received under a life insurance contract paid by reason of the death of the insured (sec. 101(a)). The policyholder may borrow with respect to the life insurance contract without affecting these exclusions, subject to certain limitations.

The limitations on borrowing with respect to a life insurance contract under present law provide that no deduction is allowed for any interest paid or accrued on any indebtedness with respect to one or more life insurance policies owned by the taxpayer covering the life of any individual who (1) is an officer or employee of, or (2) is financially interested in, any trade or business carried on by the taxpayer to the extent that the aggregate amount of such debt with respect to policies covering the individual exceeds $50,000 (sec. 264(a)(4)).

Further, no deduction is allowed for any amount paid or accrued on debt incurred or continued to purchase or carry a life insurance, endowment, or annuity contract pursuant to a plan of purchase that contemplates the systematic direct or indirect borrowing of part or all of the increases in the cash value of the contract.[22] An exception to the latter rule is provided, permitting deductibility of interest on bona fide debt that is part of such a plan, if no part of 4 of the annual premiums due during the first 7 years is paid by means of debt (the ''4-out-of-7 rule'') (sec. 264(c)(1)). Provided the transaction gives rise to debt for Federal income tax purposes, and provided the 4-out-of-7 rule is met,[23] a company may under present law borrow up to $50,000 per employee, officer, or financially interested person to purchase or carry a life insurance contract covering such a person, and is not precluded under section 264 from deducting the interest on the debt, even though the earnings inside the life insurance contract (inside buildup) are tax-free, and in fact the taxpayer has full use of the borrowed funds.

House bill

No provision.

Senate amendment

Under the Senate amendment, no deduction is allowed for interest paid or accrued on any indebtedness with respect to one or more life insurance policies or annuity or endowment contracts owned by the taxpayer covering any individual who is (1) an officer or employee of, or (2) financially interested in, any trade or business carried on by the taxpayer, regardless of the aggregate amount of debt with respect to policies or contracts covering the individual.

An exception is provided retaining present law for interest on indebtedness with respect to life insurance policies covering up to 10 key persons. A key person is an individual who is either an officer or a 20-percent owner of the taxpayer. The number of individuals that can be treated as key persons may not exceed the greater of (1) 5 individuals, or (2) the lesser of 5 percent of the total number of officers and employees of the taxpayer or 10 individuals. Interest paid or accrued on debt with respect to a life insurance contract covering a key person is deductible only to the extent the rate of interest does not exceed Moody's Corporate Bond Yield Average—Monthly Average Corporates for each month interest is paid or accrued.

Effective date.—The Senate amendment provision generally is effective with respect to interest paid or accrued after December 31, 1995 (subject to a phase-in rule).

The phase-in rule provides that with respect to debt incurred before January 1, 1996, any otherwise deductible interest paid or accrued after October 13, 1995, and before January 1, 1999, is allowed to the extent the rate of interest does not exceed the lesser of (1) the borrowing rate specified in the contract as of October 13, 1995, or (2) a percentage of Moody's Corporate Bond Yield Average—Monthly Average Corporates for each month the interest is paid or accrued. For interest paid or accrued after October 13, 1995, and before January 1, 1996, the percentage of the Moody's rate is 100 percent; for interest paid or accrued in 1996, the percentage is 90 percent; for interest paid or accrued in 1997, the percentage is 80 percent; for 1998, the percentage is 70 percent; for 1999 and thereafter, the percentage is 0 percent. Only interest that would have been allowed as a deduction but for the provision is allowed under the phase-in. Interest that is deductible under the phase-in rules does not include interest on borrowings by the taxpayer with respect to contracts on the lives of more than 20,000 insured individuals, effective for interest paid or accrued after December 31, 1995. For this purpose, all persons treated as a single employer are treated as one taxpayer.

An exception is provided under the effective date with respect to any life insurance contract entered into during 1994 or 1995. In the case of such contracts, with respect to debt incurred before January 1, 1997, a deduction is allowed for interest (that is otherwise deductible) only (1) with respect to policies that satisfy the key person exception, and (2) as provided under the phase-in rule. Thus, with respect to interest on amounts borrowed during 1996 with respect to such a contract, the phase-in rule applies, capping the rate for determining the amount of deductible interest at the lesser of (1) the borrowing rate specified in the contracts as of October 13, 1995, or (2) the applicable percentage of Moody's Corporate Bond Yield Average—Monthly Average Corporates for each month the interest is paid or accrued. For example, for interest paid or accrued in 1996 on amounts borrowed in 1996 with respect to such a contract, the applicable percentage is 90 percent.

The provision generally does not apply to interest on debt with respect to contracts purchased on or before June 20, 1986 (thus generally continuing the effective date provision of the $50,000 limitation enacted in the 1986 Act.) If the policy loan interest rate under such a contract provides for a fixed rate of interest, then interest on such a contract paid or accrued after October 13, 1995, is allowable only to the extent the fixed rate of interest does not exceed Moody's Corporate Bond Yield Average—Monthly Average Corporates for the month in which the contract was purchased. If the policy loan interest rate under such a contract does not provide for a fixed rate of interest, then interest on such a contract paid or accrued after October 13, 1995, is allowable only to the extent the rate of interest for each fixed period selected by the taxpayer does not exceed Moody's Corporate Bond Yield Average—Monthly Average Corporates, for the month immediately preceding the beginning of the fixed period. The fixed period must be 12 months or less. it is intended that conforming a contract to satisfy this interest rate limitation not be treated as a material modification for purposes of this grandfather rule or sections 101(f), 7702 or 7702A. No inference is intended as to whether such a change is a material modification under present law.

Any amount included in income during 1996, 1997, or 1998, that is received under a contract described in the proposal on the

[21] This favorable tax treatment is available only if a life insurance contract meets certain requirements designed to limit the investment character of the contract (sec. 7702). Distributions from a life insurance contract (other than a modified endowment contract) that are made prior to the death of the insured generally are includible in income, to the extent that the amounts distributed exceed the taxpayer's basis in the contract; such distributions generally are treated first as a tax-free recovery of basis, and then as income (sec. 72(e)). In the case of a modified endowment contract, however, in general, distributions are treated as income first, loans are treated as distributions (i.e., income rather than basis recovery first), and an additional 10 percent tax is imposed on the income portion of distributions made before age 59–½ and in certain other circumstances (secs. 72 (e) and (v)). A modified endowment contract is a life insurance contract that does not meet a statutory ''7-pay'' test, i.e., generally is funded more rapidly than 7 annual level premiums (sec. 7702A).

[22] The statute provides that the $50,000 limitation applies only with respect to contracts purchased after June 20, 1986. However, additional limitations are imposed on the deductibility of interest with respect to single premium contracts (sec. 264(a)(2)), and on the deductibility of premiums paid on a life insurance contract covering the life of any officer or employee or person financially interested in a trade or business of the taxpayer when the taxpayer is directly or indirectly a beneficiary under the contract (sec. 264(a)(1)).

[23] Interest deductions are disallowed if any of the disallowance rules of section 264(a) (2)–(4) apply. The disallowance rule of section 264(a)(3) is not applicable if one of the exceptions of section 264(c), such as the 4-out-of-7 rule (sec. 264(c)(1)) is satisfied. In addition to the specific disallowance rules of section 264, generally applicable principles of tax law apply.

complete surrender, redemption or maturity of the contract or in full discharge of the obligation under the contract that is in the nature of a refund of the consideration paid for the contract, is includable ratably over the first 4 taxable years beginning with the taxable year the amount would otherwise have been includable. Utilization of this 4-year income-spreading rule does not cause interest paid or accrued prior to January 1, 1999, to be nondeductible solely by reason of (1) failure to meet the 4-out-or-7 rule, or (2) causing the contract to be treated as single premium contract within the meaning of section 264(b)(1) (i.e., a contract in which substantially all of the premiums are paid within 4 years after the date of purchase). In addition, the lapse of a contract after October 13, 1995, due to nonpayment of premiums does not cause interest paid or accrued prior to January 1, 1999, to be nondeductible solely by reason of (1) failure to meet the 4-out-of-7 rule, or (2) causing the contract to be treated as a single premium contract within the meaning of section 264(b)(1).

In the case of an insurance company, the unamortized balance of policy expense attributable to a contract with respect to which the 4-year income-spreading treatment is allowed to the policyholder is deductible in the year in which the transaction giving rise to income-spreading occurs.

No inference, is intended as to the treatment of interest paid or accrued under present law.

Conference agreement

The conference agreement follows the Senate amendment, with the following modifications.

The exception relating to key persons is modified to apply to life insurance policies covering up to 20 key persons. Thus, under the conference agreement, the number of individuals that can be treated as key persons may not exceed the greater of (1) 5 individuals, or (2) the lesser of 5 percent of the total number of officers and employees of the taxpayer or 20 individuals.

The cap (based on Moody's Corporate Bond Yield Average—Monthly Average Corporates) on deductible interest paid or accrued with respect to (1) interest paid or accrued on debt with respect to a life insurance contract covering a key person, and (2) interest on debt with respect to contracts purchased on or before June 20, 1986, applies only for interest paid or accrued for any month beginning after December 31, 1995.

In addition, in the case of a contract purchased on or before June 20, 1986, where the policy loan interest rate under the contract does not provide for a fixed rate of interest, the interest is allowable only to the extent the rate of interest for each period does not exceed Moody's Corporate Bond Yield Average—Monthly Average Corporates for the third month preceding the first month preceding the first month preceding the period.

Effective date.—The conference agreement modifies the percentages of the Moody's Corporate Bond Yield Average—Monthly Average Corporates that apply with respect to qualified interest under the phase-in rule. Thus, under the conference agreement, the percentage of the Moody's rate is 100 percent for interest paid or accrued in 1996; 90 percent for interest paid or accrued in 1997; 80 percent for interest paid or accrued in 1998; and 0 percent thereafter. The rule limiting deductible interest to the applicable percentage of the Moody's rate does not apply for interest paid or accrued in any month beginning before January 1, 1996.

B. EXPATRIATION TAX PROVISIONS

(Secs. 421–423 of the House bill and secs. 471–473 of the Senate amendment.)

Present law

Individuals who relinquish U.S. citizenship with a principal purpose of avoiding U.S. taxes are subject to special tax provisions for 10 years after expatriation. The determination of who is U.S. citizen for tax purposes, and when such citizenship is lost, is governed by the provisions of the Immigration and Nationality Act, 8 U.S.C. section 1401, et seq.

An individual who relinquishes his U.S. citizenship with a principal purpose of avoiding U.S. taxes is subject to tax on his or her U.S. source income at the rates applicable to U.S. citizens, rather than the rates applicable to other non-resident aliens, for 10 years after expatriation. In addition, the scope of items treated as U.S. source income for this purpose is broader than those items generally considered to be U.S. source income. For example, gains on the sale of personal property located in the United States and gains on the sale or exchange of stock or securities issued by U.S. persons are treated as U.S. source income. This alternative method of income taxation applies only if it results in higher U.S. tax liability.

Rules applicable in the estate and gift tax contexts expand the categories of items that are subject to the gift and estate taxes in the case of a U.S. citizen who relinquished citizenship with a principal purpose of avoiding U.S. taxes within the 10-year period ending on the date of the transfer. For example, U.S. property held through a foreign corporation controlled by such individual and related persons is included in his or her estate and gifts of U.S.-situs intangible property by such individual are subject to the gift tax.

House bill

Overview

The House bill expands and substantially strengthens in several ways the present-law provisions that subject U.S. citizens who lose their citizenship for tax avoidance purposes to special tax rules for 10 years after such loss of citizenship (secs. 877, 2107, and 2501(a)(3)). First, the House bill extends the expatriation tax provisions to apply not only to U.S. citizens who lose their citizenship but also to certain long-term residents of the United States whose U.S. residency is terminated. Second, the House bill subjects certain individuals to the expatriation tax provisions without inquiry as to their motive for losing their U.S. citizenship or residency, but allows certain categories of citizens to show an absence of tax-avoidance motive if they request a ruling from the Secretary of the Treasury as to whether the loss of citizenship had a principal purpose of tax avoidance. Third, the House bill expands the categories of income and gains that are treated as U.S. source (and therefore subject to U.S. income tax under section 877) if earned by an individual who is subject to the expatriation tax provisions and includes provisions designed to eliminate the ability to engage in certain transactions that under current law partially or completely circumvent the 10-year reach of section 877. Further, the House bill provides relief from double taxation in circumstances where another country imposes tax on items that would be subject to U.S. tax under the expatriation tax provisions.

The House bill also contains provisions to enhance compliance with the expatriation tax provisions. The House bill imposes information reporting obligations on U.S. citizens who lose their citizenship and long-term residents whose U.S. residency is terminated at the time of expatriation. In addition, the House bill directs the Treasury Department to undertake a study regarding compliance by individuals living abroad with their U.S. tax reporting obligations and to make recommendations with respect to improving such compliance.

Individuals covered

The present-law expatriation tax provisions apply only to certain U.S. citizens who lose their citizenship. The House bill extends these expatriation tax provisions to apply also to long-term residents of the United States whose U.S. residency is terminated. For this purpose, a long-term resident is any individual who was a lawful permanent resident of the United States for at least 8 out of the 15 taxable year sending with the year in which such termination occurs. In applying this 8-year test, an individual is not considered to be a lawful permanent resident for any year in which the individual is taxed as a resident of another country under a treaty tie-breaker rule. An individual's U.S. residency is considered to be terminated when either the individual ceases to be a lawful permanent resident pursuant to section 7701(b)(6) (i.e., the individual loses his or her green-card status) or the individual is treated as a resident of another country under a tie-breaker provision of a tax treaty (and the individual does not elect to waive the benefits of such treaty). Furthermore, a long-term resident may elect to use the fair market value basis of property on the date the individual became a U.S. resident (rather than the property's historical basis) to determine the amount of gain subject to the expatriation tax provisions if the asset is sold within the 10-year period.

Under present law, the expatriation tax provisions are applicable to a U.S. citizen who loses his or her citizenship unless such loss did not have as a principal purpose the avoidance of taxes. Under the House bill, U.S. citizens who lose their citizenship and long-term residents whose U.S. residency is terminated are generally treated as having lost such citizenship or terminated such residency with a principal purpose of the avoidance of taxes if either: (1) the individual's average annual U.S. Federal income tax liability for the 5 taxable years ending before the date of such loss or termination is greater than $100,000 (the ''tax liability test''), or (2) the individual's net worth as of the date of such loss or termination is $500,000 or more (the ''net worth test''). The dollar amount thresholds contained in the tax liability test and the net worth test are indexed for inflation in the case of a loss of citizenship or termination of residency occurring in any calendar year after 1996. An individual who falls below the thresholds specified in both the tax liability test and the net worth test is subject to the expatriation tax provisions unless the individual's loss of citizenship or termination of residency did not have as a principal purpose the avoidance of tax (as under present law in the case of U.S. citizens).

A U.S. citizen, who loses his or her citizenship and who satisfies either the tax liability test or the net worth test, is not subject to the expatriation tax provisions if such individual can demonstrate that he or she did not have a principal purpose of tax avoidance and the individual is within one of the following categories: (1) the individual was born with dual citizenship and retains only the non-U.S. citizenship; (2) the individual becomes a citizen of the country in which the individual, the individual's spouse, or one of the individual's parents, was born; (3) the individual was present in the United States for no more than 30 days during any year in the 10-year period immediately preceding the date of his or her loss of citizenship; (4) the individual relinquishes his or her citizenship before reaching age 18½; or (5) any other category of individuals prescribed by Treasury regulations. In all of these situations, the individual would have been subject to tax on

his or her worldwide income (as are all U.S. citizens) until the time of expatriation. In order to qualify for one of these exceptions, the former U.S. citizen must, within one year from the date of loss of citizenship, submit a ruling request for a determination by the Secretary of the Treasury as to whether such loss had as one of its principal purposes the avoidance of taxes. A former U.S. citizen who submits such a ruling request is entitled to challenge an adverse determination by the Secretary of the Treasury. However, a former U.S. citizen who fails to submit a timely ruling request is not eligible for these exceptions. It is expected that in making a determination as to the presence of a principal purpose of tax avoidance, the Secretary of the Treasury will take into account factors such as the substantiality of the former citizen's ties to the United States (including ownership of U.S. assets) prior to expatriation, the retention of U.S. citizenship by the former citizen's spouse, and the extent to which the former citizen resides in a country that imposes little or no tax.

The foregoing exceptions are not available to long-term residents whose U.S. residency is terminated. However, the House bill authorizes the Secretary of the Treasury to prescribe regulations to exempt certain categories of long-term residents from the House bill's provisions.

Items subject to section 877

Under section 877, an individual covered by the expatriation tax provisions is subject to tax on U.S. source income and gains for a 10-year period after expatriation at the graduated rates applicable to U.S. citizens.[24] The tax under section 877 applies to U.S. source income and gains of the individual for the 10-year period, without regard to whether the property giving rise to such income or gains was acquired before or after the date the individual became subject to the expatriation tax provisions. For example, a U.S. citizen who inherits an appreciated asset immediately before losing citizenship and disposes of the asset immediately after such loss would not recognize any taxable gain on such disposition (because of the date of death fair market value basis accorded to inherited assets), but the individual would continue to be subject to tax under section 877 on the income or gain derived from any U.S. property acquired with the proceeds from such disposition.

In addition, section 877 currently recharacterizes as U.S. source income certain gains of individuals who are subject to the expatriation tax provisions, thereby subjecting such individuals to U.S. income tax on such gains. Under this rule, gain on the sale or exchange of stock of a U.S. corporation or debt of a U.S. person is treated as U.S. source income. In this regard, under current law, the substitution of a foreign obligor for a U.S. obligor is generally treated as a taxable exchange of the debt instrument, and therefore any gain on such exchange is subject to tax under section 877. The House bill extends this recharacterization to income and gains derived from property obtained in certain transactions on which gain or loss is not recognized under present law. An individual covered by section 877 who exchanges property that would produce U.S. source income for property that would produce foreign source income is required to recognize immediately as U.S. source income any gain on such exchange (determined as if the property had been sold for its fair market value on such date). To the extent gain is recognized under this provision, the property would be accorded the step-up in basis provided under current law. This rule requiring immediate gain recognition does not apply if the individual enters into an agreement with the Secretary of the Treasury specifying that any income or gains derived from the property received in the exchange during the 10-year period after the loss of citizenship (or termination of U.S. residency, as applicable) would be treated as U.S. source income. Such a gain recognition agreement terminates if the property transferred in the exchange is disposed of by the acquiror, and any gain that had not been recognized by reason of such agreement is recognized as U.S. source as of such date. It is expected that a gain recognition agreement would be entered into not later than the due date for the tax return for the year of the exchange. In this regard, the Secretary of the Treasury is authorized to issue regulations providing similar treatment for nonrecognition transactions that occur within 5 years immediately prior to the date of loss of citizenship (or termination of U.S. residency, as applicable).

The Secretary of Treasury is authorized to issue regulations to treat removal of tangible personal property from the United States, and other circumstances that result in a conversion of U.S. source income to foreign source income without recognition of any unrealized gain, as exchange for purposes of computing gain subject to section 877. The taxpayer may defer the recognition of the gain if he or she enters into a gain recognition agreement as described above. For example, a former citizen who removes appreciated artwork that he or she owns from the United States could be subject to immediate tax on the appreciation under this provision unless the individual enters into a gain recognition agreement.

The foregoing rules regarding the treatment under section 877 of nonrecognition transactions are illustrated by the following examples: Ms. A loses her U.S. citizenship on January 1, 1996, and is subject to section 877. On June 30, 1997, Ms. A transfers the stock she owns in a U.S. corporation, USCo, to a wholly-owned foreign corporation, FCo, in a transaction that qualifies for tax-free treatment under section 351. At the time of such transfer, A's basis in the stock of USCo is $100,000 and the fair market value of the stock is $150,000. Under present law, Ms. A. would not be subject to U.S. tax on the $50,000 of gain realized on the exchange. Moreover, Ms. A would not be subject to U.S. tax on any distribution of the proceeds from a subsequent disposition of the USCo stock by FCo. Under the House bill, if Ms. A does not enter into a gain recognition agreement with the Secretary of the Treasury, Ms. A would be deemed to have sold the USCo stock for $150,000 on the date of the transfer, and would be subject to U.S. tax in 1997 on the $50,000 of gain realized. Alternatively, if Ms. A enters into a gain recognition agreement, she would not be required to recognize for U.S. tax purposes in 1997 the $50,000 of gain realized upon the transfer of the USCo stock to FCo. However, under the gain recognition agreement, for the 10-year period ending on December 31, 2005, any income (e.g., dividends) or gain with respect to the FCo stock would be treated as U.S. source, and therefore Ms. A would be subject to tax on such income or gain under section 877. If FCo disposes of the USCo stock on January 1, 2002, Ms. A's gain recognition agreement would terminate on such date, and Ms. A would be required to recognize as U.S. source income at that time the $50,000 of gain that she previously deferred under the gain recognition agreement. (The amount of gain required to be recognized by Ms. A in this situation would not be affected by any changes in the value of the USCo stock since her June 30, 1997 transfer of such stock to FCo.)

The House bill also extends the recharacterization rules of section 877 to treat as U.S. source any income and gains derived from stock in a foreign corporation if the individual losing citizenship or terminating residency owns, directly or indirectly, more than 50 percent of the vote or value of the stock of the corporation on the date of such loss or termination or at any time during the 2 years preceding such date. Such income and gains are recharacterized as U.S. source only to the extent of the amount of earnings and profits attributable to such stock earned or accumulated prior to the date of loss of citizenship (or termination of residency, as applicable) and while such ownership requirement is satisfied.

The following example illustrates this rule: Mr. B loses his U.S. citizenship on July 1, 1996 and is subject to section 877. Mr. B has owned all of the stock of a foreign corporation, FCo, since its incorporation in 1991. As of FCo's December 31, 1995 year-end, FCo has accumulated earnings and profits of $500,000. FCo has earnings and profits of $100,000 for 1996 and does not have any subpart F income (as defined in sec. 952). FCo makes a $100,000 distribution to Mr. B in each of 1997 and 1998. On January 1, 1999, Mr. B disposes of all his stock of FCo and realizes $400,000 of gain. Under present law, neither the distributions from FCo nor the gain on the disposition of the FCo stock would be subject to U.S. tax. Under the House bill, the distributions from FCo and the gain on the sale of the stock of FCo would be treated as U.S. source income and would be taxed to Mr. B under section 877, subject to the earnings and profits limitation. For this purpose, the amount of FCo's earnings and profits for 1996 is prorated based on the number of days during 1996 that Mr. B is a U.S. citizen. Thus, the amount of FCo's earnings and profits earned or accumulated before Mr. B's loss of citizenship is $550,000. Accordingly, the $100,000 distributions from FCo in 1997 and 1998 would be treated as U.S. source income taxable to Mr. B under section 877 in such years. In addition, $350,000 of the gain realized from the sale of the stock of FCo in 1999 would be treated as U.S. source income taxable to Mr. B under section 877 in that year.

Special rule for shift in risks of ownership

Section 877 applies to income and gains for the 10-year period following the loss of citizenship (or termination of residency, as applicable). For purposes of applying section 877, the House bill suspends this 10-year period for gains derived from a particular property during any period in which the individual's risk of loss with respect to such property is substantially diminished. For example, Ms. C loses her citizenship on January 1, 1996 and is subject to section 877. On that date Ms. C owns 10,000 shares of stock of a U.S. corporation, USCo, with a value of $1 million. On the same date Ms. C enters into an equity swap with respect to such USCo stock with a 5-year term. under the transaction, Ms. C will transfer to the counterparty an amount equal to the dividends on the USCo stock and any increase in the value of the USCo stock for the 5-year period. The counter-party will transfer to Ms. C an amount equal to a market rate of interest on $1 million and any decrease in the

[24] Under present law, all nonresident aliens (including expatriates) are subject to U.S. income tax at graduated rates on certain types of income. Such income includes income effectively connected with a U.S. trade or business and gains from the disposition of interests in U.S. real property. For example, compensation (including deferred compensation) paid with respect to services performed in the United States is subject to such tax. Thus, under current law, a U.S. citizen who earns a stock option while employed in the United States and delays the exercise of such option until after such individual loses his or her citizenship is subject to U.S. tax on the compensation income recognized upon exercise of the stock option (even if the stock received upon the exercise is stock in a foreign corporation).

value of the USCo stock for the same period. Ms. C's risk of loss with respect to the USCo stock is substantially diminished during the 5-year period in which the equity swap is in effect, and therefore, under the House bill, the 10-year period under section 877 is suspended during such period. Accordingly, under the House bill, if Ms. C sells here USCo stock for a gain on January 1, 2010, such gain would be treated as U.S. source income taxable to Ms. C under section 877. Such gain would not be subject to U.S. tax under present law.

Double tax relief

In order to avoid the double taxation of individuals subject to the expatriation tax provisions, the House bill provides a credit against the U.S. tax imposed under such provisions for any foreign income, gift, estate or similar taxes paid with respect to the items subject to such taxation. This credit is available only against the tax imposed solely as a result of the expatriation tax provisions, and is not available to be used to offset any other U.S. tax liability. For example, Mr. D loses his citizenship on January 1, 1996 and is subject to section 877. Mr. D becomes a resident of Country X. During 1996, Mr. D recognizes a $100,000 gain upon the sale of stock of a U.S. corporation, USCo. Country X imposes $20,000 tax on this capital gain. But for the double tax relief provision, Mr. D would be subject to tax of $28,000 on this gain under section 877. However, Mr. D's U.S. tax under section 877 would be reduced by the $20,000 of foreign tax paid, and Mr. D's resulting U.S. tax on this gain would be $8,000.

Effect on tax treaties

While it is believed that the expatriation tax provisions, as amended by the House bill, are generally consistent with the underlying principles of income tax treaties to the extent the House bill provides a foreign tax credit for items taxed by another country, it is intended that the purpose of the expatriation tax provisions, as amended, not be defeated by any treaty provision. The Treasury Department is expected to review all outstanding treaties to determine whether the expatriation tax provisions, as revised, potentially conflict with treaty provisions and to eliminate any such potential conflicts through renegotiation of the affected treaties as necessary. Beginning on the tenth anniversary of the enactment of the House bill, any conflicting treaty provisions that remain in force would take precedence over the expatriation tax provisions as revised.

Required information reporting and sharing

Under the House bill, a U.S. citizen who loses his or her citizenship is required to provide a statement to the State Department (or other designated government entity) which includes the individual's social security number, forwarding foreign address, new country of residence and citizenship and, in the case of individuals with a net worth of at least $500,000, a balance sheet. The entity to which such statement is to be provided is required to provide the Secretary of the Treasury copies of all statements received and the names of individuals who refuse to provide such statements. A long-term resident whose U.S. residency is terminated is required to attach a similar statement to his or her U.S. income tax return for the year of such termination. An individual's failure to provide the required statement results in the imposition of a penalty for each year the failure continues equal to the greater of (1) 5 percent of the individual's expatriation tax liability for such year, or (2) $1,000.

The House bill requires the State Department to provide the Secretary of the Treasury with a copy of each certificate of loss of nationality (CLN) approved by the State Department. Similarly, the House bill requires the agency administering the immigration laws to provide the Secretary of the Treasury with the name of each individual whose status as a lawful permanent resident has been revoked or has been determined to have been abandoned.

Further, the House bill requires the Secretary of the Treasury to publish in the Federal Register the names of all former U.S. citizens from whom it receives the required statements or whose names it receives under the foregoing information-sharing provisions.

Treasury report on tax compliance by U.S. citizens and residents living abroad

The Treasury Department is directed to undertake a study on the tax compliance of U.S. citizens and green-card holders residing outside the United States and to make recommendations regarding the improvement of such compliance. The findings of such study and such recommendations are required to be reported to the House Committee on Ways and Means and the Senate Committee on Finance within 90 days of the date of enactment.

During the course of the 1995 Joint Committee on Taxation staff study on expatriation (see Joint Committee on Taxation, Issues Presented by Proposals to Modify the Tax Treatment of Expatriation (JCS–17–95), June 1, 1995), a specific issue was identified regarding the difficulty in determining when a U.S. citizen has committed an expatriating act with the requisite intent, and thus no longer has the obligation to continue to pay U.S. taxes on his or her worldwide income due to the fact that the individual is no longer a U.S. citizen. Neither the Immigration and Nationality Act nor any other Federal law requires an individual to request a CLN within a specified amount of time after an expatriating act has been committed, even though the expatriating act terminates the status of the individual as a U.S. citizen for all purposes, including the status of being subject to U.S. tax on worldwide income. Accordingly, it is anticipated that the Treasury report, in evaluating whether improved coordination between executive branch agencies could improve compliance with the requirements of the Internal Revenue Code, will review the process through which the State Department determines when citizenship has been lost, and make recommendations regarding changes to such process to recognize the importance of such date for tax purposes. In particular, it is anticipated that the Treasury Department will explore ways of working with the State Department to insure that the State Department will not issue a CLN confirming the commission of an expatriating act with the requisite intent necessary to terminate citizenship in the absence of adequate evidence of both the occurrence of the expatriating act (e.g., the joining of a foreign army) and the existence of the requisite intent.

Effective date

The expatriation tax provisions as modified by the House bill generally apply to any individual who loses U.S. citizenship, and any long-term residents whose U.S. residency is terminated, on or after February 6, 1995. For citizens, the determination of the date of loss of citizenship remains the same as under present law (i.e., the date of loss of citizenship is the date of the expatriating act). However, a special transition rule applies to individuals who committed an expatriating act within one year prior to February 6, 1995, but had not applied for a CLN as of such date. Such an individual is subject to the expatriation tax provisions as amended by the House bill as of the date of application for the CLN, but is *not* retroactively liable for U.S. income taxes on his or her worldwide income. In order to qualify for the exceptions provided for individuals who fall within one of the specified categories, such individual is required to submit a ruling request within 1 year after the date of enactment of the House bill.

The special transition rule is illustrated by the following example. Mr. E joined a foreign army on October 1, 1994 with the intent to relinquish his U.S. citizenship, but Mr. E does not apply for a CLN until October 1, 1995. Mr. E would be subject to the expatriation tax provisions (as amended) for the 10-year period beginning on October 1, 1995. Moreover, if Mr. E falls within one of the specified categories (i.e., Mr. E is age 18 when he joins the foreign army), in order to qualify for the exception provided for such individuals, Mr. E would be required to submit his ruling request within 1 year after the date of enactment of the House bill. Mr. E would not, however, be liable for U.S. income taxes on his worldwide income for any period after October 1, 1994.

Senate amendment

In general

The Senate amendment replaces the present-law expatriation income tax rules with rules that generally subject certain U.S. citizens who relinquish their U.S. citizenship and certain long-term U.S. residents who relinquish their U.S. residency to tax on the net unrealized gain in their property as if such property were sold for fair market value on the expatriation date. The Senate amendment also imposes information reporting obligations on U.S. citizens who relinquish their citizenship and long-term residents whose U.S. residency is terminated.

Individuals covered

The Senate amendment applies the expatriation tax to certain U.S. citizens and long-term residents who terminate their U.S. citizenship or residency. For this purpose, a long-term resident is any individual who was a lawful permanent resident of the United States for at least 8 out of the 15 taxable years ending with the year in which the termination of residency occurs. In applying this 8-year test, an individual is not considered to be a lawful permanent resident of the United States for any year in which the individual is taxed as a resident of another country under a treaty tie-breaker rule. An individual's U.S. residency is considered to be terminated when either the individual ceases to be a lawful permanent resident pursuant to section 7701(b)(6) (i.e., the individual loses his or her green-card status) or the individual is treated as a resident of another country under a tie-breaker provision of a tax treaty (and the individual does not elect to waive the benefits of such treaty).

The expatriation tax under the Senate amendment applies only to individuals whose average income tax liability or net worth exceeds specified levels. U.S. citizens who lose their citizenship and long-term residents who terminate U.S. residency are subject to the expatriation tax if they meet either of the following tests: (1) the individual's average annual U.S. Federal income tax liability for the 5 taxable years ending before the date of such loss or termination is greater than $100,000, or (2) the individual's net worth as of the date of such loss or termination is $500,000 or more. The dollar amount thresholds contained in these tests are indexed for inflation in the case of a loss of citizenship or termination of residency occurring in any calendar year after 1996.

Exceptions from the expatriation tax under the Senate amendment are provided for individuals in two situations. The first exception applies to an individual who was

born with citizenship both in the United States and in another country, provided that (1) as of the date of relinquishment of U.S. citizenship the individual continues to be a citizen of, and is taxed as a resident of, such other country, and (2) the individual was a resident of the United States for no more than 8 out of the 15 taxable years ending with the year in which the relinquishment of U.S. citizenship occurred. The second exception applies to a U.S. citizen who relinquishes citizenship before reaching age 18½, provided that the individual was a resident of the United States for no more than 5 taxable years before such relinquishment.

Deemed sale of property upon expatriation

Under the Senate amendment, individuals who are subject to the expatriation tax generally are treated as having sold all of their property at fair market value immediately prior to the relinquishment of citizenship or termination of residency. Gain or loss from the deemed sale of property is recognized at that time, generally without regard to provisions of the Code that would otherwise provide nonrecognition treatment. The net gain, if any, on the deemed said of all such property is subject to U.S. tax at such time to the extent it exceeds $600,000 ($1.2 million in the case of married individuals filing a joint return, both of whom expatriate).

The deemed sale rule of the Senate amendment generally applies to all property interests held by the individual on the date of relinquishment of citizenship or termination of residency, provided that the gain on such property interest would be includible in the individual's gross income if such property interest were sold for its fair market value on such date. Special rules apply in the case of trust interests (see ''Interests in trusts,'' below). U.S. real property interests, which remain subject to U.S. taxing jurisdiction in the hands of nonresident aliens, generally are excepted from the Senate amendment. An exception also applies to interests in qualified retirement plans and, subject to a limit of $500,000, interests in certain foreign pension plans as prescribed by regulations. The Secretary of the Treasury is authorized to issue regulations exempting other property interests as appropriate. For example, an exclusion may be provided for an interest in a nonqualified compensation plan of a U.S. employer, where payments from such plan to the individual following expatriation would continue to be subject to U.S. withholding tax.

Under the Senate amendment, an individual who is subject to the expatriation tax is required to pay a tentative tax equal to the amount of tax that would be due for a hypothetical short tax year ending on the date the individual relinquished citizenship or terminated residency. Thus, the tentative tax is based on all income, gain, deductions, loss and credits of the individual for the year through such date, including amounts realized from the deemed sale of property. The tentative tax is due on the 90th day after the date of relinquishment of citizenship or termination of residency.

Deferral of payment of tax

Under the Senate amendment, an individual is permitted to elect to defer payment of the expatriation tax with respect to the deemed sale of any property. Under this election, the expatriation tax with respect to a particular property, plus interest thereon, is due when the property is subsequently disposed of. For this purpose, except as provided in regulations, the disposition of property in a nonrecognition transaction constitutes a disposition. In addition, if an individual holds property until his or her death, the individual is treated as having disposed of the property immediately before death. In order to elect deferral of the expatriation tax, the individual is required to provide adequate security to ensure that the deferred expatriation tax and interest ultimately will be paid. A bond in the amount of the deferred tax and interest constitutes adequate security. Other security mechanisms are also permitted provided that the individual establishes to the satisfaction of the Security of the Treasury that the security is adequate. In the event that the security provided with respect to a particular property subsequently becomes inadequate and the individual fails to correct such situation, the deferred expatriation tax and interest with respect to such property will become due. As a further condition to making this election, the individual is required to consent to the waiver of any treaty rights that would preclude the collection of the expatriation tax.

Interests in trusts

In general.—Under the Senate amendment, special rules apply to trust interests held by the individual at the time of relinquishment of citizenship or termination of residency. The treatment of trust interests depends upon whether the trust is a qualified trust. For this purpose, a ''qualified trust'' is a trust that is organized under and governed by U.S. law and that is required by its instruments to have at least one U.S. trustee.

Constructive ownership rules apply to a trust beneficiary that is a corporation, partnership, trust or estate. In such cases, the shareholders, partners or beneficiaries of the entity are deemed to be the direct beneficiaries of the trust for purposes of applying these provisions. In addition, an individual who holds (or who is treated as holding) a trust interest at the time of relinquishment of citizenship or termination of residency is required to disclose on his or her tax return the methodology used to determine his or her interest in the trust, and whether such individual knows (or has reason to know) that any other beneficiary of the trust uses a different method.

Nonqualified trusts.—If an individual holds an interest in a trust that is not a qualified trust, a special rule applies for purposes of determining the amount of the expatriation tax due with respect to such trust interest. The individuals interest in the trust is treated as a separate trust consisting of the trust assets allocable to such interest. Such separate trust is treated as having sold its assets as of the date of relinquishment of citizenship or termination of residency and having distributed all proceeds to the individual, and the individual is treated as having recontributed such proceeds to the trust. The individual is subject to the expatriation tax with respect to any net income or gain arising from the deemed distribution from the trust. The election to defer payment is available for the expatriation tax attributable to a nonqualifed trust interest.

A beneficiary's interest in a nonqualified trust is determined on the basis of all facts and circumstances. These include the terms of the trust instrument itself, any letter of wishes or similar document, historical patterns of trust distributions, and the role of any trust protector or similar advisor.

Qualified trusts.—If the individual has an interest in a qualified trust, a different set of rules applies. Under these rules, the amount of unrealized gain allocable to the individual's trust interest is calculated at the time of expatriation. In determining this amount, all contingencies and discretionary interests are assumed to be resolved in the individual's favor (i.e., the individual is allocated the maximum amount that he or she potentially could receive under the terms of the trust instrument). the expatriation tax imposed on such gains generally is collected when the individual receives distributions from the trust, or, if earlier, upon the individual's death. Interest is charged for the period between the date of expatriation and the date on which the tax is paid.

If an individual has an interest in a qualified trust, the individual is subject to expatriation tax upon the receipt of any distribution from the trust. Such distributions may also be subject to U.S. income tax. For any distribution from a qualified trust made to an individual after he or she has expatriated, expatriation tax is imposed in an amount equal to the amount of the distribution multiplied by the highest tax rate generally applicable to trusts and estates, but in no event will the tax imposed exceed the deferred tax amount with respect to such trust interest. The ''deferred tax amount'' would be equal to (1) the tax calculated with respect to the unrealized gain allocable to the trust interest at the time of expatriation, (2) increased by interest thereon, and (3) reduced by the tax imposed under this provision with respect to prior trust distributions to the individual.

If an individual's interest in a trust is vested as of the expatriation date (e.g., if the individual's interest in the trust is non-contingent and non-discretionary), the gain allocable to the individual's trust interest is determined based on the truth assets allocable to his or her trust interest. If the individual's interest in the trust is not vested as of the expatriation date (e.g., if the individual's trust interest is a contingent or discretionary interest), the gain allocable to his or her trust interest is determined based on all of the trust assets that could be allocable to his or her trust interest, determined by resolving all contingencies and discretionary powers in the individual's favor. In the case where more than one trust beneficiary is subject to the expatriation tax with respect to trust interests that are not vested, the rules are intended to apply so that the same unrealized gain with respect to assets in the trust is not taxed to both individuals.

If the individual disposes of his or her trust interest, the trust ceases to be a qualified trust, or the individual dies, expatriation tax is imposed as of such date. The amount of such tax equal to the lesser of (1) the tax calculated under the rules for nonqualified trust interests applied as of such date or (2) the deferred tax amount with respect to the trust interest as of such date.

If the individual agrees to waive any treaty rights that would preclude collection of the tax, the tax is imposed under this provision with respect to distributions from a qualified trust to the individual deducted and withheld from distributions. If the individual does not agree to such a waiver of treaty rights, the tax with respect to distributions to the individual is imposed on the trust, the trustee is personally liable therefore, and any other beneficiary of the trust has a right of contribution against such individual with respect to such tax. Similarly, in the case of the tax imposed in connection with an individual's disposition of a trust interest, the individual's death while holding a trust interest or the individual's holding of an interest in a trust that ceases to be qualified, the tax is imposed on the trust, the trustee is personnaly liable therefor, and any other beneficiary of the trust has a right of contribution against such individual with respect to such tax.

Election to be treated as a U.S. citizen

Under the Senate amendment, an individual is permitted to make an irrevocable election to continue to be taxed as a U.S. citizen with respect to all property that otherwise is

covered by the expatriation tax. This election is an ''all-or-nothing'' election; an individual is *not* permitted to elect this treatment for some property but not other property. The election, if made, applies to all property that would be subject to the expatriation tax and to any property the basis of which is determined by reference to such property. Under this election, the individual continues to pay U.S. income taxes at the rates applicable to U.S. citizens following expatriation on any income generated by the property and on any gain realized on the disposition of the property, as well as any excise tax imposed with respect to property (see, e.g., sec 1491). In addition, the property continues to be subject to U.S. gift, estate, and generation-shipping taxes. However, the amount of any transfer tax so imposed is limited to the amount of income tax that would have been due if the property had been sold for its fair market value immediately before the transfer or death. The $600,000 exclusion provided with respect to the expatriation tax under the Senate amendment is available to reduce the tax imposed by reason of this election. In order to make this election, the taxpayer is required to waive any treaty rights that would preclude the collection of the tax. The individual is also required to provide security to ensure payment of the tax under this election in such form, manner, and amount as the Secretary of the Treasury requires.

Date of relinquishment of citizenship

Under the Senate amendment, as individual is treated as having relinquished U.S. citizenship on the date that the individual first makes known to U.S. government of consular officer his or her intention to relinquish U.S. citizenship. Thus, a U.S. citizen who relinquishes citizenship by formally renouncing his or her U.S. nationality before a diplomatic or consular officer for the United States is treated as having relinquished ciizenship on that date, provided that the renunciation is later confirmed by the issuance of a CLN. A U.S. citizen who furnishes to the State Department a signed statement of voluntary relinquishment of U.S. nationality confirming the performance of an expatriating act with the requisite interest to relinquish his or her citizenship is treated as having relinquished his or her citizenship on the date the statement is so furnished (regardless of when the expatriating act was performed), provided that the voluntary relinquishment is later confirmed by the issuance of a CLN. If neither of these circumstances exist, the individual is treated as having relinquished citizenship on the date a CLN is issued or a certificate of naturalization is cancelled. The date of relinquishment of citizenship determined under the Senate amendment applies for all purposes.

Effect on present-law expatriation provisions

Under the Senate amendment, the present-law income tax provisions with respect to U.S. citizens who expatriate with a principal purpose of avoiding tax (sec. 877) and certain aliens who have a break in residency status (sec. 7701(b)(10)) do applying to U.S. citizens who are treated as relinquishing their citizenship on or after February 6, 1995 or to long-term U.S. residents who terminate their residency on or after such date. The special estate and gift tax provisions with respect to individuals who expatriate with a principal purpose of avoiding tax (secs. 2107 and 2501(a)(3)), however, continue to apply; a credit against the tax imposed solely by reason of such special provisions is allowed for the expatriation tax imposed with respect to the same property.

Treatment of gifts and inheritances from an expatriate

Under the Senate amendment, the exclusion from income provided in section 102 does not apply to the value of any property received by gift or inheritance from an individual who was subject to the expatriation tax (i.e., an individual who relinquished citizenship or terminated residency and to whom the expatriation tax was applicable). Accordingly, a U.S. taxpayer who receives a gift or inheritance from such an individual is required to include the value of such gift or inheritance in gross income and is subject to U.S. income tax on such amount.

Required information reporting and sharing

Under the Senate amendment, an individual who relinquishes citizenship or terminates residency is required to provide a statement which includes the individual's social security number, forwarding foreign address, new country of residence and citizenship and, in the case of individuals with a net worth of at least $500,000, a balance sheet. In the case of a former citizen, such statement is due not later than the date the individual's citizenship is treated as relinquished and is to be provided to the State Department (or other government entity involved in the administration of such relinquishment). The entity to which the statement is to be provided by former citizens is required to provide to the Secretary of the Treasury copies of all statements received and the names of individuals who refuse to provide such statements. In the case of a former long-term resident, the statement is provided to the Secretary of the Treasury with the individual's tax return for the year in which the individual's U.S. residency is terminated. An individual's failure to provide the statement required under this provision results in the imposition of a penalty for each year the failure continues equal to the greater of (1) 5 percent of the individual's expatriation tax liability for such year or (2) $1,000.

The Senate amendment requires the State Department to provide the Secretary of the Treasury with a copy of each CLN approved by the State Department. Similarly, the Senate amendment requires the agency administering the immigration laws to provide the Secretary of the Treasury with the name of each individual whose status as a lawful permanent resident has been revoked or has been determined to have been abandoned.

Further, the Senate amendment requires the Secretary of the Treasury to publish in the Federal Register the names of all former U.S. citizens with respect to whom it receives the required statements or whose names it receives under the foregoing information-sharing provisions.

Treasury report on tax compliance by U.S. citizens and residents living abroad

The Treasury Department is directed to undertake a study on the tax compliance of U.S. citizens and green-card holders residing outside the United States and to make recommendations regarding the improvement of such compliance. The findings of such study and such recommendations are required to be reported to the House Committee on Ways and Means and the Senate Committee on Finance within 90 days of the date of enactment.

Effective date

The provision is effective for U.S. citizens whose date of relinquishment of citizenship (as determined under the Senate amendment, see ''Date of relinquishment of citizenship'' above) occurs on or after February 6, 1995. Similarly, the provision is effective for long-term residents who terminate their U.S. residency on or after February 6, 1995.

U.S. citizens who committed an expatriating act with the requisite intent to relinquish their U.S. citizenship prior to February 6, 1995, but whose date of relinquishment of citizenship (as determined under the Senate amendment) does not occur until after such date, are subject to the expatriation tax under the Senate amendment as of date of relinquishment of citizenship. However, the individual is not subject retroactively to worldwide tax as a U.S. citizen for the period after he or she committed the expatriating act (and therefore ceased being U.S. citizen for tax purposes under present law). Such an individual continues to be subject to the expatriation tax imposed by present-law section 877 until the individual's date of relinquishment of citizenship (at which time the individual would be subject to the expatriation tax of the Senate amendment). The rules described in this paragraph do not apply to an individual who committed an expatriating act prior to February 6, 1995, but did not do so with the requisite intent to relinquish his or her U.S. citizenship.

The tentative tax is not required to be paid, and the reporting requirements would not be required to be met, until 90 days after the date of enactment. Such provisions apply to all individuals whose date of relinquishment of U.S. citizenship or termination of U.S. residency occurs on or after February 6, 1995.

Conference agreement

The conference agreement follows the House bill with modifications. Under the conference agreement, modified rules apply if an individual who is covered by section 877 contributes property that would produce U.S. source income to a foreign corporation if (1) the individual, directly or indirectly, owns 10 percent or more (by vote) of the stock of such corporation and (2) the individual, directly, indirectly or constructively, owns more than 50 percent (by vote or by value) of the stock of such corporation. For purposes of determining indirect and constructive ownership, the rules of section 958 apply. Under the modified rules, for the ten-year period following expatriation the individual is treated as receiving or accruing directly the income or gains received or accrued by the foreign corporation with respect to the contributed property (or other property which has a basis determined by reference to the basis of such contributed property). Moreover, if the individual disposes of the stock of the foreign corporation, the individual is subject to U.S. tax on the gain that would have been recognized if the corporation had sold such property immediately before the disposition. If the individual disposes of less than all of his or her stock in the foreign corporation, such disposition is treated as a disposition of a pro rata share (determined based on value) of such contributed property (e.g., if the individual owns 100 shares of the foreign corporation's stock and disposes of 10 of such shares, such disposition is treated as a disposition of 10 percent of the property contributed to the foreign corporation). Regulatory authority is provided to prescribe regulations to prevent the avoidance of this rule. Information reporting will be required as necessary to carry out the purposes of this rule. In addition, under the conference agreement, in the case of any former U.S. citizen, a request for a ruling that such individual's loss of citizenship would be due not earlier than 90 days after date of enactment.

C. TREATMENT OF BAD DEBT DEDUCTIONS OF THRIFT INSTITUTIONS

(Sec. 401 of the House bill and and sec. 611 of the Senate amendment.)

Present law

Generally, a taxpayer engaged in a trade or business may deduct the amount of any debt that becomes wholly or partially worthless during the year (the ''specific charge-off''

method of sec. 166). Certain thrift institutions (building and loan associations, mutual savings banks, or cooperative banks) are allow deductions for bad debts under methods more favorable than those granted to other taxpayers (and more favorable than the rules applicable to other financial institutions). Qualified thrift institutions may compute deductions for bad debts using either the specific charge-off method or the reserve method of section 593.

Under section 593, a thrift institution annually may elect to deduct bad debts under either (1) the ''percentage of taxable income'' method applicable only to thrift institutions, or (2) the ''experience'' method that also is available to small banks. Under the ''percentage of taxable income'' method, a thrift institution generally is allowed a deduction for an addition to its bad debt reserve equal to 8 percent of its taxable income (determined without regard to this deduction and with additional adjustments). Under the experience method, a thrift institution generally is allowed a deduction for an addition to its bad debt reserve equal to the greater of (1) an amount based on its actual average experience for losses in the current and five preceding taxable years, or (2) an amount necessary to restore the reserve to its balance as of the close of the base year.

If a thrift institution becomes ineligible to use the section 593 method, it is required to change its method of accounting for bad debts and, under proposed Treasury regulations, is required to recapture all or a portion of its bad debt reserve. In addition, a thrift institution eligible to use the section 593 method may be subject to a form of reserve recapture if the institution makes certain excessive distributions to its shareholders (sec. 593(e)).

House bill

Repeal of section 593

The House bill repeals the section 593 reserve method of accounting for bad debts by thrift institutions, effective for taxable years beginning after 1995. Thrift institutions that would be treated as small banks are allowed to utilize the experience method applicable to such institutions, while thrift institutions that are treated as large banks are required to use only the specific charge-off method. Thus, the percentage of taxable income method of accounting for bad debts is no longer available for any financial institution.

Treatment of recapture of bad debt reserves

A thrift institution required to change its method of computing reserves for bad debts will treat such change as a change in a method of accounting, initiated by the taxpayer, and having been made with the consent of the Secretary of the Treasury. Any section 481(a) adjustment required to be recaptured with respect to such change generally will be determined solely with respect to the ''applicable excess reserves'' of the taxpayer. The amount of applicable excess reserves will be taken into account ratably over a six-taxable year period, beginning with the first taxable year beginning after 1995, subject to the residential loan requirement described below. In the case of a thrift institution that becomes a large bank, the amount of the institution's applicable excess reserves generally is the excess of (1) the balances of its reserve for losses on qualifying real property loans and its reserve for losses on nonqualifying loans as of the close of its last taxable year beginning before January 1, 1996, over (2) the balances of such reserves as of the close of its last taxable year beginning before January 1, 1988 (i.e., the ''pre-1988 reserves.'') Similar rules are provided for small banks that are allowed to use the experience method.

For taxable years that begin after December 31, 1995, and before January 1, 1998, if the taxpayer continues to make a certain level of residential loans, the recapture of the applicable excess reserves otherwise required to be taken into account for such years will be suspended.

The balance of the pre-1988 reserves is subject to the provisions of section 593(e), as modified by the House bill (requiring recapture in the case of certain excessive distributions to shareholders.)

Other special recapture rules are provided if a thrift institution no longer qualifies as a bank or if a thrift institution becomes a credit union.

Effective date

The provision generally is effective for taxable years beginning after December 31, 1995.

Senate amendment

The Senate amendment generally is the same as the House bill, with certain modifications.

Conference agreement

The conference agreement does not include either the provision in the House bill or the provision in the Senate amendment.

D. EARNED INCOME CREDIT PROVISIONS

(Sec. 411 of the House bill.)

Present law

In general

Certain eligible low-income workers are entitled to claim a refundable credit on their income tax return. The amount of the credit an eligible individual may claim depends upon whether the individual has one, more than one or no qualifying children and is determined by multiplying the credit rate by the individual's[25] earned income up to an earned income amount. The maximum amount of the credit is the product of the credit rate and the earned income amount. For individuals with earned income (or adjusted gross income (AGI), if greater) in excess of the beginning of the phaseout range, the maximum credit amount is reduced by the phaseout rate multiplied by the amount of earned income (or AGI, if greater) in excess of the beginning of the phaseout range. For individuals with earned income (or AGI, if greater) in excess of the end of the phaseout range, no credit is allowed.

The parameters for the credit depend upon the number of qualifying children the individual claims. For 1996, the parameters are given in the following table:

	Two or more qualifying children—	One qualifying child—	No qualifying children—
Credit rate (percent)	40.00	34.00	7.65
Earned income amount	$8,890	$6,330	$4,220
Maximum credit	$3,356	$2,152	$323
Phaseout begins	$11,610	$11,610	$5,280
Phaseout rate (percent)	21.06	15.98	7.65
Phaseout ends	$28,495	$25,078	$9,500

For years after 1996, the credit rates and the phaseout rates will be the same as in the preceding table. The earned income amount and the beginning of the phaseout range are indexed for inflation; because the end of the phaseout range depends on those amounts as well as the phaseout rate and the credit rate, the end of the phaseout range will also increase if there is inflation.

In order to claim the credit, an individual must either have a qualifying child or meet other requirements. A qualifying child must meet a relationship test, an age test, an identification test, and a residence test. In order to claim the credit without a qualifying child, an individual must not be a dependent and must be over age 24 and under age 65.

To satisfy the identification test, individuals must include on their tax return the name and age of each qualifying child. For returns filed with respect to tax year 1996, individuals must provide a taxpayer identification number (TIN) for all qualifying children born on or before November 30, 1996. For returns filed with respect to tax year 1997 and all subsequent years, individuals must provide TINs for all qualifying children, regardless of their age. An individual's TIN is generally that individual's social security number.

Mathematical or clerical errors

The IRS may summarily assess additional tax due as a result of a mathematical or clerical error without sending the taxpayer a notice of deficiency and giving the taxpayer an opportunity to petition the Tax Court. Where the IRS uses the summary assessment procedure for mathematical or clerical errors, the taxpayer must be given an explanation of the asserted error and a period of 60 days to request that the IRS abate its assessment. The IRS may not proceed to collect the amount of the assessment until the taxpayer has agreed to it or has allowed the 60-day period for objecting to expire. If the taxpayer files a request for abatement of the assessment specified in the notice, the IRS must abate the assessment. Any reassessment of the abated amount is subject to the ordinary deficiency procedures. The request for abatement of the assessment is the only procedure a taxpayer may use prior to paying the assessed amount in order to contest an assessment arising out of a mathematical or clerical error. Once the assessment is satisfied, however, the taxpayer may file a claim for refund if he or she believes the assessment was made in error.

House bill

Under the House bill, individuals are not eligible for the credit if they do not include their taxpayer identification number (and, if married, their spouse's taxpayer identification number) on their tax return. Solely for these purposes and for purposes of the present-law identification test for a qualifying child, a taxpayer identification number is defined as a social security number issued to an individual by the Social Security Administration other than a number issued under section 205(c)(2)(B)(i)(II) (or that portion of sec. 205(c)(2)(B)(i)(III) relating to it) of the Social Security Act (regarding the issuance of a number to an individual applying for or receiving Federally funded benefits).

If an individual fails to provide a correct taxpayer identification number, such omission will be treated as a mathematical or clerical error. If an individual who claims the credit with respect to net earnings from self-employment fails to pay the proper amount of self-employment tax on such net earnings, the failure will be treated as a mathematical or clerical error for purposes of the amount of credit allowed.

Effective date.—The provision is effective for taxable years beginning after December 31, 1995.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill provision.

E. MODIFY TREATMENT OF FOREIGN TRUSTS

(Secs. 601–606 of the Senate amendment).

Present law

Inbound grantor trusts with foreign grantors

Under the grantor trust rules (secs. 671–679), a grantor that retains certain rights or

[25] In the case of a married individual who files a joint return with his or her spouse, the income for purposes of these tests is the combined income of the couple.

powers generally is treated as the owner of the trust's assets without regard to whether the grantor is a domestic or foreign person. Under these rules, U.S. trust beneficiaries are not subject to U.S. tax on distributions from a trust where a foreign grantor is treated as owner of the trust, even though no tax may be imposed on the trust income by any jurisdiction. In addition, a special rule provides that if a U.S. beneficiary of an inbound grantor trust transfers property to the foreign grantor by gift, that U.S. beneficiary is treated as the grantor of the trust to the extent of the transfer.

Foreign trusts that are not grantor trusts

Under the accumulation distribution rules (which generally apply to distributions from a trust in excess of the trust's distributable net income for the taxable year), a distribution by a foreign nongrantor trust of previously accumulated income generally is taxed at the U.S. beneficiary's average marginal rate for the prior 5 years, plus interest (secs. 666 and 667). Interest is computed at a fixed annual rate of 6 percent, with no compounding (sec. 668). If adequate records of the trust are not available to determine the proper application of the rules relating to accumulation distributions to any distribution from a trust, the distribution is treated as an accumulation distribution out of income earned during the first year of the trust (sec. 666(d)).

If a foreign nongrantor trust makes a loan to one of its beneficiaries, the principal of such a loan generally is not taxable as income to the beneficiary.

Outbound foreign grantor trusts with U.S. grantors

Under the grantor trust rules, a U.S. person that transfers property to a foreign trust generally is treated as the owner of the portion of the trust comprising that property for any taxable year in which there is a U.S. beneficiary of any portion of the trust (sec. 679(a)). This treatment generally does not apply, however, to transfers by reason of death, to transfers made before the transferor became a U.S. person, or to transfers that represent sales or exchanges of property at fair market value where gain is recognized to the transferor.

Residence of trusts and estates

An estate or trust is treated as foreign if it is not subject to U.S. income taxation on its income that is neither derived from U.S. sources nor effectively connected with the conduct of a U.S. trade or business. Thus, if a trust is taxed in a manner similar to a nonresident alien individual, it is considered to be a foreign trust. Any other trust is treated as domestic.

Section 1491 generally imposes a 35-percent excise tax on a U.S. person that transfers appreciated property to certain foreign entities, including a foreign trust. In the case of a domestic trust that changes its situs and becomes a foreign trust, it is unclear whether property has been transferred from a U.S. person to a foreign entity and, thus, whether the transfer is subject to the excise tax.

Information reporting and penalties related to foreign trusts

Any U.S. person that creates a foreign trust or transfers money or property to a foreign trust is required to report that event to the Treasury Department without regard to whether the trust is a grantor trust or a nongrantor trust. Similarly, any U.S. person that transfers property to a foreign trust that has one or more U.S. beneficiaries is required to report annually to the Treasury Department. In addition, any U.S. person that makes a transfer described in section 1491 is required to report the transfer to the Treasury Department.

Any person that fails to file a required report with respect to the creation of, or a transfer to, a foreign trust may be subject to a penalty of 5 percent of the amount transferred to the foreign trust. Similarly, any person that fails to file a required annual report with respect to a foreign trust with U.S. beneficiaries may be subject to a penalty of 5 percent of the value of the corpus of the trust at the close of the taxable year. The maximum amount of the penalty imposed under either case may not exceed $1,000. A reasonable cause exception is available.

Reporting of foreign gifts

There is no requirement to report gifts or bequests from foreign sources.

House bill

No provision.

Senate amendment

Inbound grantor trusts with foreign grantors

The Senate amendment generally applies the grantor trust rules only to the extent that they result, directly or indirectly, in income or other amounts being currently taken into account in computing the income of a U.S. citizen or resident or a domestic corporation. Certain exceptions apply to this general rule. Under one exception, the grantor trust rules continue to apply to a revocable trust. Under another exception, the grantor trust rules continue to apply to a trust where the only amounts distributable during the lifetime of the grantor are to the grantor or the grantor's spouse. The general rule denying grantor trust status does not apply to trusts established to pay compensation, and certain trusts in existence as of September 19, 1995 provided that such trust is treated as owned by the grantor under section 676 or 677 (other than sec. 677(a)(3)).[26] In addition, the grantor trust rules generally apply where the grantor is a controlled foreign corporation (as defined in sec. 957). Finally, the grantor trust rules continue to apply in determining whether a foreign corporation is characterized as a passive foreign investment company (''PFIC''). Thus, a foreign corporation cannot avoid PFIC status by transferring its assets to a grantor trust.

If a U.S. beneficiary of an inbound grantor trust transfers property to the foreign grantor, such beneficiary generally is treated as a grantor of a portion of the trust to the extent of the transfer. This rule applies without regard to whether the foreign grantor is otherwise treated as the owner of any portion of such trust. However, this rule does not apply if the transfer is a gift that qualifies for the annual exclusion described in section 2503(b).

The Senate amendment provides a special rule that allows the Secretary of the Treasury to recharacterize a transfer, directly or indirectly, from a partnership or foreign corporation which the transferee treats as a gift or bequest, to prevent the avoidance of the purpose of section 672(f). In a case where a foreign person (that would be treated as the owner of a trust but for the above rule) actually pays tax on the income of the trust to a foreign country, it is anticipated that Treasury regulations will provide that, for foreign tax credit purposes, U.S. beneficiaries that are subject to U.S. income tax on the same income will be treated as having paid the foreign taxes that are paid by the foreign grantor. Any resulting foreign tax credits will be subject to applicable foreign tax credit limitations.

Effective date.—The provisions described in this part are effective on the date of enactment.

[26] The exception does not apply to the portion of any such trust attributable to any transfers made after September 19, 1995.

Foreign trusts that are not grantor trusts

The Senate amendment changes the interest rate applicable to accumulation distributions from foreign trusts from simple interest at a fixed rate of 6 percent to compound interest determined in the same manner as interest imposed on underpayments of tax under section 6621(a)(2). Simple interest is accrued at the rate of 6 percent through 1995. Beginning on January 1, 1996 compound interest based on the underpayment rate is imposed on tax amounts determined under the accumulation distribution rules and the total simple interest for pre-1996 periods, if any. For purposes of computing the interest charge, the accumulation distribution is allocated proportionately to prior trust years in which the trust has undistributed net income (and the beneficiary receiving the distribution was a U.S. citizen or resident), rather than to the earliest of such years. An accumulation distribution is treated as reducing proportionately the undistributed net income from prior years.

In the case of a loan of cash or marketable securities by the foreign trust to a U.S. grantor or a U.S. beneficiary (or a U.S. person related to such grantor or beneficiary), except to the extent provided by Treasury regulations, the Senate amendment treats the full amount of the loan as distributed to the grantor or beneficiary. It is expected that the Treasury regulations will provide an exception from this treatment for loans with arm's-length terms. In applying this exception, it is further expected that consideration be given to whether there is a reasonable expectation that a loan will be repaid. In addition, any subsequent transaction between the trust and the original borrower regarding the principal of the loan (e.g., repayment) is disregarded for all purposes of the Code. This provision does not apply to loans made to persons that are exempt from U.S. income tax.

Effective date.—The provision to modify the interest charge on accumulation distributions applies to distributions after the date of enactment. The provision with respect to loans to U.S. grantors, U.S. beneficiaries or a U.S. person related to such a grantor or beneficiary applies to loans made after September 19, 1995.

Outbound foreign grantor trusts with U.S. grantors

The Senate amendment makes several modifications to the general rule of section 679(a)(1) under which a U.S. person who transfers property to a foreign trust generally is treated as the owner of the portion of the trust comprising that property for any taxable year in which there is a U.S. beneficiary of the trust. The Senate amendment also conforms the definition of certain foreign corporations the income of which is deemed to be accumulated for the benefit of a U.S. beneficiary to the definition of controlled foreign corporations (as defined in sec. 957(a)).

Sale or exchange at market value.—Present law contains several exceptions to grantor trust treatment under section 679(a)(1) described above. Under one of the exceptions, grantor trust treatment does not result from a transfer of property by a U.S. person to a foreign trust in the form of a sale or exchange at fair market value where gain is recognized to the transferor. In determining whether the trust paid fair market value to the transferor, the Senator amendment provides that obligations issued (or, to the extent provided by regulations, guaranteed) by the trust, by any grantor or beneficiary of the trust, or by any person related to any grantor or beneficiary (referred to as ''trust obligations'') are not taken into account except as provided in Treasury regulations. It

is expected that the Treasury regulations will provide an exception from this treatment for loans with arm's-length terms. In applying this exception, it is further expected that consideration be given to whether there is a reasonable expectation that a loan will be repaid. Principal payments by the trust on any such trust obligations generally will reduce the portion of the trust attributable to the property transferred (i.e., the portion of which the transferor is treated as the grantor).

Other transfers.—The Senate amendment adds a new exception to the general rule of section 679(a)(1) described above. Under the Senate amendment, a transfer of property to certain charitable trusts is exempt from the application of the rules treating foreign trusts with U.S. grantors and U.S. beneficiaries as grantor trusts.

Transferors or beneficiaries who become U.S. persons.—The Senate amendment applies the rule of section 679(a)(1) to certain foreign persons who transfer property to a foreign trust and subsequently become U.S. persons. A nonresident alien individual who transfers property, directly or indirectly, to a foreign trust and then becomes a resident of the United States within 5 years after the transfer generally is treated as making a transfer to the foreign trust on the individual's U.S. residency starting date (as defined in sec. 7701(b)(2)(A)). The amount of the deemed transfer is the portion of the trust (including undistributed earnings) attributable to the property previously transferred. Consequently, the individual generally is treated under section 679(a)(1) as the owner of that portion of the trust in any taxable year in which the trust has U.S. beneficiaries.

Outbound trust migrations.—The Senate amendment applies the rules of section 679(a)(1) to a U.S. person that transferred property to a domestic trust if the trust subsequently becomes a foreign trust while the transferor is still alive. Such a person is deemed to make a transfer to the foreign trust on the date of the migration. The amount of the deemed transfer is the portion of the trust (including undistributed earnings) attributable to the property previously transferred. Consequently, the individual generally is treated under the rules of section 679(a)(1) as the owner of that portion of the trust in any taxable year in which the trust has U.S. beneficiaries.

Effective date.—The provisions to amend section 679 apply to transfers of property after February 6, 1995.

Anti-abuse regulatory authority

The Senate amendment includes an anti-abuse rule which authorizes the Secretary of the Treasury to issue regulations, on or after the date of enactment, that may be necessary or appropriate to carry out the purposes of the rules applicable to estates, trusts and beneficiaries, including regulations to prevent the avoidance of those purposes.

Effective date.—The provision is effective on the date of enactment.

Residence of trusts and estates

The Senate amendment establishes a two-part objective test for determining for tax purposes whether a trust is foreign or domestic. If both parts of the test are satisfied, the trust is treated as domestic. Only the first part of the test applies to estates. Under the first part of the test, if a U.S. court (i.e., Federal, State, or local) exercises primary supervision over the administration of a trust or estate, the trust or estate is treated as domestic. Under the second part of the test, in order for a trust to be treated as domestic, one or more U.S. fiduciaries must have the authority to control all substantial decisions of the trust.

Under the Senate amendment, if a domestic trust changes its situs and becomes a foreign trust, the trust is treated as having made a transfer of its assets to a foreign trust and is subject to the 35-percent excise tax imposed by present-law section 1491 unless one of the exceptions to this excise tax is applicable.

Effective date.—The provision to modify the treatment of a trust or estate as a U.S. person applies to taxable years beginning after December 31, 1996. In addition, if the trustee of a trust so elects, the provision would apply to taxable years ending after the date of enactment. The amendment to section 1491 is effective on the date of enactment.

Information reporting and penalties relating to foreign trusts

The Senate amendment generally requires the grantor, transferor or executor (i.e., the ''responsible party'') to notify the Treasury Department upon the occurrence of certain reportable events. The term ''reportable event'' means the creation of any foreign trust by a U.S. person, the direct and indirect transfer of any money or property to a foreign trust, including a transfer by reason of death, and the death of a U.S. citizen or resident if any portion of a foreign trust was included in the gross estate of the decedent. In addition, a U.S. owner of any portion of a foreign trust is required to ensure that the trust files an annual return to provide full accounting of all the trust activities for the taxable year. Finally, any U.S. person that relieves (directly or indirectly) any distribution from a foreign trust is required to file a return to report the aggregate amount of the distributions received during the year.

The Senate amendment provides that if a U.S. owner of any portion of a foreign trust fails to appoint a limited U.S. agent to accept service of process with respect to any requests and summons by the Secretary of the Treasury in connection with the tax treatment of any items related to the trust, the Secretary of the Treasury may determine the tax consequences of amounts to be taken into account under the grantor trust rules. In cases where adequate records are not provided to the Secretary of Treasury to determine the proper treatment of any distributions from a foreign trust, the distribution is includible in the gross income of the U.S. distributee and is treated as an accumulation distribution from the middle year of a foreign trust (i.e., computed by taking the number of years that the trust has been in existence divided by 2) for purposes of computing the interest charge applicable to such distribution, unless the foreign trust elects to have a U.S. agent for the limited purpose of accepting service of process (as described above).

Under the Senate amendment, a person that fails to provide the required notice or return in cases involving the transfer of property to a new or existing foreign trust, or a distribution by a foreign trust to a U.S. person, is subject to an initial penalty equal to 35 percent of the gross reportable amount (generally the value of the property involved in the transaction). A failure to provide an annual reporting of trust activities will result in an initial penalty equal to 5 percent of the gross reportable amount. An additional $10,000 penalty is imposed for continued failure for each 30-day period (or fraction thereof) beginning 90 days after the Treasury Department notifies the responsible party of such failure. Such penalties are subject to a reasonable cause exception. In no event will the total amount of penalties exceed the gross reportable amount.

Effective date.—The reporting requirements and applicable penalties generally apply to reportable events occurring or distributions received after the date of enactment. The annual reporting requirement and penalties applicable to U.S. grantors apply to taxable years of such persons beginning after the date of enactment.

Reporting of foreign gifts

The Senate amendment generally requires any U.S. person (other than certain tax-exempt organizations) that receives purported gifts or bequests from foreign sources totaling more than $10,000 during the taxable year to report them to the Treasury Department. The threshold for this reporting requirement is indexed for inflation. The definition of a gift to a U.S. person for this purpose excludes amounts that are qualified tuition or medical payments made on behalf of the U.S. person, as defined for gift tax purposes (sec. 2503(e)(2)). If the U.S. person fails, without reasonable cause, to report foreign gifts as required, the Treasury Secretary is authorized to determine, in his sole discretion, the tax treatment of the unreported gifts. In addition, the U.S. person is subject to a penalty equal to 5 percent of the amount of the gift for each month that the failure continues, with the total penalty not to exceed 25 percent of such amount.

Effective date.—The provision applies to amounts received after the date of enactment.

Conference agreement

The conference agreement does not include the Senate amendment.

F. REPEAL OF FINANCIAL INSTITUTION TRANSITION RULE TO INTEREST ALLOCATION RULES

Present law

For foreign tax credit purposes, taxpayers generally are required to allocate and apportion interest expense between U.S. and foreign source income based on the proportion of the taxpayer's total assets in each location. Such allocation and apportionment is required to be made for affiliated groups (as defined in sec. 864(e)(5)) as a whole rather than on a subsidiary-by-subsidiary basis. However, certain types of financial institutions that are members of an affiliated group are treated as members of a separate affiliated group for purposes of allocating and apportioning their interest expense. Section 1215(c)(5) of the Tax Reform Act of 1986 (P.L. 99–514, 100 Stat. 2548) includes a targeted rule which treats a certain corporation as a financial institution for this purpose.

House bill

No provision.

Senate amendment

No provision. However, section 1606 of the Senate amendment to H.R. 3448 (Small Business Job Protection Act of 1996) contained a provision that repeals section 1215(c)(5) of the Tax Reform Act of 1986.

Effective date.—Taxable years beginning after December 31, 1995.

Conference agreement

The conference agreement includes the provision in the Senate amendment to H.R. 3448 with one modification. The conference agreement repeals section 1215(c)(5) of the Tax Reform Act of 1986 effective on the date of enactment. Under the conference agreement, a taxpayer will perform two computations with respect to its taxable year that includes the enactment date. Under the first computation, the taxpayer's pre-effective date interest expense is allocated and apportioned taking into account the targeted rule, and under the second computation, the taxpayer's post-effective date interest expense is allocated and apportioned without regard to the targeted rule. These computations will not require a closing of a taxpayer's books and records and it is intended that an

administratively simple approach be used in applying this rule.

BILL ARCHER,
BILL THOMAS,
TOM BLILEY,
MICHAEL BILIRAKIS,
WILLIAM F. GOODLING,
H.W. FAWELL,
HENRY HYDE,
BILL MCCOLLUM,
J. DENNIS HASTERT,
Managers on the Part of the House.

BILL ROTH
NANCY LANDON KASSEBAUM,
TRENT LOTT,
TED KENNEDY,
Managers on the Part of the Senate.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. BROWN of California) to revise and extend their remarks and include extraneous material:)

Mrs. COLLINS of Illinois, for 5 minutes, today.

Mr. STUPAK, for 5 minutes, today.

Ms. MILLENDER-MCDONALD, for 5 minutes, today.

Mr. BROWN of California, for 5 minutes, today.

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

(The following Members (at the request of Mr. DREIER) to revise and extend their remarks and include extraneous material:)

Mr. RIGGS, for 5 minutes, today.

Mr. METCALF, for 5 minutes, today.

Mr. FOLEY for 5 minutes, today and August 1.

Mr. TORKILDSEN, for 5 minutes, today and August 1.

Mr. MILLER of Florida, for 5 minutes, today.

Mr. DREIER, for 5 minutes, today and August 1.

(The following Member (at his own request) to revise and extend his remarks and include extraneous material:)

Mr. LONGLEY, for 5 minutes, today.

(The following Members (at his own request) to revise and extend his remarks and include extraneous material:)

Mr. LONGLEY, for 5 minutes, today.

EXTENSION OF REMARKS

By unanimous consent, permission to revise and extend remarks was granted to:

(The following Members (at the request of Mr. BROWN of California) and to include extraneous material:)

Mrs. COLLINS of Illinois.

Mrs. MINK of Hawaii.

Mr. EVANS.

Mr. SISISKY.

Mr. TORRES.

Mr. CLAY.

Mrs. MALONEY.

Mr. TORRICELLI.

Mr. FRAZER.

Mr. WYNN.

Mr. VENTO.

Mr. LIPINSKI.

Ms. VELÁZQUEZ.

(The following Members (at the request of Mr. DREIER) and to include extraneous matter:)

Mr. FIELDS of Texas.

Mr. DUNCAN.

Mr. DAVIS.

Mr. WOLF.

Mr. SCHIFF.

Mr. THOMAS.

Mr. SOLOMON in two instances.

Mr. ZELIFF.

Mr. SAXTON.

Mr. DORNAN.

Mr. HANSEN.

(The following Members (at the request of Mr. HASTERT) and to include extraneous matter:)

Mr. PAYNE of New Jersey.

Mr. BARCIA.

ADJOURNMENT

Mr. HASTERT. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 11 o'clock and 44 minutes p.m.), the House adjourned until tomorrow, Thursday, August 1, 1996, at 10 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XXIV, executive communications were taken from the Speaker's table and referred as follows:

4456. A letter from the Administrator, Agricultural Marketing Service, transmitting the Service's final rule—Dried Prunes Produced in California; Assessment Rate [Docket No. FV96–993–1 IFR] received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

4457. A letter from the Administrator, Agricultural Marketing Service, transmitting the Service's final rule—Onions Grown in Certain Designated Counties in Idaho, and Malheur, Oregon; Relaxation of Pack and Marketing Requirements [FV96–958–3 IFR] received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

4458. A letter from the Administrator, Agricultural Marketing Service, transmitting the Service's final rule—Almonds Grown in California; Assessment Rate [Docket No. FV96–981–2 IFR] received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

4459. A letter from the Congressional Review Coordinator, Animal and Plant Health Inspection Service, transmitting the Service's final rule—Horses from Mexico; Quarantine Requirements [Docket No. 96–052–1] received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

4460. A letter from the Chief, Programs and Legislation Division, Office of Legislative Liaison, Department of the Air Force, transmitting notification that the Commander of Air Force Space Command is initiating a multifunction cost comparison of portions of communications, civil engineering, information management, and services and personnel activities at Vandenberg AFB, CA, pursuant to 38 U.S.C. 5010(c)(5) (96 Stat. 1448); to the Committee on National Security.

4461. A letter from the Chief, Programs and Legislation Division, Office of Legislative Liaison, Department of the Air Force, transmitting notification that the Commander of Air Force Space Command is initiating a multifunction cost comparison of portions of communications, civil engineering, information management, and services and personnel activities at Peterson AFB, CO, pursuant to 38 U.S.C. 5010(c)(5) (96 Stat. 1448); to the Committee on National Security.

4462. A letter from the Chief, Programs and Legislation Division, Office of Legislative Liaison, Department of the Air Force, transmitting notification that the Commander of Air Force Space Command is initiating a multifunction cost comparison of portions of communications, civil engineering, information management, and services and personnel activities at Patrick AFB, FL, pursuant to 38 U.S.C. 5010(c)(5) (96 Stat. 1448); to the Committee on National Security.

4463. A letter from the General Counsel, Federal Emergency Management Agency, transmitting the Agency's final rule—National Flood Insurance Program; Assistance to Private Sector Property Insurers (RIN: 3067–AC26) received July 30, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Banking and Financial Services.

4464. A letter from the Managing Director, Federal Housing Finance Board, transmitting the Board's final rule—Modification of Definition of Deposits in Banks or Trust Companies [No. 96–48] received July 30, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Banking and Financial Services.

4465. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Accidental Release Prevention Requirements: Risk Management Programs Under Clean Air Act Section 112(r)(7) (FRL–5516–5) (RIN: 2050–AD26) received July 29, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

4466. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Approval and Promulgation of Implementation Plans; Illinois (FRL–5424–4) received July 29, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

4467. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Approval and Promulgation of Air Quality Implementation Plans; Pennsylvania Emission Statement Program (FRL–5427–2) received July 29, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

4468. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Interim Final Determination that State has Corrected the Deficiency; Ohio (FRL–5462–2) received July 9, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

4469. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Designation of Areas for Air Quality Planning Purposes; Michigan [MI45–01–7240a; FRL–5545–2] received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

4470. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Designation of Areas for Air Quality Planning Purposes; Illinois [IL146–1a; FRL–5540–6] received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

4471. A letter from the Director, Office of Regulatory Management and Information, Environmental Protection Agency, transmitting the Agency's final rule—Illinois: Final Authorization of Revisions to State Hazardous Waste Management Program (FRL–5544–9) received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

4472. A letter from the Chair, Federal Energy Regulatory Commission, transmitting the Commission's final rule—Standards for Business Practices of Interstate Natural Gas Pipelines [Docket No. RM96–1–000] received July 30, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

4473. A letter from the Chair, Federal Energy Regulatory Commission, transmitting the Commission's final rule—Oil Pipelines Cost-of-Service Filing Requirements [Docket No. RM96–10–000] received July 30, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce.

4474. A letter from the Director, Regulations Policy Management Staff, Office of Policy, Food and Drug Administration, transmitting the Administration's final rule—Medical Devices; Medical Device Distributor and Manufacturer Reporting; Certification, Registration, Listing, and Premarket Notification Submission; Stay of Effective Date; Revocation of Final Rule [Docket No. 91N–0295] (RIN: 0910–AA09) received July 30, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Commerce,

4475. A letter from the Assistant Legal Adviser for Treaty Affairs, Department of State, transmitting copies of international agreement, other than treaties, entered into by the United States, pursuant to 1 U.S.C. 112b(a); to the Committee on International Relations.

4476. A letter from the Acting Director, Office of Fisheries Conservation and Management, National Marine Fisheries Service Agency, transmitting the Service's final rule—Fisheries of the Northeastern United States; Framework Adjustment 8 Gear Restrictions [Docket No. 950615156–6193–02; I.D. 070196C] received July 30, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

4477. A letter from the Director, Office of Surface Mining, transmitting the Office's final rule—Wyoming Regulatory Program (shrub density stocking requirements and wildlife habitat) [SPATS No. WY–022] received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Resources.

4478. A letter from the Under Secretary of Commerce for Technology, Department of Commerce, transmitting the Department's final rule—Acquisition and Protection of Foreign Rights in Inventions; Licensing of Foreign Patents Acquired by the Government; Uniform Patent Policy for Rights in Inventions Made by Government Employees [Docket No. 960604157–6157–01] (RIN: 0692–AA15) received July 30, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on the Judiciary.

4479. A letter from the General Counsel, Department of Transportation, transmitting the Department's final rule—Airworthiness Directives; Boeing Model 767 Series Airplanes (Federal Aviation Administration) [Docket No. 96–NM–161–AD; Amendment 39–9695; AD 96–14–51] (RIN: 2120–AA64) received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4480. A letter from the General Counsel, Department of Transportation, transmitting the Department's final rule—Airworthiness Directives; British Aerospace Model BAe 146–100A, –200A, and –300A Series Airplanes (Federal Aviation Administration) [Docket No. 96–NM–162–AD; Amendment 39–9694; AD 96–14–09] (RIN: 2120–AA64) received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4481. A letter from the General Counsel, Department of Transportation, transmitting the Department's final rule—Amendment to Class E Airspace, Ames, IA (Federal Aviation Administration) [Airspace Docket No. 96–ACE–5] (RIN: 2120–AA66) received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4482. A letter from the General Counsel, Department of Transportation, transmitting the Department's final rule—Amendment to Class E Airspace, McCook, NE (Federal Aviation Administration) [Docket No. 96–ACE–8] received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4483. A letter from the General Counsel, Department of Transportation, transmitting the Department's final rule—Amendment to Class E Airspace, Russell, KS (Federal Aviation Administration) [Docket No. 96–ACE–7] received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4484. A letter from the General Counsel, Department of Transportation, transmitting the Department's final rule—Modification of Class E Airspace; Rice Lake, WI (Federal Aviation Administration) [Airspace Docket No. 95–AGL–19] received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4485. A letter from the General Counsel, Department of Transportation, transmitting the Department's final rule—IFR Altitudes; Miscellaneous Amendments (Federal Aviation Administration) [Docket No. 28621; Amdt. No. 397] received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4486. A letter from the General Counsel, Department of Transportation, transmitting the Department's final rule—Amendment to Definition of ''Substance Abuse Professional'' (RIN: 2105–AC33) received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4487. A letter from the General Counsel, Department of Transportation, transmitting the Department's final rule—Amendments to Laboratory Certification Requirements [OST Docket No. OST–96–1532] (RIN: 2105–AC37) received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4488. A letter from the General Counsel, Department of Transportation, transmitting the Department's final rule—Safety Zone: Cuyahoga River, Cleveland, OH (U.S. Coast Guard) [CGD09–95–018] received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4489. A letter from the General Counsel, Department of Transportation, transmitting the Department's final rule—Federal Motor Vehicle Safety Standards; Air Brake Systems; Long-Stroke Brake Chambers [Docket No. 93–54, Notice 3] (RIN: 2127–AG25) received July 31, 1996, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

4490. A letter from the Comptroller General of the United States, transmitting a report entitled ''Financial Audit: Federal Deposit Insurance Corporation's 1995 and 1994 Financial Statements'' [GAO/AIMD–96–89] July 1996, pursuant to 31 U.S.C. 9106(a); jointly, to the Committees on Government Reform and Oversight and Banking and Financial Services.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. LIVINGSTON: Committee on Appropriations. Revised subdivision of budget totals for fiscal year 1997 (Rept. 104–727). Referred to the Committee of the Whole House on the State of the Union.

Mr. CANADY: Committee on the Judiciary. H.R. 351. A bill to amend the Voting Rights Act of 1965 to eliminate certain provisions relating to bilingual voting requirements; with an amendment (Rept. 104–728). Referred to the Committee of the Whole House on the State of the Union.

Mr. SOLOMON: Committee on Rules. House Resolution 495. Resolution waiving points of order against the conference report to accompany the bill (H.R. 3734) to provide for reconciliation pursuant to section 201(a)(1) of the concurrent resolution on the budget for fiscal year 1997 (Rept. 104–729). Referred to the House Calendar.

Mr. GOSS: Committee on Rules. House Resolution 496. Resolution waiving points of order against the conference report to accompany the bill (H.R. 3603) making appropriations for Agriculture, Rural Development, Food and Drug Administration, and related agencies program for the fiscal year ending September 30, 1997, and for other purposes (Rept. 104–730). Referred to the House Calendar.

Ms. PRYCE: Committee on Rules. House Resolution 497. Resolution waiving points of order against the conference report to accompany the bill (H.R. 3517) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 1997, and for other purposes (Rept. 104–731). Referred to the House Calendar.

Mr. SOLOMON: Committee on Rules. House Resolution 498. Resolution waiving points of order against the conference report to accompany the bill (H.R. 3230) to authorize appropriations for fiscal year 1997 for military activities of the Department of Defense, to prescribe military personnel strengths for fiscal year 1997, and for other purposes (Rept. 104–732). Referred to the House Calendar.

Mr. PACKARD: Committee on Conference. Conference report on H.R. 3754. A bill making appropriations for the legislative branch for the fiscal year ending September 30, 1997, and for other purposes (Rept. 104–733). Ordered to be printed.

Mr. LINDER: Committee on Rules. House Resolution 499. Resolution providing for consideration of the bill (H.R. 123) to amend title 4, United States Code, to declare English as the official language of the Government of the United States (Rept. 104–734). Referred to the House Calendar.

Mr. GOSS: Committee on Rules. House Resolution 500. Resolution waiving a requirement of clause 4(b) of rule XI with respect to consideration of a certain resolution reported from the Committee on Rules (Rept. 104–735). Referred to the House Calendar.

Mr. HASTERT: Committee of Conference. Conference report on H.R. 3103. A bill to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for

other purposes (Rept. 104–736). Ordered to be printed.

PUBLIC BILLS AND RESOLUTIONS

Under clause 5 of rule X and clause 4 of rule XXII, public bills and resolutions were introduced and severally referred as follows:

By Mr. SHUSTER (for himself, Mr. DUNCAN, Mr. OBERSTAR, Mr. LIPINSKI, Mr. HUTCHINSON, Mr. BAKER of California, Mr. FRANKS of New Jersey, Mr. BLUTE, Mr. EHLERS, Mr. BACHUS, Ms. BROWN of Florida, Mr. LATHAM, Mrs. KELLY, Mr. LATOURETTE, Mr. MASCARA, Mr. LAZIO of New York, and Mr. LAHOOD):

H.R. 3923. A bill to amend title 49, United States Code, to require the National Transportation Safety Board and individual air carriers to take actions to address the needs of families of passengers involved in aircraft accidents; to the Committee on Transportation and Infrastructure.

By Mr. HORN (for himself and Mrs. MALONEY):

H.R. 3924. A bill to provide uniform safeguards for the confidentiality of information acquired for exclusively statistical purposes, and to improve the efficiency of Federal statistical programs and the quality of Federal statistics by permitting limited sharing of records for statistical purposes under strong safeguards; to the Committee on Government Reform and Oversight.

By Mr. DORNAN (for himself, Mr. HUNTER, Mr. CHAMBLISS, Mr. STEARNS, and Mr. CRANE):

H.R. 3925. A bill to amend title 10, United States Code, to restore the regulations prohibiting service of homosexuals in the Armed Forces; to the Committee on National Security.

H.R. 3926. A bill to amend title 10, United States Code, to require the separation from military service under certain circumstances of members of the Armed Forces diagnosed with the HIV–1 virus; to the Committee on National Security.

By Mr. EVANS (for himself, Mr. GUTIERREZ, Mr. FILNER, Mr. STOCKMAN, Mr. ACKERMAN, Mr. KILDEE, Mrs. THURMAN, Mr. FALEOMAVAEGA, Mr. FROST, Ms. MCKINNEY, Mr. JOHNSON of South Dakota, Mr. MCDERMOTT, and Mr. METCALF):

H.R. 3927. A bill to amend title 38, United States Code, to provide benefits for certain children of Vietnam veterans who are born with spina bifida, and for other purposes; to the Committee on Veterans' Affairs.

By Mr. FRANK of Massachusetts:

H.R. 3928. A bill to amend the Immigration and Nationality Act with respect to waiver of exclusion for certain excludable aliens; to the Committee on the Judiciary.

By Mr. STUMP (for himself, Mr. SHADEGG, and Mr. HAYWORTH):

H.R. 3929. A bill to direct the Secretary of the Interior to utilize certain Federal lands in Arizona to acquire by eminent domain State trust lands located in or adjacent to the other Federal lands in Arizona; to the Committee on Resources, and in addition to the Committee on Veterans' Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. TOWNS:

H.R. 3930. A bill to protect the personal privacy rights of insurance customers and claimants, and for other purposes; to the Committee on Commerce, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. VELAZQUEZ (for herself, Mr. RANGEL, Mr. SCHUMER, Mrs. MALONEY, Mr. MANTON, Mr. ACKERMAN, Mr. TOWNS, Mrs. LOWEY, Mr. FLAKE, Mr. NADLER, Mr. OWENS, Mr. SERRANO, Mr. ENGEL, Mr. GILMAN, Mr. HINCHEY, and Mr. KING):

H.R. 3931. A bill to amend the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 to require the development and implementation of a national financial crimes strategy to combat financial crimes involving money laundering and other related activities, and for other purposes; to the Committee on Banking and Financial Services, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. WISE:

H.R. 3932. A bill to amend title II of the Social Security Act to provide that the waiting period for disability benefits shall not be applicable in the case of a disabled individual suffering from a terminal illness; to the Committee on Ways and Means.

By Mr. WOLF (for himself, Mr. LIVINGSTON, Mr. SAM JOHNSON, Mr. DAVIS, Mr. BLILEY, Mr. GOODLATTE, Mr. MORAN, Mr. PAYNE of Virginia, Mr. BOUCHER, Mr. PICKETT, Mr. SISISKY, Mr. BATEMAN, and Mr. SCOTT):

H.R. 3933. A bill to authorize construction of the Smithsonian Institution National Air and Space Museum Dulles Center at Washington Dulles International Airport, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mr. ZELIFF (for himself, Mr. PAXON, and Mr. QUINN):

H.R. 3934. A bill to provide protections against bundling of contract requirements in Federal procurement; to the Committee on National Security, and in addition to the Committee on Government Reform and Oversight, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mrs. MALONEY (for herself, Mr. YATES, and Mrs. LOWEY):

H. Res. 501. Resolution calling upon the Government of Germany to negotiate in good faith regarding expansion of eligibility for Holocaust survivor compensation; to the Committee on International Relations.

MEMORIALS

Under clause 4 of rule XXII,

239. The SPEAKER presented a memorial of the Senate of the Commonwealth of Massachusetts, relative to momorializing Congress to require the Federal Railway Administration to postpone a ruling relative to the sounding of train whistles; to the Committee on Transportation and Infrastructure.

PRIVATE BILLS AND RESOLUTIONS

Under clause 1 of rule XXII,

Mr. HEFLEY introduced a bill (H.R. 3935) to authorize the Secretary of Transportation to issue a certificate of documentation with appropriate endorsement for employment in the coastwise trade for each of the vessels *High Hopes* and *High Hopes II;* which was referred to the Committee on Transportation and Infrastructure.

H.R. 249: Mr. WELDON of Pennsylvania.

H.R. 878: Mr. PALLONE and Mr. HOYER.

H.R. 1073: Mr. BEREUTER, Mr. TORRICELLI, Mr. CHRYSLER, Mr. WICKER, and Mrs. MYRICK.

H.R. 1074: Mr. BEREUTER, Mr. TORRICELLI, Mr. POMEROY, Mr. CHRYSLER, Mr. WICKER, and Mrs. MYRICK.

H.R. 1090: Mr. SMITH, of New Jersey.

H.R. 1309: Mr. FRAZER, Mr. GONZALEZ, Mr. TORRICELLI, Mr. GREEN of Texas, Mrs. CLAYTON, Mr. BROWN of Ohio, Mr. MASCARA, Mr. PARKER, and Ms. NORTON.

H.R. 1386: Mr. STEARNS.

H.R. 1389: Ms. McKinney.

H.R. 1406: Mr. MCKEON, Mr. HOBSON, and Mr. STOKES.

H.R. 1711: Mr. WICKER.

H.R. 1923: Mr. STEARNS.

H.R. 2011: Mrs. LOWEY, Mr. STOCKMAN, Mr. RANGEL, and Mr. COYNE.

H.R. 2193: Mr. POMBO.

H.R. 2270: Mr. BARR.

H.R. 2320: Mr. FARR.

H.R. 2472: Ms. NORTON and Ms. EDDIE BERNICE JOHNSON of Texas.

H.R. 2582: Mr. TAYLOR of North Carolina, Mr. MORAN, and Mr. FOX.

H.R. 2603: Mr. QUINN.

H.R. 2651: Mr. POMBO.

H.R. 2654: Mr. LAFALCE.

H.R. 2928: Mr. FUNDERBURK.

H.R. 3022: Mr. MARKEY, Mr. MASCARA, and Mr. PAYNE of Virginia.

H.R. 3047: Mr. CONDIT.

H.R. 3117: Mr. DELLUMS.

H.R. 3119: Mr. DELLUMS.

H.R. 3181: Mr. CLYBURN and Mr. DEFAZIO.

H.R. 3187: Mr. KENNEDY of Rhode Island and Mr. BOEHLERT.

H.R. 3195: Mr. SENSENBRENNER, Mr. TAUZIN, and Mr. COLLINS of Georgia.

H.R. 3202: Mr. CONYERS and Ms. WOOLSEY.

H.R. 3207: Ms. KAPTUR.

H.R. 3211: Mr. CALVERT and Mr. WICKER.

H.R. 3226: Mr. YATES.

H.R. 3251: Mr. CAMP.

H.R. 3374: Mr. COBURN and Mr. SMITH of New Jersey.

H.R. 3391: Mrs. VUCANOVICH.

H.R. 3401: Ms. PRYCE, Mr. CONDIT, and Mr. DORNAN.

H.R. 3430: Mr. WISE, Mr. BLILEY, Mr. SCARBOROUGH, Mr. BREWSTER, and Mr. ABERCROMBIE.

H.R. 3467: Mr. NETHERCUTT.

H.R. 3498: Mr. MARTINEZ and Mr. SPRATT.

H.R. 3565: Mrs. SEASTRAND.

H.R. 3578: Mr. DELLUMS.

H.R. 3633: Mr. BURR.

H.R. 3636: Ms. PRYCE.

H.R. 3645: Mr. GREENWOOD, Mr. REGULA, Mr. PASTOR, Mr. GUTIERREZ, Ms. FURSE, and Mr. KENNEDY of Rhode Island.

H.R. 3654: Mr. LAHOOD, Mr. JOHNSON of South Dakota, Mr. KLUG, and Mr. MEEHAN.

H.R. 3688: Mr. COYNE and Mr. DURBIN.

H.R. 3714: Mr. FRANK of Massachusetts, Mr. ROGERS, and Mr. CLYBURN.

H.R. 3747: Mr. TORRES, Mr. MCDERMOTT, Mrs. MEEK of Florida, and Mr. BEILENSON.

H.R. 3790: Mr. CHRISTENSEN.

H.R. 3830: Mr. OWENS, Mr. SANDERS, Mr. FRAZER, Mr. HASTINGS of Florida, and Mr. STUDDS.

H.R. 3849: Mr. GILLMOR.

H.R. 3863: Mr. ROHRABACHER, Mr. EWING, Mr. WATTS of Oklahoma, Ms. GREENE of Utah, Mr. PALLONE, Mr. GREEN of Texas, Mr. HOLDEN, and Mr. FLAKE.

H.R. 3902: Mr. POMEROY.

H.R. 3905: Mr. HUTCHINSON.

H.J. Res. 97: Ms. DELAURO and Mr. MILLER of California.

H.J. Res. 114: Ms. DELAURO.

H. Con. Res. 100: Mr. WICKER.

H. Con. Res. 200: Mr. DEFAZIO, Mr. DORNAN, Mr. POMBO, Mr. STEARNS, Mr. TORRICELLI, Mr. HAYWORTH, Mr. KLECZKA, Mrs. KENNELLY, Mr. MCNULTY, Mr. EVERETT, Mr. LIPINSKI, Mr. HASTINGS of Florida, Mr. SHADEGG, Mr. LIVINGSTON, Mr. TANNER, Mr. MONTGOMERY, Mr. MCCOLLUM, Ms. MILLENDER-MCDONALD, and Mr. SPRATT.

H. Res. 470: Mr. FRANKS of Connecticut, Mr. CAMPBELL, Ms. FURSE, and Mr. LIPINSKI.

H. Res. 478: Ms. GREENE of Utah and Mr. BOUCHER.