Today, it has grown into the largest Valley-based bank with nearly $387 million in assets and more than 230 employees with nine branches and eight specialty credit centers.

Community Health Systemso Fresno is a $400 million-a-year organization that employs more than 4,700 people and has a medical staff of more than 1,100 physicians. Its chief executive officer is Dr. J. Philip Hinton.

Duncan Enterprises of Fresno makes paint and other items for hobbyists. The company expects a 37 percent growth in sales this fiscal year. Duncan Enterprises has been a fixture in Fresno for many years. The company brought the assets of a Massachusetts company and planned to move its operations to Fresno over six months. It worked with the production employees of the company to allow them to stay employed during the phase-out of the operation, while also coordinating training for them in resume writing and interviewing skills.

Valley Public Television of Fresno has operated the San Joaquin Valley's only public television station from its Fresno studios since 1977. It has continued over the years to provide services and programs to meet the diverse demands of the changing community. Colin Dougherty serves as the general manager and executive director of the station.

Denham Personnel Services of Fresno was founded 28 years ago by B. G. ''Bud'' and Jean Denham. It started off as a single office and has grown to include offices in Madera and Selma and a full-time staff of 14. On every working day of the year, an estimated 200–300 people in the Valley get up and go to work because they have been placed in jobs by Denham Personnel Services.

Sherwood Lehman Massucco, Inc. of Fresno is an executive search firm that has been finding top management talent for companies located in Central California since 1978. The firm believes in recruiting locally if possible, but has extensive experience in nationwide searches when the best candidate is not available in the Valley.

Pearson Realty of Fresno was founded in 1919 and has become one of the largest independently owned commercial real estate firms in the Valley. Its farm division is the largest in California and possibly the nation. The company pays a portion of net profit back to employees in the form of bonuses.

Gottschalks, Inc. of Fresno was founded in 1903 in downtown Fresno by Emil Gottschalk. The regional retailer has grown to 37 department stores and 22 specialty stores employing more than 5,500 people at sites in California, Nevada, Washington and Oregon. It is the only Central Valley-based company traded on the New York Stock Exchange, going public in 1986.

Hall of Fame winner, Marilyn Hamilton of Fresno had a sudden turn of events in her life almost 20 years ago when she became paralyzed in a hang-gliding accident. Frustrated by the clunky design of her wheelchair, Hamilton and two hangglider friends built their own lightweight chairs. They formed Motion Designs, which was bought by Sunrise Medical in 1986. Hamilton is now vice president of consumer development at Sunrise, and the Quickie wheelchair she designed has become an industry leader.

Mr. Speaker, it is with great honor that I congratulate these fine businesses and business leaders in the community. These exceptional businesses and business leaders were honored for their unique contributions to the business community and exemplary business skills. I ask my colleagues to join me in wishing Kuckenbecker Tractor of Madera, Boys and Girls Clubs of Fresno County, Bank of the Sierra of Porterville, Community Health System of Fresno, Duncan Enterprises of Fresno, Valley Public Television of Fresno, Denham Personnel Services of Fresno, Sherwood Lehman Massucco, Inc., Pearson Reality of Fresno, Gottschalks Inc. of Fresno, and Hall of Fame winner, Marilyn Hamilton of Fresno many more years of continued success.

CLASSIFICATION OF NATURAL GAS GATHERING LINES

HON. SAM JOHNSON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 20, 1998

Mr. SAM JOHNSON of Texas. Mr. Speaker, today I have introduced legislation, H.R.—to provide much needed certainty with respect to the proper depreciation classification of natural gas gathering lines. Natural gas gathering lines play an integral role in the production and processing of natural gas as they are used to carry gas from the wellhead to a gas processing unit or interconnection with a transmission pipeline. In many instances, the gathering network for a single gas field can consist of hundreds of miles and represents a substantial investment for natural gas processors.

The proper depreciation classification for specific assets is determined by reference to the asset guideline class that describes the property. Asset class 13.2, subject to a 7-year cost recovery period, clearly includes:

> . . . assets used by petroleum and natural gas producers for drilling wells and production of petroleum and natural gas, including gathering pipelines and related production facilities.

Not only are gathering lines specifically referenced in asset class 13.2, but gathering lines are integral to the extraction and production process. Nonetheless, it has come to my attention that some Internal Revenue Service auditors now seek to categorize natural gas gathering lines as assets subject to a 15-year cost recovery period under asset class 46.0, titled ''Pipeline Transportation.''

Over the past several years, I have corresponded and met with officials of the Department of Treasury seeking clarification of Internal Revenue Service policy and the issuance of guidance to taxpayers as to the proper treatment of these assets for depreciation purposes. These efforts have been to no avail. In the meantime, the continued controversy over this issue has imposed significant costs on the gas processing industry on audit and in litigation, and has resulted in a division of authority among the lower courts as to the proper depreciation of these assets. While it is not my intent to interfere with ongoing litigation, I do believe that legislation is needed to clarify the treatment of these assets under the Internal Revenue Code in order to provide certainty to the industry for tax planning purposes, and to avoid costly and protracted audits or litigation.

Accordingly, I have introduced legislation that would amend the Internal Revenue Code to specifically provide that natural gas gathering lines are subject to a 7-year cost recovery period. While I believe that this result should be axiomatic under existing law, this bill would eliminate any uncertainty surrounding the proper treatment of these assets. The bill also includes a proper definition of ''natural gas gathering lines'' to distinguished these assets from pipeline transportation for purposes of depreciation.

I urge my colleagues to support this important legislation.

H.R. —

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. NATURAL GAS GATHERING LINES TREATED AS 7-YEAR PROPERTY.

(a) IN GENERAL.—Subparagraph (C) of section 168(e)(3) of the Internal Revenue Code of 1986 (relating to classification of certain property) is amended by redesignating clause (ii) as clause (iii) and by inserting after clause (i) the following new clause:

''(ii) any natural gas gathering line, and''.

(b) NATURAL GAS GATHERING LINE.—Subsection (i) of section 168 of such Code is amended by adding at the end the following new paragraph:

''(15) NATURAL GAS GATHERING LINE.—The term 'natural gas gathering line' means the pipe, equipment, and appurtenances used to deliver natural gas from the wellhead to the point at which such gas first reaches—

''(A) a gas processing plant,

''(B) an interconnection with an interstate natural-gas company (as defined in section 2(6) of the Natural Gas Act), or

''(C) an interconnection with an intrastate transmission pipeline.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to property placed in service before, on, or after the date of the enactment of this Act.

ON THE SPEAKER'S VISION FOR HEALTH IN THE 21ST CENTURY

HON. RICHARD K. ARMEY

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 20, 1998

Mr. ARMEY. Mr. Speaker, I would like to insert in the record a transcript of a recent speech on the subject of health in the 21st century by the Speaker of the House, the gentleman from Georgia, Mr. GINGRICH.

As is so often the case, this speech by the gentleman, given to the American Association of Health Plans in mid-February, is full of insight.

At a time when the liberals and some doctors' associations are pressing for new government mandates on health insurance companies, and President Clinton is trying to achieve socialized medicine incrementally, it is important that we step back, as the Speaker wisely observes, and rethink the whole question of how to improve health and not just health care or health insurance.

In the coming health-care revolution, which promises to be an age of highly informed consumers and entrepreneurial doctors and insurers coming together to provide ever greater quality for customers at ever lower cost—in such an age the old prescriptions of regulation and mandates will be shown for the anachronisms they really are.

America's health-care system, for all its many faults, is still the best system in the

world when it comes to the quality of our doctors, our drugs, our devices, our treatments, our techniques, and our technologies.

But all of that progress would be threatened by the Democrats' ''Patients' Bill of Rights Act,'' H.R. 3605. This bill puts me in mind of medieval barbers applying leeches. It is one of the more misguided, irresponsible, and politically inspired bills I have seen. It is a breathtaking collection of costly mandates and grants of bureaucratic power. It would regulate the health insurance industry in every imaginable way. It would eliminate all but the most restrictive HMOs. It would enable nurses and doctors to go on strike. It would divert scarce health resources to lawyers and bureaucrats. It would make insurance unaffordable for millions of working Americans. It would swell the ranks of the uninsured. And it would impose innovation-stifling restrictions on the practice of medicine, just to name a few of its likely effects.

Happily, I have confidence that this Congress is not going to pass this backward bill, or anything like it. Members are increasingly aware of the dangers of such politically inspired legislation, and will, I think, warmly embrace the happier, freer vision for health in America outlined in the address of the gentleman from Georgia. I commend that address to the attention of all of my colleagues.

''HEALTH CARE REFORM IN 1998: WHAT CAN WE EXPECT FROM THE 105TH CONGRESS?''—KEYNOTE ADDRESS BY NEWT GINGRICH, AAHP 1998 POLICY CONFERENCE, FEBRUARY 22, 1998

Let me tell you where I think we are on health, and I want to start with a very simple planning model of eight words. I want to share this model with you because I think it's the heart of our current challenge in health. It's four words that are a hierarchy and then four words that are a straight line. The top word is ''vision,'' and I think this is the place we most have failed. What is our vision of America's future in health? And notice, I didn't say ''health care.'' I think when you say ''health care,'' you've already come down a layer of detail.

Our interests ought to be health and then, secondarily, health care. Take the example of diabetes. We know there are Indian tribes that have 50 percent diabetes rates. If we could save 45 of that 50 percent from needing kidney dialysis, we would lower the cost of health care because we would increase health. So it's very important at the vision level what words do you use, what do they mean, because that then defines all the other layers.

The second layer is strategies. What are your strategies for getting something done? For example, I am passionate about preventive care and wellness, and one of our strategies in Medicare reform was to begin to move towards more early screening, more preventive care, which we believe will ultimately save money, but is scored in this city as a cost. The Centers for Disease Control estimates if you had really effective screening and education on diabetes, it would save $14 billion a year. Yet you cannot get the Congressional Budget Office or the Office of Management and Budget to score that.

The third level is a project, and a project in this model is the real building block of management, but it's an entrepreneurial model, so I want to give you a definition. A project is a definable, delegatable achievement. That's a very important distinction.

The bottom line is tactics. What do you do every day? And tactics relate directly back to the top. For example, if you're interested in preventive care and wellness, one of the things you do every day to remind people that they have an obligation to check at least once a year to see how they are doing. One of the things you try to figure out is to remind diabetics they have an obligation every day, several times a day, to check their blood sugar, so that it's a very different model than the model we've traditionally had.

Now, coming off of tactics, I put four words in a straight line because they are a process; that is, they are not a hierarchy. They are all equally important, but they occur in a sequence, the words which we use for what we think is the essence of leadership, and they are very simple, but I think they apply directly to the challenge you all face: listen, learn, help, and lead. Now, we figured out in a democracy in the Information Age, the first job of leadership is to listen.

Now, we put ''learn'' second because we discovered two interesting phenomena about Americans. Americans will spend a lot of time with their eyes glazed over standing next to somebody at a cocktail party while that person babbles. That is not listening; that's patience. We also discovered that most Americans have a habit of paying very careful attention to their own arguments. If you get in an argument, you really listen to yourself when you argue. When it's the other person's turn, you pretend to listen, but you're actually restructuring your own argument. That's not listening; that's cheating.

What we are trying to do is what consultants describe as appreciative understanding. You have to understand what the other person is saying and appreciate why it is true for them. You don't have to agree with them. You don't have to sympathize, but you have to understand what they are saying. So you haven't finished your listening/learning phase until you know what they are saying and why they think it makes sense, even if you don't.

Now, in a rational world, as a general principle, if somebody will listen to you and learn from you, you help them. First of all, because they ventilate. You help them, second, because you put them in that position where you might ask them good questions, so they think thoughts they never had before; you open them up. You might have ideas they didn't have. You may have information to empower them that they didn't have. You may actually have authority or resources you can give to them.

In a rational world, if somebody knows you will listen to them, learn from them, and help them, they will ask you to lead. Now, what I usually do is I draw a line, then, from the word ''lead'' back up to ''vision.'' You then say: Here is my vision, here are my strategies, here are my projects, here are my tactics, and you immediately go back to listen and say, what do you think of them? Now I think that model applies exactly to where we are in health in America today.

Now, let me tell you the mistake I think we all make. When the Clinton administration came in, they saw a charge, which is very real, which is that we need to rediscuss health in America. Notice, I didn't say ''health care.'' This is going to be one of my first real efforts at redefining this dialogue. We should not talk about health care in America until we first finish talking about health in America, because they are not the same topic. And the minute you get into health care, you're already in a narrower and smaller future than if you start by discussing health, a subset of which is health care.

And I think the president was right in 1993 to say we need a dialogue. I think he was wrong in offering a solution that was a failed, centralized, bureaucratic model of control. And the country, after it thought about it for a year, decided that was the wrong answer. But I think where we all collectively failed is that at that point what we should have said is, okay, now can we go back to the original dialogue? And instead, what happened was all the folks were very busy. Everybody went back to their own game, most of which are at the level of a tactic or a project. So there is almost no vision-level discussion in America about health. And yet the most objective fact about health in America is that it is an obsolete model of delivery based on, first, you have to get really sick.

We need to return to the overall dialogue on health. Let me give you a very simple premise for that dialogue. The National War Labor Board, in 1943, for totally wartime-related, wage-and-price-control reasons, created the tax incentive and the way we now structure third-party payments. And this is entirely an artificial artifact. It makes no sense. If you were to actually sit down and say, let's design health for America, you would not say, if you pay all your own health costs, you get no tax deduction until seven percent of your income has been spent, but if you will go and work for a company, you can get a 100 percent. By the way, if you're self-employed, you won't get the 100 percent. It is all a historical anachronism.

In this national dialogue on health, we need to start with basic health research. We need to look at things like the National Institutes of Health database MEDLINE and the ability to create a computer-based system where any patient anywhere in the country can get access to any information, which is, frankly, going to drive doctors nuts because it's going to mean they are going to have patients with specialized diseases who know more about the state of the art than they do, and you're going to have a patient-led information system.

And the real reason we are having a fight over HMOs has nothing to do with quality of care; it has to do with power. This is a country which hates concentrations of power, and in a very real sense HMOs are suffering from the same challenge that any other concentration of power suffers from. Americans hate to be controlled. Remember, we did have a flag in the Revolutionary War on which was a snake, and which said: ''Don't tread on me.'' It's very close to the American model.

There is a wonderful new history by Paul Johnson called ''A History of the American People,'' which I recommended to all of you; he really captured the heart of American civilization. One of his lines is that in 1775, we were possibly the lowest taxed people in the history of the world, and we hated every penny. There was no sense of gratitude.

Now, the reason I'm suggesting this is, we are trying to design a health system for Americans. Americans believe it is their natural right, that they are endowed by their creator with the right to have total access, with the right to question any authority figure, with the right that if they don't like the first diagnosis, they get a second one. They need a ventilation point that is an authority figure that they can go to beat up the other authority figure that they are mad at. We need to ask: What are the patients' rights? What are their responsibilities? Do they agree those are their rights and their responsibilities? What's their ventilation point?

There is a power struggle between medical professionals and administrators, and that's a big part of what's happening with the HMOs because every time the medical doctor is mad, he or she explains to the patient that it's the HMO's fault. Or every time they can't do something the patient wants, they say, ''I would, but they won't let me.'' And so you have a real power struggle.

If you look, for example, at the PARCA bill, it is largely a design of all the professionals who now want their share of the pie, and it's their version of how they would redesign it if health care was a pork-barrel project. But what you need to understand is, that is a natural partner of historic evolution once you politicize these decisions.

I'm not up here today to say anybody is right. I'm up here today saying let's look at the whole country. The M.D. is going to be threatened because the truth is we can begin to turn into expert systems. We can begin to have more preventive care. We can begin to have more patient responsibility. We can begin to have more information to the patient.

All of that is going to threaten the medical doctor. But their problem now is going to be science and the Information Age, not the HMO administrator. The HMO administrator must recognize that if you don't have a very high-quality response, if you're not very customer oriented, and if you haven't built a very good response system for your customer so that they have a ventilation point where they can get a second opinion, where they can appeal to a higher authority against the authority that's made them mad, you're guaranteed to get political action; that the only way to avoid political action is to have a self-fine-tuning, a self-responding, and a self-evolving system that is customer-friendly and consumer oriented.

In addition, I would argue that if we are really at the vision level talking about the future of health in America, it's likely to be a different system than anything we've seen, that the ideal model is one that goes back to dramatically strengthening the patient, that the patient ought to have a lot more choices and more responsibilities.

I've always like the International Paper model where they list every doctor in the area and every hospital in the area, and they say, here is how much they cost, and here is their background, and, by the way, we'll pay 100 percent of the median price. Go to anybody you want to. Now, if you want to go to a more expensive doctor, fine, you pay the additional costs. But it begins to dramatically transfer knowledge and power and responsibility.

Dr. Tom Coburn, who serves as a Member of Congress for Oklahoma, came up to me at our retreat in Williamsburg, and he said, I think we ought to reapply free-markets principles to health care; and being a conservative, I promptly said, yes, what do you mean? I know it's right theoretically. I know Adam Smith is right theoretically, but what does it mean in the middle of this 1943 tax code, third-party payment, highly convoluted, big structure, HMO, provider-sponsored network, hospital-based, doctor-based, secondary professions—in this mess, this huge, complex ecosystem of health, what does ''free market'' mean?

He said, I'll tell you a true story. He said, during the break, I had a couple who were between jobs and they had lost their health coverage, but they had savings. She needed an operation. I gave her five surgeons and three hospitals to call. They negotiated. They got an $11,000 procedure for $5,000, but they paid in cash without paper work.

Now, that's a fairly astonishing number. My guess is all of you could find similar stories or already know similar stories. From my standpoint, what I want to do is say, so how do we maximize the rate of change? Because what the human genome projects is telling you and what lasers are telling you and what all the other breakthroughs are telling you is you're going to see a rate of change in health capabilities. And, again, I don't want to talk about health care yet. You're going to see a rate of change in health capabilities that is stunning.

So how do we maximize that rate of change? How do we maximize the citizens' access to knowledge, including their knowledge about their own responsibilities and knowledge about their own characteristics and knowledge about how to stay well rather than get sick? How do we maximize the ability to connect the citizen to the professional at the minimum cost with the maximum choice? How do we create feedback loops, both so that we know it's the right professional, and so if something goes wrong, we can check on it?

And if you could tomorrow morning take your HMO or take your health organization and find a way to have 100-percent deductibility for health, so that a person who paid out of their own pocket had exactly the same deductibility as a big corporation and said to all of your members, ''Here is basically a cafeteria plan. Which of these nine things do you like better?'' you would lose some of your mass purchasing power, but you would put back on their shoulders their responsibility. So you like the HMO? Fine. Come in and join one. You would rather go and buy it all on your own? Fine. Go buy it all on your own.

And what I'm suggesting is that where we need your help is not only doing better, and a lot of you represent some of the most enlightened and most aggressive and most patient-oriented and also most health-research-oriented people in the country. But I'm also asking you to take a little extra time, go back up to the vision level. Help us solve the big issues. Help us think about what do we mean in the 21st century by health in America. What should a citizen have access to? How do we maximize the rate of change?

And I'll just close with this thought. Health is not a problem. Health is an opportunity. Health will be the largest, foreign-exchange, income earner in the 21st century. If we have the best system of health on the planet, if we have the best research on the planet, if we provide the best care on the planet, as people get wealthier worldwide, they will come to America, either personally, or by electronic means, in order to have access to the finest health in the world.

We will earn far more money out of providing the best health capabilities on the planet than we will earn out of the motion picture industry, jet airplanes or computers, and we ought to see health as that opportunity—the opportunity to provide the best health for our own citizens and to provide the highest-paying jobs on the planet in a growth industry of enormous potential if we maximize the rate of change and innovation and bring to bear the best science we can as rapidly as we can.

And if we then educate our citizens into a knowledge-based model of caring for themselves, we will maximize their health and minimize their costs, and we will do so in a way that I think will be profoundly different than the current debate between more bureaucracy-less bureaucracy, more trial lawyers-fewer trial lawyers, and I think we need this much larger level dialogue in order to define where we want to go over the next 15 or 20 years.

DRUG-FREE AMERICA TASK FORCE AWARENESS

HON. GEORGE R. NETHERCUTT, JR.

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 20, 1998

Mr. NETHERCUTT. Mr. Speaker, as a Member of the Drug-Free America Task Force, I have had the opportunity to meet with numerous organizations and individuals interested in finding ways to reduce drug use. One of the studies that caught my attention was a study by the Center on Addiction and Substance Abuse. It stated that a 12-year-old who smokes marijuana is roughly 80 times more likely to use cocaine than one who does not, adults who as adolescents smoked marijuana are 17 more times likely to use cocaine regularly, and 60 percent of adolescents who use marijuana before age 15 will later use cocaine.

It seems to me, Mr. Speaker, that the key to reduce overall drug use is to find ways to curtail the number of our children who use drugs. As a parent, I realize that the lifestyle decisions my wife and I make will impact our children. Our children are fortunate that they have had a good example set for them, but there are many kids whose parents or other role models send them the wrong message that drugs are acceptable by their own drug use. I believe the government has an obligation to punish more severely those who influence the children of America by using or possessing drugs in their presence.

Mr. Speaker, the Save Our Children Act, which I am introducing today, sends a strong message that drug use or possession of drugs around children will not be tolerated. Under current law, there are enhanced penalties for the distribution of a controlled substance to persons under age 21 by persons over age 18 (21 U.S.C. 859); employment of persons under age 18 for violation of the Controlled Substance Act or unauthorized distribution to a pregnant individual (21 U.S.C. 861) and distribution or manufacturing of a controlled substance in or near schools, colleges or youth-centered recreational facilities (21 U.S.C. 860).

The Save Our Children Act, Mr. Speaker, fills a gap in our Sentencing Guidelines by directing the U.S. Sentencing Commission to enhance the sentences for the commission of a drug offense in the presence of a minor. While the Sentencing Commission is given discretion to amend the Sentencing Guidelines, the Save Our Children Act sets a minimum of two offense levels greater or 1 year whichever is greater for the first offense, and 4 offense levels greater or 2 years for a second offense.

I urge all my colleagues to consider becoming a cosponsor of my legislation.

WEST LIBERTY CLASSICAL ACADEMY HONORED BY DEPARTMENT OF EDUCATION

HON. WILLIAM J. COYNE

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 20, 1998

Mr. COYNE. Mr. Speaker, I rise to commend the students, faculty, and administration of West Liberty Classical Academy, whose outstanding performance was recently honored by the Department of Education and the National Association of State Coordinators of Compensatory Education. West Liberty is one of only 109 schools nationwide to be recognized by the Title I Recognition Program. The Title I Recognition Program honors schools that have set and reached high student achievement goals, fostered professional development, and built partnerships with parents and the community.